No. A113662

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA
FIRST APPELLATE DISTRICT
DIVISION TWO

MOHAMMAD KASHMIRI, *et al.*,
individually and on behalf of a class of similarly situated persons,

Plaintiffs and Respondents,

v.

THE REGENTS OF THE UNIVERSITY OF CALIFORNIA,

Defendant and Appellant,

Appeal From The Superior Court Of
San Francisco County
Case No. CGC-03-422747
Hon. James L. Warren

REQUEST FOR LEAVE TO FILE AMICI CURIAE AND AMICI CURIAE BRIEF OF AMERICAN MEDICAL ASSOCIATION AND CALIFORNIA MEDICAL ASSOCIATION IN SUPPORT OF PLAINTIFFS AND RESPONDENTS

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STATEMENT OF INTEREST

The American Medical Association ("AMA"), an Illinois not-for-profit corporation with approximately 240,000 members, is the largest organization of physicians, residents, and medical students in the United States. Its objects are "to promote the science and art of medicine and the betterment of public health." It members practice in all areas of medical specialization and in every state, including California.

The California Medical Association ("CMA") is a non-profit, incorporated professional association of more than 30,000 physicians practicing in the State of California. CMA's membership includes California physicians engaged in the private practice of medicine in all specialties. CMA's primary purposes are "... to promote the science and art of medicine, the care and well-being of patients, the protection of ;public health and the betterment of the medical profession." CMA and its members share the objective of promoting high quality, cost-effective health care for the people of California.[1]

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[1] Amici appear herein in their own persons and as representatives of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition of the AMA and the state medical societies of every state and the District of Columbia. Its purpose is to represent the general interests of the medical profession in the courts, according to AMA policy.

INTRODUCTION

The University of California ("UC") explicitly promised its medical students that professional degree fees ("PDF") would not be increased subsequent to their enrollment. *See* Statement of Decision Granting Plaintiffs' Motion for Summary Judgment, at 11 (entered Mar. 2, 2006). Nonetheless, the Regents blatantly ignored that promise and subsequently authorized repeated fee increases. The Regents' actions breached their contract with the students, dashing their well justified expectations regarding the cost of their education and jeopardizing their ability to continue their studies. While amici American Medical Association and California Medical Association are very concerned about the impact of the rising cost of medical education and physicians' educational debt levels on the medical profession in general, we are particularly concerned with the Regents' actions here – where students have chosen to attend public institutions for financial reasons, to minimize the cost and potential future debt, only to have the Regents violate their explicit promise to keep fees constant to the order of thousands of dollars a year per student.

A medical educational program, inasmuch as it entails an integrated course of learning extending over many years, cannot simply be interrupted at any time. Based on the explicit fixed-fee promise, UC medical students passed up other employment and/or educational opportunities. *Id.* When that promise was broken, many students were forced into debt, while others had to add to already onerous debt levels. There was no practical alternative to paying the additional amount if students were to continue the UC program.

The tuition fee increases that violated UC's compact exacerbated already significant growth in medical students' educational debt.

Escalating debt poses a particularly difficult challenge for new physicians earning modest salaries during their postgraduate training. Even afterwards, debt continues to be a heavy burden, especially in an era of generally flat or declining physician incomes and ubiquitous practice cost inflation.

Amici submit this brief to inform the Court of their strong concern regarding the Regents' conduct, particularly in view of the relationship between rapidly escalating tuition charges at public medical schools and the growing crisis of medical education debt. Moreover, aside from the personal hardships caused by the Regents' broken promises, spiraling medical education costs and resulting debt substantially impact public health concerns regarding underserved geographic areas and underrepresented minority physicians. Amici believe this brief will help the Court better appreciate the ramifications that underlie this case.

ARGUMENT

I. Increases in Medical School Tuition Exacerbate Medical School Debt and Upset Medical Students' Career Plans.

Contracts are enforced to facilitate long term economic planning. *See State of California ex rel. Dept. of Transportation v. Guy F. Atkinson Co.,* (1986) 187 Cal.App. 3d 25, 31-34 (where changes ordered by one party to contract seriously impacted other party's planning ability, injured party had right to additional or adjusted compensation for material change in character of work). This principle is particularly important in the pursuit of a medical education and the consideration of the burdens and sacrifices it entails. Medical students' financial obligations bear strongly on their career choices and the fulfillment of their lifetime goals.

