No. 09-837

IN THE
Supreme Court of the United States

MAYO FOUNDATION FOR MEDICAL EDUCATION AND RESEARCH; MAYO CLINIC; AND REGENTS OF THE UNIVERSITY OF MINNESOTA,

Petitioners,

v.

UNITED STATES,

Respondent.

On Writ Of Certiorari
To The United States Court of Appeals
For The Eighth Circuit

BRIEF FOR THE AMERICAN HOSPITAL ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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The American Hospital Association ("AHA") respectfully submits this brief as *amicus curiae* in support of Petitioners.[1]

INTEREST OF *AMICUS CURIAE*

The AHA is a national not-for-profit association that represents the interests of roughly 5,000 hospitals, health care systems, networks, and other care providers, as well as 37,000 individual members. The members of the AHA are committed to finding innovative and effective ways of improving the health of the communities they serve. The AHA educates its members on health care issues and trends, and it also advocates on their behalf in legislative, regulatory, and judicial fora to ensure that their perspectives and needs are understood and addressed. The AHA's members include teaching hospitals that sponsor medical residency programs as well as other participants in the health care field that benefit from the existence of a robust cadre of teaching hospitals. The AHA therefore has a significant interest in the validity of the Treasury Department's regulation deeming all medical residents to be categorically excluded from coverage under the "student" exemption from Social Security taxes codified in 26 U.S.C. § 3121(b)(10).

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[1] The parties have consented to the filing of this brief and their letters of consent are on file with the Clerk. No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person other than *amicus*, its members, or its counsel made a monetary contribution to its preparation or submission.

SUMMARY OF ARGUMENT

Nationwide, the amount of Social Security taxes levied each year for medical residents is estimated to be approximately $700 million. Pet. 20. On April 1, 2005, a Treasury Department regulatory amendment went into effect that categorically excludes medical residents from Social Security's "student" exemption, simply because residents, in addition to the lectures, conferences, and other types of more formal classroom education that they receive, perform at least 40 hours a week of supervised patient care. *See Mayo Found. for Med. Educ. & Research v. United States*, 568 F.3d 675, 676-78 (8th Cir. 2009) ("*Mayo III*"). The amendment thus forecloses teaching hospitals from demonstrating that their residents are nonetheless properly characterized as "students" under the longstanding regulatory definition, which otherwise takes account of all relevant facts and circumstances and does not place dispositive significance on the hours spent performing services. *See id.* Notably, when teaching hospitals and the Government have litigated the specific issue whether medical residents fall within the longstanding definition notwithstanding their long hours of supervised patient care, courts appear to have uniformly ruled in favor of the hospitals. In short, the amended regulation subjects teaching hospitals to Social Security taxation based upon an arbitrary and immaterial fact.

Consequently, the practical effect of the amended regulation is to "divert the scarce resources of our country's teaching hospitals and medical schools from their crucial missions of patient care, physician training, and medical research" in a manner that

Congress did not intend, 15 U.S.C. § 37b(a)(1)(E)—the same type of diversion that Congress deemed so deleterious in 2004 that it passed special legislation shielding teaching hospitals from antitrust lawsuits challenging the matching process those hospitals used to select residents, *id.* § 37b(b). Notably, since 2004, the economic climate has simultaneously rendered the myriad services our nation's hospitals provide for their communities all the more "crucial" and the resources of those hospitals even more "scarce." Teaching hospitals are, among other things, a critical part of the safety net protecting indigent patients in need of health care and health education, yet the economic downturn has increased the size of the population in need of such protection while challenging the ability of hospitals to continue providing such protection.

For the foregoing reasons, it is of vital importance that this Court reverse the judgment of the Eighth Circuit and invalidate the Treasury Department's arbitrary regulation.

