No. 09-837

IN THE

Supreme Court of the United States

MAYO FOUNDATION FOR MEDICAL EDUCATION AND RESEARCH, et al.,

Petitioners,

v.

UNITED STATES,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF FOR AMICI CURIAE ASSOCIATION OF AMERICAN MEDICAL COLLEGES, AMERICAN COUNCIL ON EDUCATION, ASSOCIATION OF AMERICAN UNIVERSITIES, ASSOCIATION OF PUBLIC AND LAND-GRANT UNIVERSITIES, AMERICAN OSTEOPATHIC ASSOCIATION, AND AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE IN SUPPORT OF PETITIONERS

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INTEREST OF AMICI CURIAE

The **Association of American Medical Colleges** ("AAMC") is a nonprofit educational association whose members include all 133 accredited allopathic medical schools in the United States, approximately 400 major teaching hospitals and health systems,

and nearly 90 scientific societies.[1] Collectively, these institutions and organizations sponsor the vast majority of the nation's medical residents. AAMC's mission is to improve the nation's health by strengthening the quality of medical education and training, enhancing the search for biomedical knowledge, advancing health services research, and integrating education and research into the provision of effective health care.

The **American Council on Education** ("ACE") was founded in 1918 and is the nation's unifying voice for higher education. Its more than 1,800 members include colleges and universities throughout the United States. ACE represents all sectors of American higher education and serves as a consensus leader on key issues affecting higher education. ACE participates as an amicus curiae only in cases that raise issues of widespread importance to institutions of higher education. ACE, for example, has filed briefs in this Court in recent years in cases such as *Christian Legal Society* v. *Martinez*, 130 S. Ct. 2971 (2010) and *Parents Involved in Community Schools* v. *Seattle School District No. 1*, 551 U.S. 701 (2007).

The **Association of American Universities** ("AAU") is a nonprofit association of 61 U.S. and two Canadian preeminent public and private research universities. Founded in 1900, AAU focuses on national and institutional policies that promote strong

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[1] 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 the amici curiae or their counsel made a monetary contribution to its preparation or submission. The parties have consented to the filing of this brief.

programs of university research and undergraduate, graduate, and professional education. Well over half of AAU member universities have medical schools and medical residency programs, and all have strong programs of biomedical research and advanced education that will provide the future doctors, researchers, and medical breakthroughs that will enhance the health and well-being of the nation.

Founded in 1887, the **Association of Public and Land-grant Universities** ("A·P·L·U") is an association of public research universities, land-grant institutions, and many state public university systems. A·P·L·U member campuses enroll more than 3.5 million undergraduate and 1.1 million graduate students, employ more than 645,000 faculty members, and conduct nearly two-thirds of all academic research, totaling more than $34 billion annually. As the nation's oldest higher education association, A·P·L·U is dedicated to excellence in learning, discovery and engagement.

The **American Osteopathic Association** ("AOA"), an Illinois not-for-profit corporation, is a member association representing more than 70,000 osteopathic physicians ("DOs"). The AOA, founded in 1897, is the accrediting agency for all osteopathic medical colleges, osteopathic residency training programs, and osteopathic continuing medical education, and accredits health care facilities. The AOA's 18 certifying boards serve as the primary certifying body for DOs who complete osteopathic residency training. The AOA's mission is to advance the distinctive philosophy and practice of osteopathic medicine.

The **American Association of Colleges of Osteopathic Medicine** ("AACOM") represents the

administrations, faculty, and students of the nation's 26 colleges of osteopathic medicine and three branch campuses that offer the doctor of osteopathic medicine degree. Today, more than 18,000 students are enrolled in osteopathic medical schools at 34 locations in 25 states. Nearly one in five U.S. medical students is training to be an osteopathic physician. In 2010, colleges of osteopathic medicine graduated 3,845 students eligible to enter post-graduate medical training. AACOM's mission is to promote excellence in osteopathic medical education, research, and service and foster innovation and quality among osteopathic colleges to improve the health of the American public.