UCSF medical student Janet Lee, one of the class members, chose to enroll at UCSF rather than elsewhere because UC's fee-freeze promise made UCSF affordable to her. But, she was forced to incur student loan

debt of more than $60,000 by July, 2004, after the PDF increased from $5,000 per year to $12,673 between her enrollment and the start of the 2004-2005 academic year. *See* Respondents' Appendix ("RA") 37-39 (Declaration of Janet Lee in Support of Preliminary Injunction, included as Exh. 9 to Plaintiffs' Evidence Submitted in Support of Motion for Summary Judgment, or, in the Alternative, for Summary Adjudication (filed June 3, 2005)).

Ms. Lee is but one among many.[2] Tanya Schevitz, *Students Win Suit Over UC Fee Hikes*, S.F. Chronicle, Mar. 7, 2006; Jennifer Jacobson, *Students Sue States Over Tuition Increases but Face an Uphill Battle*, The Daily Report, The Chronicle of Higher Education, (Sept. 19, 2003). The Regents' decision to violate their promise to several classes of students at the UC medical schools has had a real impact on the finances and career choices of hundreds of doctors in California. The true value of the Regents' promise to this group of students – what these students lost when the Regents broke that promise--can only be understood when set against the backdrop of escalating debt within the medical profession.

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[2] The lead plaintiff in this case, Mohammad Kashmiri, decided to enroll at UC largely because of the student budget UC provided him, which included UC's promise not to raise his PDF during his enrollment. Kashmiri was forced to drop out of school temporarily in the wake of the 2003 tuition increase because he was unable to make the increased payment imposed on him and other UC professional students. *See* RA 33-35 (Declaration of Mohammad Kashmiri in support of Preliminary Injunction, included as Exh. 8 to Plaintiffs' Evidence Submitted in Support of Motion for Summary Judgment or, in the Alternative, for Summary Adjudication (filed June 3, 2005)).

A. Medical School Debt Has Risen Faster than Inflation, and Tuition Expense Increases Have Been the Principal Reason for the Accelerating Debt.

From 1996-97 to 2006-07, total fees at UC system medical schools for in-state resident first-year medical students increased by approximately 160%. American Association of Medical Colleges ("AAMC") Tuition and Student Fees Reports 1996-1997 through 2006-2007, *available at* www.aamc.org/tsfreports. UC's tuition fee spike far exceeded the cost of living increases during that period and is remarkable, even in an era in which public university medical school tuition overall has grown faster than private medical school tuition. *See generally* Alik S. Widge, et al., *Effects of Medical Education Debt on Access to Healthcare*, POLICY & PRACTICE, at 2, *available at* www.contextjournal.org/category5.php ("*Effects of Medical Education Debt*").

Tuition-related increases have been the principal reason for medical school graduates' upward-spiraling debt burden in recent years. *Effects of Medical Education Debt*, at 2. Educational debt levels for graduates of public university medical schools overall have risen 360% in actual dollars since 1984. During the same period, medical tuition and fees rose 312% in public medical schools generally, compared to 165% growth in private medical schools. AMA Medical Student Section Report on Medical Student Debt (Feb. 2007), *available at* www.ama-assn.org/ama1/pub/upload/mm/15/cola_debt_pres.pdf (*"AMA MSS Feb. 2007 Debt Report"*); Paul Jolly, Medical School Tuition and Young Physicians' Indebtedness, (AAMC Mar. 23, 2004) *available at* www.aamc.org/publications (14 December 2004), and 24 Health Affairs 2 (2005), *available at* content.healthaffairs.org/cgi/content/full/24/2/527 ("*Medical School Tuition and Young Physicians' Indebtedness*").