ARGUMENT

I. THE TREASURY DEPARTMENT'S CATEGORICAL EXCLUSION OF MEDICAL RESIDENTS FROM THE "STUDENT" EXEMPTION IS ARBITRARY

In 1939, Congress exempted from Social Security taxation under the Federal Insurance Contributions Act any "service performed in the employ of a school, college, or university" by a "student who is enrolled and is regularly attending classes at such school, college, or university." 26 U.S.C. § 3121(b)(10). For over sixty years, the Treasury Department's regulation implementing the "student" exemption

essentially instructed that "student" status should be determined "on the basis of the relationship of [the] employee with the organization for which the services are performed" and that "[a]n employee who performs services … as an incident to and for the purpose of pursuing a course of study ... has the status of a student in the performance of such services." *See* 26 C.F.R. § 31.3121(b)(10)-2(c) (pre-Apr. 1, 2005).

That regulation required a case-specific inquiry into all of the relevant "facts and circumstances" concerning a putative student's employment. *See Mayo Found. for Med. Educ. & Research v. United States*, 503 F. Supp. 2d 1164, 1176 n.12 (D. Minn. 2007) ("*Mayo II*"), *rev'd on other grounds by Mayo III*; *see also United States v. Mount Sinai Med. Ctr. of Fla., Inc.*, 486 F.3d 1248, 1253 (11th Cir. 2007) ("case-by-case analysis is necessary to determine whether a medical resident … qualifies for … the student exemption"); *Univ. of Chi. Hosps. v. United States*, 545 F.3d 564, 570 (7th Cir. 2008) ("case-by-case analysis is required to determine whether medical residents qualify for the [student] exemption"); *United States v. Detroit Med. Ctr.*, 557 F.3d 412, 417-18 (6th Cir. 2009) ("need to know what the residents in the program do and under what circumstances"); *United States v. Mem'l Sloan-Kettering Cancer Ctr.*, 563 F.3d 19, 28 (2d Cir. 2009) ("particularized review [necessary] of whether … medical residents [at issue] qualify for the student exclusion").

A. Courts Have Uniformly Ruled That Medical Residents Are Students Under The Case-Specific "Facts And Circumstances" Inquiry

Of critical importance here, when teaching hospitals have litigated this case-specific issue against the Government in the context of medical residents, courts have *uniformly* ruled in their favor in every case of which the AHA is aware. *See United States v. Mayo Found. for Med. Educ. & Research*, 282 F. Supp. 2d 997 (D. Minn. 2003) ("*Mayo I*"); *Regents of the Univ. of Minnesota v. United States*, No. 06-5084, 2008 WL 906799 (D. Minn. Apr. 1, 2008) (*"Regents*"), *rev'd on other grounds by Mayo III*; *United States v. Mount Sinai Med. Ctr. of Fla.*, No. 02-22715, 2008 WL 2940669 (S.D. Fla. July 28, 2008) ("*Mt. Sinai*"); *Ctr. for Family Med. v. United States*, No. 05-4049, 2008 WL 3245460 (D.S.D. Aug. 6, 2008) ("*CFM*"); *see also Minnesota v. Chater*, No. 4-96-756, 1997 WL 33352908 (D. Minn. May 21, 1997), *aff'd sub nom. Minnesota v. Apfel*, 151 F.3d 742 (8th Cir. 1998) (involving analogous student exemption under the Social Security Act). In finding that the "student" exemption applied to medical residents, these courts generally emphasized the same basic points.

First, post-medical-school residency programs provide critical substantive education. They are "organized according to comprehensive, educational curricula, as dictated and approved by … pertinent accrediting bod[ies] and other prevailing educational standards." *Mt. Sinai*, 2008 WL 2940669, at *15. The "curricul[a]" of these programs include numerous types of conventional classroom-style learning, such as reading relevant "textbooks and

journal articles," attending "lectures and conferences," taking "examinations," and receiving "grade[s]" on overall "performance." *Mayo I*, 282 F. Supp. at 1004, 1016; *see also Mt. Sinai*, 2008 WL 2940669, at *16-17, 29-30; *CFM*, 2008 WL 3245460, at *3, 9; *Regents*, 2008 WL 906799, at *6; *Chater*, 1997 WL 33352908, at *7. This post-medical-school education is necessitated by the complexity of modern medicine. Completion of a residency program is virtually essential to practicing medicine in a given field or to obtaining privileges to work at a hospital. *See Mt. Sinai*, 2008 WL 2940669, at *3 n.6; *Mayo I*, 282 F. Supp. 2d at 1007; *CFM*, 2008 WL 3245460, at *10.