Amici have a substantial interest in the outcome of this case. Their member medical schools, teaching hospitals and universities and the training programs they sponsor provide clinical education for medical residents and are therefore directly affected by the Eighth Circuit's holding that residents are categorically ineligible for the student exemption to the Federal Insurance Contribution Act ("FICA").

Amici are committed to protecting the student status of medical residents. Education is the predominant consideration in developing and implementing medical residency programs. Medical residents are students, acquiring the knowledge to deliver safe and effective healthcare and, by the completion of their residencies, to practice as independent, fully-licensed physicians. This educational regimen is the basis for the United States' ability to provide the best medical care in the world. By categorically eliminating the student exemption for medical residency programs and residents, the Treasury Department's arbitrary "40-

hour" exception uses a single criterion to make a judgment that is contrary to any basic understanding of the totality of residency training.

SUMMARY OF THE ARGUMENT

Congress exempted from FICA taxation all services performed in the employ of a school, college or university by any "student" who is enrolled and regularly attending classes at such institutions. 26 U.S.C. § 3121(b)(10). Reversing decades of consistent administrative practice, the Treasury Department has decreed that no medical residents can ever be "students," solely because their "normal work schedule is 40 hours or more per week." 26 C.F.R § 31.3121(b)(10)-2(d)(3)(iii), (e). The question in this case is whether this categorical regulatory exclusion is unlawful because it contravenes the plain language of the statute or is otherwise arbitrary or capricious.

The regulation is invalid. Residencies are educational programs and residents are "students" under any reasonable understanding of that word. Medical school graduates do not enter residencies because they need a paid job, but because completion of a residency is the next required step in their goal of becoming a physician who can practice independently. Completion of at least one year of a residency is an *educational* prerequisite to becoming a fully licensed physician in all 50 states. Completion of a residency also is required if a physician wishes to attain "board certification" in his or her medical specialty, a credential that is increasingly becoming necessary, and generally is required by hospitals for physicians who wish to be granted privileges.

Residents are not "junior doctors" in the first stage of their working life; rather, they are engaged in a rigorous course of graduate clinical education that prepares them for the working life that will follow. To be accredited, all residency programs must meet strict criteria to ensure their educational content. Residents must follow study curricula, attend educational conferences and lectures, engage in other scholarly activities, take exams and be continually evaluated. The tasks in which they engage have educational value. They learn by observing faculty members on their "rounds" and by obtaining hands-on clinical experience under the supervision of a faculty member. The federal Medicare program has also recognized the educational value of residency programs by providing direct graduate medical education funding, which pays institutions that sponsor residency programs for some costs of residency training.

The Treasury Department's mandate that residents can never be "students" merely because their normal weekly work schedule is 40 hours or more contravenes the statute's plain language. It creates the backwards rule that individuals cease to be "students" simply because their education requires more time. But patients do not get sick on a set schedule, and physicians must learn how to care for them the right way, even if it means investing a substantial amount of time. Learning how to diagnose, treat, and provide follow-up to patients with complex medical and surgical conditions entails sustained commitment beyond a typical work day. Under the regulations, a resident with a "normal work schedule" of 39 hours could be a "student." But he or she would arbitrarily lose that status simply by

receiving another hour of education or, in the case of many residents, by receiving twice as much. That perverse result is not only inconsistent with the plain meaning of the term "student" but is the very definition of arbitrary government action.

While pursuing the residency component of their education, medical residents are paid a stipend that is relatively modest, given that they have already completed four years of graduate school and are now engaging in a prolonged and intense educational experience. By taxing the stipends received by residents—and thereby taxing the time they devote to learning how to become physicians—the Government's categorical rule fails to acknowledge the nature of residency education to the possible detriment of both residents and the institutions where they train.

