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 Petition For A 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 industry that benefit from the existence of a robust regime of teaching hospitals. The AHA therefore has a significant interest in a definitive resolution of the question whether all medical residents can 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] Counsel of record for all parties received notice at least 10 days prior to the due date of the intention of *amicus* to file this brief. 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. Br. 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. Pet. App. 5a-7a. 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. 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.

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 imperiling the ability of hospitals to continue providing such protection.

For the foregoing reasons, the Eighth Circuit's decision upholding the Treasury Department's categorical exclusion of medical residents from the "student" exemption is sufficiently important that it warrants this Court's review. And such review is especially necessary given that the Eighth Circuit's decision is in stark conflict with decisions of the Second, Sixth, Seventh, and Eleventh Circuits, all of which hold that teaching hospitals are not categorically precluded from proving that their residents are properly characterized as students. *See* Pet. Br. at 12-16.

ARGUMENT

I. THE TREASURY DEPARTMENT'S CATEGORICAL EXCLUSION OF FULL-TIME EMPLOYEES FROM THE "STUDENT" EXEMPTION HAS A SIGNIFICANT PRACTICAL EFFECT ON OUR NATION'S TEACHING HOSPITALS

In 1939, Congress exempted from Social Security taxation "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 enforcing 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." 26 C.F.R. § 31.3121(b)(10)-2(c) (pre-Apr. 1, 2005).

This regulation required a case-specific inquiry into all of the relevant "facts and circumstances" concerning a putative student's employment. Pet. App. 42a n. 12; *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").

And, of critical importance here, when teaching hospitals have litigated this case-specific issue against the Government in the context of medical

residents, courts appear to have uniformly ruled in their favor.

For example, in one of the cases below, the district court granted summary judgment to the University of Minnesota, notwithstanding the fact-intensive nature of the question, given the irrefutable record established by the university. Pet. App. 60a-65a. And, in the other, the district court granted summary judgment to the Mayo Foundation, because the record did not materially diverge from the facts established in a prior case in which Mayo had prevailed over the Government in a bench trial in front of the same court. *Id.* at 43a-46a; *United States v. Mayo Found. for Med. Educ. & Research*, 282 F. Supp. 2d 997, 999, 1015-19 (D. Minn. 2003); *see also, e.g.*, *Ctr. for Family Med. v. United States*, No. 05-4049, 2008 WL 3245460, *1, 8-11 (D.S.D. Aug. 6, 2008) (granting summary judgment for the teaching hospital).

The practical significance of a case-specific inquiry is perhaps most vividly illustrated by *United States v. Mount Sinai Medical Center of Florida, Inc.*, No. 02-22715, 2008 WL 2940669 (S.D. Fla. July 28, 2008). There, the district court had initially ruled that medical residents were categorically excluded from the "student" exemption, but had been reversed by the Eleventh Circuit. *Id.* at *1. On remand, the court then ruled in favor of the teaching hospital after holding a bench trial in which it considered all the relevant facts and circumstances. *Id.* at *1, 28-36. Of particular salience here, the court held, as others had held previously, that "'[t]ime alone cannot be the sole measure of the relationship between

services performed and a course of study.'" *Id.* at *35 (quoting *Mayo*, 282 F. Supp. 2d at 1018).

As noted above, *amicus* is unaware of a single case to the contrary—i.e., one in which a court has ruled that a medical resident is not a "student" under the case-specific approach, let alone so ruled based exclusively on the amount of time residents spend providing supervised patient care.

Nonetheless, in 2005, the Treasury Department amended its regulation: while generally retaining its longstanding regulatory definition of "students" as well as the case-specific, "facts and circumstances" approach, it promulgated a categorical exclusion of "full-time employee[s]," including "an[y] employee whose normal work schedule is 40 hours or more per week." *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 under its prior regulation, Pet. Br. at 7.

The practical effect of the regulatory amendment is obvious in light of the uniform success teaching hospitals have had litigating under the case-specific regulatory interpretation of the "student" exemption, the fact that such litigation has recently "exploded across the country," Pet. App. 3a, and the magnitude of the stakes that are collectively involved. 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 that 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 February 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 Feb. 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 Feb. 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 Feb. 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 (emphasis 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. Pet. Br. at 4-5. And, as petitioners have noted, this requires immersing residents, while supervised, in the real-world performance of patient care, despite the fact that supervised patient care performed by residents is far less cost-efficient for the hospital. *Id.* 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 Feb. 11, 2010).

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 Feb. 11, 2010).

But it is far from the only service that teaching hospitals provide to their communities.

2. While all hospitals generally act as a safety net for their community, *see supra* at 7-10, 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. Association of American Medical Colleges ("AAMC"), *Key Facts About Teaching Hospitals* at 6 (Feb. 2009) ("*Key Facts*"), http://www.aamc.org/newsroom/presskits/keyfactsaboutth.pdf (last visited Feb. 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 Feb. 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 Feb. 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 Feb. 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 autumn of 2009, 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 when comparing the survey period with the equivalent period from 2008. 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 Feb. 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 Feb. 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.* at 2.

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 the AHA's recent survey documents, when comparing the survey period with the equivalent period from 2008, 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 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.*

4. Given the significant role that teaching hospitals, in particular, play in providing care to the indigent, *see supra* at 11, 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 these circumstances, a potential savings of up to $700 million in Social Security taxes for medical residents, Pet. Br. 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). Today, this Court should determine whether the Eighth Circuit has authorized a similar diversion, in conflict with the Second, Sixth, Seventh, and Eleventh Circuits, by upholding the categorical exclusion of medical residents from the "student" exemption and thereby foreclosing teaching hospitals from proving in court, as they have successfully and repeatedly done in the past, that their residents fall within the longstanding regulatory definition of the term despite performing long hours of supervised patient care.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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