Second, although medical residents spend significant amounts of time providing patient-care services under the supervision of attending faculty doctors, the performance of such services is likewise essential to their education. "[T]he principal classroom for residents must be the clinical setting because patient care in a medical specialty is what residents are receiving training for." *Mayo I*, 282 F. Supp. 2d at 1015. In other words, "[p]laying just an observational role in this [context] is not the same as actually being involved directly in patient care," and so "it is impossible to separate 'education' from 'patient care.'" *See id.* at 1014-15; *see also Mt. Sinai*, 2008 WL 2940669, at *9, 26-27; *CFM*, 2008 WL 3245460, at *9, 11; *Regents*, 2008 WL 906799, at *6; *Chater*, 1997 WL 33352908, at *7. Notably, the "patient care activities" performed in residencies are "quite analogous" to those "that occur in the third and fourth years of medical school"—although the resident "takes on" "progressively more and more responsibility," the services remain "always under

the supervision of the attending faculty." *See Mt. Sinai*, 2008 WL 2940669, at *4-5, 23, 35. Moreover, even in the context of patient care, residents and their attending "participate in daily teaching rounds" that are "more traditionally 'didactic,'" during which the attending "draw[s] out and explore[s] all of the salient teaching points presented by each patient." *Mayo I*, 282 F. Supp. 2d at 1016; *see also Mt. Sinai*, 2008 WL 2940669, at *6.

Third, teaching hospitals offer residency programs to train the future generation of doctors, not to obtain a cheap source of labor for providing patient care. Teaching hospitals "could provide patient care far more cost-efficiently *without* residents," due to "the time and effort required to supervise and teach" them as well as, among other things, the "increased costs necessary to purchase better, state of the art equipment … [and] to hir[e] the best and the brightest teachers." *See Mt. Sinai*, 2008 WL 2940669, at *11 n.12, 24-25; *see also Mayo I*, 282 F. Supp. 2d at 1014, 1018; *Regents*, 2008 WL 906799, at *6. For example, "large portions of the patient-care services performed by residents—such as physical examinations and the review of test results—[are] repeated by the supervising staff physicians who [are] ultimately responsible for the patients' care." *Mayo I*, 282 F. Supp. 2d at 1018. Moreover, the Accreditation Council on Graduate Medical Education ("ACGME")—of which the AHA is a member—explicitly requires that residency programs "must provide services and develop systems to minimize the work of residents that is extraneous to their education programs," consistent with ACGME's status as "a major driving force in the standardization of robust educational curricula

across all teaching hospitals." *See Mt. Sinai*, 2008 WL 2940669, at *7-9. Consequently, residents typically do not "perform ancillary procedures that have no 'educational value' in the residency context." *Id.* at *9; *see also Mayo I*, 282 F. Supp. 2d at 1015; *CFM*, 2008 WL 3245460, at *7.

Finally, and most importantly, "[t]ime alone cannot be the sole measure of the relationship between services performed and a course of study." *Mayo I*, 282 F. Supp. 2d at 1018. Rather, given the inextricably intertwined nature of patient care and medical education, "the patient care services provided by residents … were [found to be] incidental to and for the purpose of pursuing a course of study in postgraduate medical education." *See id.*; *see also Mt. Sinai*, 2008 WL 2940669, at *35; *CFM*, 2008 WL 3245460, at *9, 11; *Regents*, 2008 WL 906799, at *6.

B. The Treasury Department Has Adopted An Arbitrary 40-Hour Cut-off Rule

In 2005, the Treasury Department amended its regulation implementing the "student" exemption. It generally retained its longstanding regulatory definition of "students," including the "incident to and for the purpose of pursuing a course of study" test, as well as the case-specific, "facts and circumstances" approach for applying that test. But it then categorically decreed that "[t]he services of a full-time employee"—including "an[y] employee whose normal work schedule is 40 hours or more per week"—"are not incident to and for the purpose of pursuing a course of study," *regardless* of whether "the services performed … may have an educational, instructional, or training aspect." *See* 26 C.F.R. § 31.3121(b)(10)-2(d)(3)(i), (iii) (post-Apr. 1, 2005).