ARGUMENT

I. MEDICAL RESIDENTS ARE STUDENTS.

The governing statute exempts from FICA taxation any "service performed in the employ of * * * a school, college, or university * * * if such service is performed by *a student* who is enrolled and regularly attending classes at such school, college, or university." 26 U.S.C. § 3121(b)(10) (emphasis added). The challenged regulations do not preclude medical residents from proving—as the trial court in this case found—that they are both in the "employ of," and "enrolled and regularly attending classes at," a school, college, or university. However, the Treasury Department has imposed a blanket rule that residents are not "students" within the meaning of the statute merely because their "normal work schedule is 40 hours or more per week." 26 C.F.R. §

31.3121(b)(10)-2(d)(3)(iii).[2] Because it is undisputed that medical residents' schedules far exceed that amount, the regulations bar them from ever being considered "students." *See also* 26 C.F.R. § 31.3121(b)(10)-2(e) (example 4) (medical residents categorically ineligible to claim exemption).

The Treasury Department's categorical exclusion entirely—and quite deliberately—ignores the purpose of residency training and the way in which it is conducted. It is no accident that the current regulations eschew any "case-by case examination" of the "individual's relationship with a school," *Minnesota* v. *Apfel*, 151 F.3d 742, 747-48 (8th Cir. 1998), in favor of an arbitrary 40-hour rule that is entirely disconnected from *what* residents are doing during those hours and *why* they are doing it. The regulations were specifically drafted to try to evade a cascade of judicial decisions holding that "[t]he student exception unambiguously does *not* categorically exclude medical residents as 'students'

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[2] Under the regulation, individuals employed by, enrolled in, and regularly attending classes at a school, college or university must meet the "addition[al]" requirement that their services be "incident to and for the purpose of pursuing a course of study" in order to qualify as "students" who can claim the statutory exemption. 26 C.F.R. § 31.3121(b)(10)-2(d). But "[t]he services of a full-time employee are not incident to and for the purpose of pursuing a course of study," and "an employee whose normal work schedule is 40 hours or more per week is considered a full-time employee." 26 C.F.R. § 31.3121(b)(10)-2(d)(3)(iii). Thus, the regulation categorically precludes residents from claiming that they are "students," but does *not* preclude them from satisfying (on a case-by-case basis) the separate requirement that they be employed by, enrolled in, and regularly attending classes at an educational institution. Residents sponsored by schools, colleges or universities, such as the petitioners in this case, easily meet that requirement. *See* Pet. App. 60a-65a.

potentially eligible for exemption from payment of FICA taxes." *Univ. of Chicago Hosps.* v. *United States*, 545 F.3d 564, 565 (7th Cir. 2008).[3]

The regulations are designed to preclude any factual inquiry because courts that have closely examined the actual facts have concluded that the purpose and substance of residency programs is to educate residents, not put them to work.[4] Under any "detailed review" of graduate medical education—precisely what the regulations improperly seek to avoid—medical residents "presumptively qualify" for the student exemption. Patrick Timothy Rowe, *The Impossible Student Exception to FICA Taxation and Its Applicability to Medical Residents*, 66 Wash. & Lee L. Rev. 1369, 1399 (2009). Indeed, residents training in a program that is sponsored by accredited educational institutions should always qualify for the exemption.

1. Graduation from medical school does not make one a fully qualified clinician. It is through the completion of residency training that a medical school graduate becomes able to fully and effectively practice medicine. Graduation from medical school

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[3] *See also United States* v. *Mem'l Sloan-Kettering Cancer Ctr.*, 563 F.3d 19, 27 (2d Cir. 2009) (student exemption unambiguous, and can cover residents enrolled in medical residency programs and attending classes); *United States* v. *Detroit Med. Ctr.*, 557 F.3d 412, 417-18 (6th Cir. 2009) (same); *United States* v. *Mount Sinai Med. Ctr. of Fla., Inc.*, 486 F.3d 1248, 1251-56 (11th Cir. 2007) (same).