According to a recent survey by AAMC, in 2006 the average medical student graduated with indebtedness of $130,571. AAMC 2006 Medical School Graduation Questionnaire, *available at* www.aamc.org/data/gq/allschoolsreports/2006.pdf. Seventy-two percent of medical students have debt levels of more than $100,000. *Id.* Even for medical students graduating from public universities, the median debt burden is projected to rise this year to approximately $120,000. *Id.*

Such debt levels are crushing, since the average starting salary for a resident physician is a modest $43,266. AAMC 2006 Survey of Housestaff, Stipends, Benefits and Funding, *available at* www.aamc.org/data/housestaff/hss2006report.pdf. While these numbers present a dismal picture nationally, the situation is even worse in California, with its extremely high cost of living. The problem is compounded by relatively flat physician incomes. AAMC Medical Educational Costs and Student Debt: A Working Group Report to the AAMC Governance (Mar. 2005), *available at* www.aamc.org/studentdebt (*"Medical Educational Costs and Student Debt"*). All indications are that medical education debt is evolving into a crisis.[3]

B. The Dramatic Increase in Medical School Graduates' Average Indebtedness Has Been Exacerbated by Federal Loan Limits That Have Not Kept Pace With Tuition Increases, as Well as by Unforgiving Federal Loan Repayment Policies.

Most student loans are guaranteed by the federal government under the Stafford and Perkins loan programs. *See* 20 U.S.C. §§ 1078, 1087. *See also* FinAid: The Smart Student Guide to Financial Aid, *available at*

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[3] *Accord*, *Medical School Tuition and Young Physicians' Indebtedness*, at 531; Transcript of Panel Presentation of Harrison Wadsworth, Washington Partners, LLC, at National Conference to Address Medical Student Debt: Solutions to the Medical Education Debt Problem, Sept. 21, 2005, at 19; *Effects of Medical Education Debt*, at 1.

www.finaid.org/loans/studentloan.phtml. The burden created by rising medical school debt has been worsened in part by federal loan limits that for years have not kept pace with the rising cost of medical education.[4] Moreover, save for a narrowly defined "hardship" exception[5] or forbearance,[6] federal loan repayments begin shortly after attainment of a formal degree.[7] After medical school graduation, the majority of new physicians continue their education through several years of low-paid residency and even subsequent fellowship programs, in which case they do not qualify for deferment because they are no longer completing a formal degree program. *See* 20 U.S.C §§ 1078, 1087.

Beginning physicians who fall outside the exceptions, which is the great majority, must start repaying their loans during their residency. This often results in resident physicians, with modest salaries and long work days, being confronted with loan repayments in which capitalized interest (i.e., interest added to the loan principal each year) is a substantial component. The repayment obligation can exceed 25% of a resident physician's net income and contribute significantly to physician stress and exhaustion. Indeed, a 1998 survey of more than 4,000 residents revealed

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[4] For example, the limit on unsubsidized Stafford loans, which had been $10,000 since 1992, was increased to $12,000 just last year. The Deficit Reduction Act of 2005 (P.L. 109-171).

[5] The economic hardship exception applies to a full-time worker earning a monthly gross income not exceeding the greater of (a) the minimum wage or (b) the federal poverty line for a family of two *or* who has a federal educational debt burden that is at least 20% of monthly gross income. 20 U.S.C. § 1085(o).

[6] A forbearance is a period of time during which a lender may, at its discretion, grant a temporary cessation or extension of time for making loan repayments. AMA Medical Education Financing and Debt Management, at 7.

[7] A medical school graduate must begin repayment of a federal Stafford loan within six months after graduation (20 U.S.C. § 1078(b)(E)(i)) and of a federal Perkins loan within nine months of graduation (20 U.S.C. § 1087dd(c)(1)(A)).

that: (1) 43% had a monthly disposable income of less than $100; (2) 16% could not afford safe housing; (3) 52% were unable to purchase necessary books or equipment; and (4) 33% worked as moonlighters. Virginia Collier, *et al.*, *Stress in Medical Residency: Status Quo After A Decade of Reform?*, 136 Annals of Internal Medicine 384-90 (2002), *available at* www.annals.org/cgi/reprint/136/5/384.pdf.