The amended regulation specifically identifies medical residents as an example of a "full-time employee," *id.* § 31.3121(b)(10)-2(e), Ex. 4, consistent with the Department's candid admission that the amendment was designed to abrogate adverse judicial decisions applying the longstanding regulation in favor of medical residents, *see* Petrs. Br. 41-42.

The AHA fully agrees with the myriad reasons Petitioners have given for why the Department's "full-time employee" carve-out is both foreclosed by the statutory text as well as arbitrary and unreasonable. Moreover, as the AHA showed above, the Department's interpretation is inconsistent with a line of judicial interpretations of the "student" exemption that was unbroken until the Eighth Circuit's decision below. *See supra* at Part I.A.

Furthermore, the AHA observes that the Department's current position is especially arbitrary in that it appears to be inconsistent. Under *both* the new and old versions of the Department's regulation, the relevant regulatory test is whether the services performed were "incident to and for the purpose of pursuing a course of study." The Department contends that, under the new version, the performance of 40+ hours is *dispositive*. But, under the old version, every court that considered the question held that the length of time spent by medical residents performing patient-care services was *not dispositive*. Notably, the Department has formally "accept[ed] th[at] position" for tax periods ending before its "new … regulations went into effect." *See* IR-2010-25 (Mar. 2, 2010), http://www.irs.gov/newsroom/article/0,,id=219731,00.html (last

visited Aug. 11, 2010). Since, however, the Department is entitled to "deference" when interpreting its "own regulations," *see Auer v. Robbins*, 519 U.S. 452, 461 (1997), the Department's acceptance of those courts' interpretation of its old regulation is irreconcilable with the Department's claim that its contrary interpretation in the new regulation is itself entitled to deference under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 (1984). After all, either 40+ hours of service is dispositive under the "incident to and for the purpose of pursuing a course of study" regulatory test, or it is not. The Department cannot simultaneously take the enforcement position that it is both.

Finally, the AHA stresses that the practical effect of the Department's arbitrary amendment is significant, in light of the uniform success teaching hospitals have had litigating under the case-specific regulatory interpretation of the "student" exemption, *see supra* at Part I.A, the fact that such litigation has recently "exploded across the country," *Mayo III*, 568 F.3d at 676, and the magnitude of the stakes that are collectively involved, Pet. 20. By depriving hospitals of the ability even to attempt to demonstrate that their medical residents qualify as "students" under the longstanding definition of that term, the amended regulation "divert[s] the scarce resources of our country's teaching hospitals and medical schools from their crucial missions of patient care, physician training, and medical research" in a manner that Congress did not intend. 15 U.S.C. § 37b(a)(1)(E). As discussed below, that diversion is particularly harmful in the current economic climate, which has strained the resources of our nation's

hospitals at the very time our hospitals are being increasingly called upon to act as the safety net for the communities they serve.

II. IN THE FACE OF TRYING ECONOMIC CIRCUMSTANCES, OUR NATION'S HOSPITALS STRIVE TO CONTINUE SERVING THEIR COMMUNITIES IN MYRIAD WAYS

As this Court recognized long ago, "hospitals … have become centers for the 'delivery' of health care" and thus have "assume[d] a larger community character." *Abbott Labs. v. Portland Retail Druggists Ass'n, Inc.*, 425 U.S. 1, 11 (1976). For both hospitals generally and teaching hospitals in particular, this "community character" manifests itself in various ways. Yet the current economic climate has posed a serious challenge to the ability of hospitals to maintain the panoply of services that they provide.

A. Hospitals In General Give Back To Their Communities In A Wide Variety Of Ways

1. Hospitals throughout the nation provide "uncompensated care," i.e., "hospital care provided for which no payment was received from the patient or insurer." AHA, *Uncompensated Hospital Care Cost Fact Sheet* at 1 (Nov. 2009) ("*Uncompensated Care*"), http://www.aha.org/aha/content/2009/pdf/09uncompensatedcare.pdf (last visited Aug. 11, 2010). In addition to unanticipated "bad debt," which "is often generated by medically indigent and/or uninsured patients," hospitals also provide "charity care," which "consists of services for which hospitals neither received, nor expected to receive, payment because they had determined, with the assistance of

the patient, the patient's inability to pay." *Id.* at 2. The most common form of charity care involves the free performance of "medically necessary services" for "individuals with annual incomes up to a specified percentage of the [f]ederal [p]overty [l]evel (usually 150 percent to 200 percent)." John D. Colombo *et al.*, *Charity Care for Nonprofit Hospitals: A Legal and Administrative Guide* § 3.02[A] at 3-12 (2009).

But charity care is by no means limited to such emergency services. It often also encompasses care in the form of "free clinics, vaccinations," "health screenings," and other "[s]ubsidized health services." AHA, *Beyond Health Care: The Economic Contribution of Hospitals* at 6 (Apr. 2008) ("*Beyond Health Care*"), http://www.aha.org/aha/trendwatch/2008/twapr2008econcontrib.pdf (last visited Aug. 11, 2010). Various examples of such programs can be found within a recent AHA publication. *See* AHA, *Community Connections: Ideas & Innovations for Hospital Leaders, Case Examples 5* (Jan. 2010) ("*Community Connections*"), http://www.caringforcommunities.org/caringforcommunities/content/10commconncaseex.pdf (last visited Aug. 11, 2010).

Although the precise characterization of what constitutes "uncompensated care" varies somewhat among hospitals, general estimates of the magnitude of the costs of such care are still possible. According to data generated from the AHA's Annual Survey of Hospitals, which is the most comprehensive source of hospital financial data, uncompensated care cost our nation's hospitals $36.4 billion in 2008, which constituted 5.8% of their total expenses (exclusive of bad debt). *Uncompensated Care* at 1-2, 4.

2. In addition to wholly uncompensated care, reimbursement for care provided to Medicare and Medicaid patients, which "account[s] for 55 percent of all care provided by hospitals," frequently "result[s] in underpayment." AHA, *Underpayment by Medicare and Medicaid Fact Sheet* at 1 (Nov. 2009), http://www.aha.org/aha/content/2009/pdf/09medicunderpayment.pdf (last visited Aug. 11, 2010). This underpayment results from the fact that the "[p]ayment rates for Medicare and Medicaid [generally] are set by law rather than through a negotiation process," and "[t]hese payment rates are currently set below the costs of providing care" in most hospitals. *Id.*

According to aggregate data generated from the AHA's Annual Survey of Hospitals, "hospitals received payment of only 91 cents for every dollar spent … caring for Medicare patients in 2008," and "only 89 cents for every dollar spent … caring for Medicaid patients in 2008." *Id.* at 2 (emphases omitted). Combined underpayments amounted to $32.4 billion in 2008, a massive increase from 2000, when the equivalent amount was only $3.8 billion. *Id.* at 3.

3. Nor are the services hospitals perform for their communities strictly limited to the provision of traditional health care. "Hospitals offer services that aid in disease prevention, promote health awareness, contribute to advances in medicine and address other societal needs." *Beyond Health Care* at 6. For example, "community programs" offered by hospitals include "[h]ealth programs[,] such as educational outreach … and support groups," and "[p]rograms to address the social needs of communities," such as

"Meals on Wheels" and "various [types of] shelters." *Id.*; *see also Community Connections*. Hospitals also conduct "[c]linical research" and provide "training programs" and "[c]ontinuing education for health professionals." *Beyond Health Care* at 6.