C. Net Incomes For Many Physicians are Essentially Flat, as Payment Levels Erode While Practice Expenses Increase.

Even after physicians complete their post-graduate work, they still usually carry significant medical educational debt burdens, which are not easily or quickly paid off. Although it is true that physicians frequently earn above-average incomes, in recent years median physicians' incomes have been essentially flat. *Medical School Tuition and Young Physicians' Indebtedness*, at 531; *Medical Educational Costs and Student Debt*, at 2; *Effects of Medical Education Debt*, at 4. Physician Medicare payments, which in themselves represent more that 20% of all payments for physician services in the United States (Health, United States, 2006 With Chartbook on Trends in the Health of Americans (U.S. Dept. of Health and Human Services 2006), at 98), not only make no accommodation for general inflationary increases but are even expected to decline substantially, starting next year and continuing with further decreases thereafter. *See* 2006 Annual Report of the Board of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds ("2006 Medicare Trustees Report"), at 92. The problem is compounded because many private payers--particularly health and liability insurance companies--index physician compensation to Medicare payment levels.

The 2008 federal budget proposal President Bush presented in February, 2007 allocated no new funding for physician reimbursement. This can only make matters worse for physicians. Although current

average Medicare payments to physicians are approximately at the same level as in 2001, the Congressional Budget Office recently forecast that, based on the anticipated "sustainable growth rate" formula, Medicare physician payment rates will be reduced by approximately 10% next year.[8] Additional Medicare rate reductions, based on existing law, are projected in each of the next several years. David Glendinning & Doug Trapp, *Bush Budget Plan Slashes Billions From Medicare, Medicaid Spending*, American Medical News, Feb. 26, 2007; AMA National Legislative Activities-Medicare (Feb. 12, 2007), *available at* www.ama-assn.org/ama/pub/category/6583.html. Moreover, beyond the existing law, the President's budget plan anticipates, after considering competing national funding priorities, that Congress will reduce Medicare reimbursement rates for physicians even further in each of the next five years. *Id.* Similarly, the 2006 Medicare Trustees Report predicts that cumulative reductions in Medicare physician payment rates over the next eight years will result in approximately a 40% reduction in the overall fee schedules. 2006 Medicare Trustees Report, at 92.

Payments from private insurers are likely to move in lockstep with Medicare. A summer 2006 survey of 127 different public and private payers, representing 123 million covered lives,[9] showed that 77% of payer-respondents compensated physicians at a predetermined percentage of the Medicare fee schedule, up from a 74% adoption rate in the 1998 survey. *Non-Medicare Use of the RBRVS: Survey Data,* The RBRVS System in Your Practice, Medicare RBVS: The Physician's Guide 2007, at 136 (AMA 2007). Health care payers' wide acceptance of Medicare indexing

[8] The "sustainable growth rate" formula is a provision of the Social Security Act that determines aggregate compensation for physicians under the Medicare program. 42 U.S.C § 1395w-4.

[9] A "covered life" is an enrollee in a health care plan.

profoundly impacts physicians' income, inasmuch as it has introduced a payment benchmark that fails to reflect the numerous inflation factors that affect medical practice costs. *Medicare's Physician Payment Update Formula: The Facts* (AMA) Feb. 2007, *available at* www.ama-assn.org/ama1/pub/upload/mm/399/nac-ppfacts.pdf.

Meanwhile, physicians' practice costs are projected to increase approximately 20% in the next five years. *Id.;* Press Release, AMA, President's 2008 Budget Ignores Medicare Physician Payment Problem; Cuts Funding To Cover Uninsured (Feb. 5, 2007), *available at* www.ama-assn.org/ama/pub/category/17274.html. Not only will this widening gap between income and expenses impact access to health care, as well as physicians' ability to invest in the technology needed to support quality improvements, but it will dramatically affect new physicians' ability to pay off their significant education debts.

II. It is Essential that Medical Education, as Well as Practice in Underserved Geographic Areas and Medical Specialties and By Underrepresented Minorities, be Financially Accessible to Qualified Candidates.