B. Teaching Hospitals In Particular Provide A Wide Variety Of Benefits To Their Communities

1. Most obviously, the nation's teaching hospitals perform the invaluable task of training the next generation of physicians. As discussed at length in the cases cited above, that typically requires immersing residents, while supervised, in the real-world performance of patient care. *See supra* at 6-8. That said, it is a particularly telling reflection of the prioritization of the educational aspect of medical residency programs over the patient-care aspect of such programs that some teaching hospitals have begun "removing patients from the training equation, at least initially," in favor of "computer-based simulators to hone the skills" of residents. E. Fuchs, *Simulators Come to Life in Resident Training*, AAMC Reporter (Jan. 2008), http://www.aamc.org/newsroom/reporter/jan08/gme.htm (last visited Aug. 11, 2010). This demonstrates how supervised patient care in residency programs is simply a step in the continuum of educating physicians, rather than the object of residency programs *per se*. Indeed, "[a]lthough simulation is an expensive venture," its "proponents claim this technology is an important educational tool." *See id.*

More generally, "[i]n keeping with the ACGME's mission to ensure and improve the quality of

graduate medical education," the ACGME is pushing forward with its "Outcome Project," which "is a long-term initiative by which [it] is increasing emphasis on educational outcome assessment in the accreditation process." ACGME, *Outcome Project: Frequently Asked Questions* (2010), http://www.acgme.org/outcome/about/faq.asp (last visited Aug. 11, 2010). The ACGME is focused on "educational outcomes" in medical residencies, rather than "clinical outcomes," because "[a]chievement of learning is the ultimate purpose of any well-structured educational activity." *Id.*

And teaching hospitals wholeheartedly embrace that purpose, enabling residents to engage in supervised patient care because of the pedagogical benefits, notwithstanding the fact that the provision of such care is far less cost-efficient for the hospitals. As the AHA has explained in the past, "[t]raining resident physicians involves significant costs beyond those customarily associated with patient care," because, in addition to the fact that "the involvement of trainees in care reduces the overall efficiency of hospital operations," "teaching hospitals must pay for faculty, faculty offices, classroom space, comprehensive medical libraries[,] and advanced, highly sophisticated technological equipment to support their residency programs." AHA, *Teaching Hospitals: Their Impact on Patients and the Future Health Care Workforce* at 3 (Sept. 2009) ("*Teaching Hospitals*"), http://www.aha.org/aha/trendwatch/2009/twsept2009teaching.pdf (last visited Aug. 11, 2010).

Teaching hospitals nonetheless serve this function, in part, because they recognize that the task of training the next generation of physicians is

particularly critical given recent estimates that there will be a "shortage of 124,000 physicians" "by 2025." *Id.* at 4; *see generally* AHA, *Workforce 2015: Strategy Trumps Shortage* (Jan. 2010), http://www.aha.org/aha/content/2010/pdf/workforce2015report.pdf (last visited Aug. 11, 2010). And, of course, there is an even greater need for well-trained doctors given the recent enactment of health-care reform, which was estimated last year to "add to overall demand for doctors and increase the projected [2025] shortfall by 25 percent." Association of American Medical Colleges ("AAMC"), *The Physician Shortage and Health Care Reform*, at 1 (July 2009), http://www.aamc.org/newsroom/presskits/physicianshortagefs.pdf (last visited Aug. 11, 2010).

All that said, while the primary purpose of medical residency programs is to provide adequate education to novice residents so they can become effective physicians, that is far from the only service that teaching hospitals provide to their communities.

2. Although hospitals generally act as a safety net for their community, *see supra* at Part II.A, teaching hospitals are among the highest providers of uncompensated care and community programs. For example, in 2006, teaching hospitals incurred 71% of total charity care costs among hospitals surveyed while constituting only 22% of the hospitals surveyed. AAMC, *Key Facts About Teaching Hospitals* at 6 (Feb. 2009) ("*Key Facts*"), http://www.aamc.org/newsroom/presskits/keyfactsaboutth.pdf (last visited Aug. 11, 2010); *see also* AHA, *Teaching Hospitals—Social Missions at Risk* at 2 (May 2002) ("*Social Missions*"), http://www.aha.org/aha/trendwatch/2002/twmay2002.pdf (last visited Aug. 11,

2010). Teaching hospitals likewise play an exemplary role in providing community programs, such as AIDS services, substance abuse outpatient services, and crisis prevention assistance. *See Key Facts* at 5.

3. Furthermore, as the AHA recently documented, "[t]eaching hospitals play distinct roles in their communities' care delivery systems [by] offering specialized services not available in other facilities." *Teaching Hospitals* at 1. "76 percent of hospitals that provide heart transplants are teaching institutions," and "teaching hospitals treat[] approximately 96 percent of all patients needing burn care services and 91 percent of all patients needing pediatric intensive care services." *Id.* at 1-2; *see also Key Facts* at 3-4; AAMC, *What Roles Do Teaching Hospitals Fulfill* at 2 (2009) ("*What Roles*"), http://www.aamc.org/about/teachhosp_facts1.pdf (last visited Aug. 11, 2010); *Social Missions* at 2.

Consequently, "patients often are transferred to [teaching] hospitals when their medical needs exceed other facilities' capabilities." *Teaching Hospitals* at 2. For example, "[i]n 2006[,] there were 321,567 Medicare patient transfers, 72 percent of which were to teaching hospitals." *Id.* More generally, the AAMC estimates that teaching hospitals "receive more than 40 percent of all transferred patients whose illnesses or injuries require a sophisticated level of technology and expertise not available at a community hospital." *What Roles* at 2.

4. Last, but certainly not least, "[t]eaching hospitals serve as centers of research and innovation, helping to develop new treatments and cures." *Teaching Hospitals* at 1. Among the countless

number of breakthroughs pioneered at teaching hospitals were "[t]he first live polio vaccine, intensive care unit for newborns and pediatric heart transplant," *id.*, as well as the "[f]irst human images with an MRI," the "[f]irst successful double-lung transplant," and the "[f]irst successful surgery on a fetus in utero," *What Roles* at 1. The cost of such research is substantial. For instance, one of the petitioners in this case, the Mayo Clinic, spent $390.8 million in 2008 on research and education that was not externally sponsored. Mayo Clinic, *Annual Report* at 43 (2008), http://www.mayoclinic.org/mcitems/mc0700-mc0799/MC0710-2008.pdf (last visited Aug. 11, 2010).

C. The Current Economic Climate Threatens The Ability Of Hospitals To Continue To Serve Their Communities

1. According to a recent AHA survey conducted in March of 2010, "[n]early three-quarters of hospitals reported reduced operating margins." AHA, *Hospitals Continue to Feel Lingering Effects of the Economic Recession*, at 1 (June 2010) ("*Lingering Effects*"), http://www.aha.org/aha/content/2010/pdf/10june-econimpact.pdf (last visited Aug. 11, 2010). These responses were similar to those received in an AHA study conducted in August of 2009, which showed that a third of hospitals experienced losses in the first half of 2009 and nearly half of hospitals suffered a moderate or significant decrease in operating margins. AHA, *The Economic Crisis: Ongoing Monitoring of Impact on Hospitals* at 12-13 (Nov. 11, 2009) ("*Economic Crisis*"), http://www.aha.org/aha/trendwatch/2009/09nov-econimpsurvresults.pdf (last visited Aug. 11, 2010). Likewise, as of

November of 2008, Moody's "downgraded the outlook for the not-for-profit hospital sector from stable to negative." AHA, *The Economic Downturn and its Impact on Hospitals* at 2 (Jan. 2009) ("*Economic Downturn*"), http://www.aha.org/aha/trendwatch/2009/twjan2009econimpact.pdf (last visited Aug. 11, 2010).

2. This data reflects the myriad ways in which the economic downturn affects the financial health of hospitals. Most notably, "[w]hen the economy weakens, hospitals see fewer elective cases, provide more charity care, absorb more bad debt, and care for an increasing share of Medicaid patients." *Id.*

Given that "[m]ore than 60 percent of Americans get their health insurance through employers," "[t]he recent growth in unemployment" has simultaneously "resulted in a loss of employer-sponsored insurance" and "swelled Medicaid enrollment." *Id.* at 4. At the same time, "state tax revenue … is falling precipitously," which has dire implications for Medicaid, since it "is funded primarily by state tax revenue" and usually constitutes "the single largest state budget item." *Id.* at 1. As a result, Medicaid "is particularly vulnerable to cuts in … provider payment[s]," which directly affect hospitals, as well as "to cuts in eligibility [and] benefits," which indirectly "stress[] hospitals and other providers" of charity care. *Id.* And hospitals' operating revenue is further reduced by the fact that "patients put off elective procedures" during an "economic downturn." *Id.* at 5. Indeed, "many people who cannot afford care will delay seeking it until their conditions worsen and their treatment becomes even more expensive," such that "hospitals are likely to see

initial drops in patients seeking care followed by an influx of emergency department visits when needs can no longer be put off." *Id.* at 6.