Any fee increase by the UC medical schools, including the thousands of dollars in increases per student challenged here, will have broader impact on the accessibility of medical care in the State of California. California's health care system is increasingly unable to meet the State's needs. California's physicians are not adequately distributed across the state. *Is There A Doctor in the House? An Examination of The Physician Workforce in California Over the Past 25 Years*, Nicholas C. Petrie Center on Health Care Markets & Consumer Welfare, UC Berkeley (June 2004) ("*Doctor in the House*"), at 48. Geographic areas are underserved, and practice areas of medical specialization are

underrepresented. *Id.* at 37 (some areas of California have such low ratios of generalist physicians to the population that the federal government has designated them as Primary Care Health Professions Shortage Areas ("HPSAs")). Maintaining the financial accessibility of a UC medical education increases the likelihood that qualified California students (including underrepresented minorities) who want to attend a UC medical school will remain in-state for a less costly education. It also increases the likelihood that those who wish to work in California's underserved geographic and specialty areas will find it financially possible and choose to do so. The fee increases challenged in this case are directly contrary to these goals.

A. The Growing Need for Physicians in Underserved Areas and Underrepresented Medical Specialties Will Continue to be Exacerbated by the Exigencies Arising from Educational Debt Burdens.

Medical school graduates' financial burdens can discourage entry into comparatively modest-paying practice areas such as primary care, including family medicine and pediatrics. In fact, there has been a recent, precipitous drop in the number of United States medical school students seeking primary care residencies. Joseph Silva, Jr. (Former Dean, UC Davis School of Medicine), *Viewpoint: Burden of Debt Creates Scarcity of General Practitioners,* AAMC Reporter (Oct. 2004)) (*"Burden of Debt"*). Moreover, the ever escalating cost of financing a medical education may contribute to a waning of diversity in medical school enrollment (particularly by Blacks, Hispanics, and Native Americans) and could threaten a diminution of even the most basic health care services to the socioeconomically disadvantaged.[10]

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[10] Such a waning in diversity would be at odds with UC medical schools' repeated commitments: *e.g.*, "The [UCSF] School of Medicine has a long-standing commitment to increasing the number of physicians who are

In acknowledgment of UC's obligation to respond to California's health workforce needs, UC President Dynes appointed an advisory council in December 2005 to review findings and recommendations contained in a June 2005 report regarding UC's Health Sciences educational programs. This report projected a shortfall of up to 17,000 physicians in California by 2015, resulting from overall population increase, aging of the current physician workforce, and lack of growth in UC's medical education programs during the last three decades. Discussion Item for Nov. 14, 2006 Meeting of Members of the Committee on Educational Policy, Summary of Findings and Recommendations of the President's Advisory Council on Future Growth in the Health Professions, University of California Office of President, at 2, *available at* www.universityofcalifornia.edu/regents/regmeet/nov06/302.pdf. The report further found that regional physician shortages already exist in California and are expected to become more severe, particularly in areas that will have the most rapid growth in the next decade. *Id.*

After analyzing the report, the advisory council recommended medical school enrollment growth--totaling 34%--on all five UC medical school campuses through 2020, with a particular focus on the unique needs of medically underserved groups. *Id.* at 4. Amici submit that a meaningful response from UC must include decisive action to make medical school enrollment financially viable for qualified candidates. Where steeply increasing medical educational debt is on a collision course with declining availability of medical service to needy patient populations, a meaningful

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members of minority groups which are underrepresented in the medical profession"; "We, the faculty and students of the David Geffen School of Medicine at UCLA ....believe that a diverse student body is an integral part of our medical education and our development as compassionate caregivers."
http://medschool.ucsf.edu/admissions/apply/gettingstarted.aspx;
http://www.medstudent.ucla.edu/propsective/admissions/?pgID=131

response by UC to medical students' financial challenges is a necessary component of avoiding a public health crisis in California.

The AAMC, similarly noting growing evidence of a national physician shortage that will have an especially profound effect on the underserved, has recommended that overall enrollment in U.S. medical schools be increased 30% by 2015. Press Release, AAMC, AAMC Calls For 30 Percent Increase in Medical School Enrollment (June 19, 2006), *available at* www.aamc.org/newsroom/pressrel/2006/060619/htm. Unfortunately, though, medical school graduates with more than $75,000 in indebtedness are simply unable or unwilling to practice in some of the neediest areas. *Effects of Medical Education Debt*, at 7. Recent survey results show that 68% of medical school graduates have more than $75,000 in medical education indebtedness alone. AAMC 2006 Medical School Graduation Questionnaire, at 49.[11]

Recognizing the connection between the burden of medical education debt and adequate provision of medical service, the AAMC's Working Group on Student Educational Costs and Debts has recommended expansion of physicians-in-training service in underserved areas as a means of assisting in the funding of medical education, as well as addressing physician shortages. *Medical Educational Costs and Student Debt*, at 12. Deborah Powell, M.D., the chair of the working group, has recommended that financial aid programs involving health care service be expanded to connect more closely to the nation's needs, including the need for physician practice in underserved specialties. Transcript of Panel Presentation of Deborah Powell, M.D. at National Conference to Address Medical Student Debt: Solutions to the Medical Education Debt Problem (Sept. 21, 2005), at 15-17.

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[11] Indeed, as discussed above at 5, in 2006 the average medical student graduated with indebtedness of $130,571.

B. A Physician Shortage Disproportionately Affects Minority Populations.

As UC's advisory council has recognized, a physician shortage poses far-reaching public health problems for California. An especially acute problem is posed with respect to the health needs of certain racial/ethnic minorities, particularly Hispanics and Blacks, who are underrepresented in the physician workforce. *Doctor in the House*, at 52-55. Medical education debt burdens fall more heavily on underrepresented minorities because of their generally lesser financial resources, and these burdens deter medical school enrollment of minorities. *Effects of Medical Education Debt,* at 6.[12]

Yet, because African-American and Hispanic physicians often practice within communities with high percentages of African-American or Hispanic residents (indeed, providing a disproportionate amount of care to persons from their own racial/ethnic groups), their very presence increases the likelihood that care will be sought before health problems become acute. *Doctor in the House*, at 51. Additionally, patients treated by physicians of the same race/ethnicity find their visits more "participatory," with better doctor-patient communication. *Id.* Thus, any thinning in the ranks of minority physicians has a far-reaching impact on public health, as minority physicians are more likely to recognize, diagnose, and research diseases that primarily affect minorities. *See* Joel S. Weissman, *et al.*, *Resident Physicians' Preparedness to Provide Cross-Cultural* Care, 294 Journal of American Medical Association 9 (Sept. 7, 2005) (discussing

[12] Accord, *Medical School Tuition and Young Physicians' Indebtedness*, at 530-31 (noting AAMC survey results showing that cost was the number-one deterrent for otherwise qualified Black, Hispanic, and Native American students with respect to enrolling in medical school and that the percentage of incidence of medical educational debt was higher among Black and Mexican-American students who did attend medical school).

need for significant improvement in cross-cultural education to help eliminate disparities in health care); *Effects of Medical Education Debt*, at 7. More generally, any diminution of diversity in medical school ranks resulting from the specter of crushing debt burdens will decrease physicians' overall cultural competency, both directly and through lack of exposure to different perspectives during training. *Effects of Medical Education Debt,* at 4-5.

These realities portend an undermining of the social role of the medical profession and its obligation to serve the most needy segments of the patient population. Therefore, California's public health needs mandate that all qualified and interested medical school candidates find a UC medical education within reach. The fee increases challenged in this case, for hundreds of medical students across the state, have made that goal less of a reality.

CONCLUSION

Amici urge the Court to affirm the judgment below. As the trial court found, the Regents explicitly promised to restrict the UC professional degree fee increases, a promise binding under the law of contracts. The increases negatively impacted hundreds of medical students' financial and career paths, and moved California further away from the goal of ensuring access to medical care for all needy Californians.

Respectfully submitted,

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Dated: April ___, 2007

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CERTIFICATE OF COMPLIANCE
PURSUANT TO CAL. R. CT. 8.204(c)(1)

Pursuant to California Rule of Court 8.204(c)(1), and in reliance upon the word count feature of the software used, I certify that the foregoing brief of amici curiae contains 3,496 words, exclusive of those materials not required to be counted under Rule 8.204(c)(3).

Dated: April ___, 2007

By:______________________