As documented in the AHA's recent survey in March, 87% of hospitals report increased bad debt and charity care as a percentage of total revenues, 65% report increased percentages of patients covered by Medicaid and similar programs, and 72% report decreased numbers of elective procedures. *Lingering Effects* at 1. Again, this was in accord with the AHA's study from the autumn of 2009, in which 59% of hospitals found a moderate or significant increase in emergency department visits by uninsured patients, 69% found a moderate or significant increase in uncompensated care as a percent of total gross revenues, 52% found a moderate or significant increase in need for subsidized services, and 43% found a moderate or significant decrease in inpatient and elective care. *Economic Crisis* at 5-8.

3. These effects from the current economic downturn are compounded by the "'once in a century' credit crisis" plaguing the country. *Economic Downturn* at 2. Hospitals often rely on credit because "payment to hospitals traditionally lags behind care delivery," requiring them to "borrow to meet operating expenses." *Id.* at 3. They likewise "borrow to fund … longer-term facility improvements and technology purchases." *Id.* at 2. Yet even "the municipal bond market, which historically has been a very stable and reliable means of raising cash for both hospitals and local governments, has been roiled by the credit crisis." *Id.* at 3. Consequently, credit for hospitals has become "difficult to secure" and "significantly more expensive when obtained."

Id. According to the AHA's recent March survey, "difficulties accessing capital persist for hospitals, with 44 percent reporting reduced access to capital continues and nearly a quarter reporting that their ability to access capital is getting worse." *Lingering Effects* at 2.

4. Given the significant role that teaching hospitals, in particular, play in providing care to the indigent, *see supra* at 16-17, it follows that "the economic crisis may put particular strain on teaching facilities' resources to support their training programs and their role in the safety net." *Teaching Hospitals* at 5. As of September of 2009, "49 percent of teaching hospitals ha[d] seen a moderate to significant jump in the proportion of patients covered by Medicaid or other public programs for low-income populations compared to [the prior] year." *Id.* at 2. And, during the same period, "27 percent" of teaching hospitals "reported a 'significant decrease' … in operating margin," "52 percent ... reduced their staff, and 29 percent … cut services such as behavioral health programs." *Id.* at 5, 6. In addition, over half of all teaching hospitals in the AHA's recent survey in March reported that they were at or over capacity in their emergency departments. AHA, *The State of America's Hospitals—Taking the Pulse*, at 7 (May 24, 2010), http://www.aha.org/aha/content/2010/pdf/100524-ths chartpk.pdf (last visited Aug. 11, 2010). In these circumstances, a potential savings of up to $700 million in Social Security taxes for medical residents, Pet. 20, could be critical to the financial health of our nation's teaching hospitals.

5. In sum, the current economic climate has impaired the financial health of our nation's hospitals, including teaching hospitals, at the same that it has rendered hospitals' services for the health of their communities all the more critical. In 2004, Congress interceded to prevent an unintended "diver[sion] [of] the scarce resources of our country's teaching hospitals and medical schools from their crucial missions of patient care, physician training, and medical research." 15 U.S.C. § 37b(a)(1)(E). Now, this Court should reverse the Eighth Circuit's authorization of a similar diversion by the Treasury Department, which arbitrarily excludes medical residents from the "student" exemption and thereby forecloses teaching hospitals from proving in court, as they have successfully and repeatedly done in the past, that their residents, despite performing long hours of supervised patient care, fall within the longstanding regulatory definition of the term.

CONCLUSION

For the foregoing reasons, the Treasury Department's regulation should be invalidated and the Eighth Circuit's judgment should be reversed.

Respectfully submitted,

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