[4] *See Ctr. for Fam. Med.* v. *United States,* No. 05-4049, 2008 WL 3245460, at *8-11 (D.S.D. Aug. 6, 2008); *United States* v. *Mount Sinai Med. Ctr. of Fla., Inc.*, No. 02-22715-CIV, 2008 WL 2940669, at *2 (S.D. Fla. July 28, 2008); *United States* v. *Mayo Found. for Med. Educ. & Res.*, 282 F. Supp. 2d 997, 1015-18 (D. Minn. 2003) ("*Mayo I*"); Pet. App. 35a n.5, 40a, 55a-65a.

does not allow one to practice medicine in the United States, nor is it designed to. Rather, all 50 states require completion of at least one year of a residency (commonly known as the internship year) in order to be licensed as a physician. *See* Federation of State Medical Boards, *State-specific Requirements for Initial Medical Licensure* (www.fsmb.org/usmle_eliinitial.html). These state laws consistently describe the required residency training as a period of graduate or post-graduate "education" or "training," not as prerequisite work experience.[5]

But merely being licensed is insufficient for the vast majority of physicians to independently and effectively practice their chosen specialties. For today's physicians, "licensure does not enable them to practice medicine in the specialty for which they are training and, therefore, is of no real significance." *Id*. Instead, 85% of doctors in the United States also find it necessary to become "board certified." ACGME, *Understanding the Difference Between Accreditation, Licensure and Certification* (www.acgme.org/acWebsite/RRC_140/140_20UnderstandingtheDifference.pdf). "Board certification has * * * 'come to be regarded as evidence of the skill and proficiency of those to whom they [have] been issued.'" *Peel* v. *Att'y Registration & Disciplinary*

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[5] *See*, *e.g.*, Ala. Code § 34-24-70(a)(2) ("post-graduate or residency training"); Conn. Gen. Stat. § 20-10 ("progressive graduate medical training as a resident physician"); Fla. Stat. § 458.311 ("medical education and postgraduate training requirements"); Idaho Code Ann. § 54-1803(c)(12) ("enrolled in a postgraduate medical training program"); Mich. Comp. Laws § 333.17031(1) ("postgraduate education to attain proficiency in the practice of the profession"); Okla. Stat. tit. 59, § 493.1(c) ("postgraduate medical training"); Tex. Occ. Code Ann. § 155.003(5) ("graduate medical training").

Comm'n of Ill., 496 U.S. 91, 102 n.11 (1990) (quoting American Board of Medical Specialties, *Evaluating the Skills of Medical Specialists* 1 (J. Lloyd & D. Langsley eds., 1983)). Board certification, in turn, generally requires completion of a full residency. *See*, *e.g.*, *Mizell* v. *United States*, 663 F.2d 772, 776 (8th Cir. 1981). As a result,

> [t]he vast majority of doctors simply cannot effectively practice and properly care for patients without completing their specialty as residents or fellows at a teaching hospital and becoming board-certified. Without being board-certified, doctors are not entitled to clinical hospital privileges and the opportunity to bill Medicare.

Mount Sinai, 2008 WL 2940669, at *2.

Medical school graduates are thus unlike their peers in other professions, such as the law. A residency is not simply the beginning of medical practice, akin to the work of a junior lawyer. It is one stop in the continuum of a physician's education that begins with medical school. At least a year of residency training is effectively a prerequisite for the practice of contemporary medicine. Unlike a lawyer who can complete law school, pass a bar exam, and hang out a shingle, physicians cannot simply pass an exam upon completion of medical school to commence independent practice of their profession. *See Ctr. for Family Med.*, 2008 WL 3245460, at *10. "If a physician wishes to practice medicine, she has little choice but to seek a residency position." Annette E. Clark, *On Comparing Apples and Oranges: The Judicial Clerk Selection Process and the Medical Matching Model*, 83 Geo. L. J. 1749, 1791 (1995). She applies to a residency "for an educational purpose," Pet. App. 38a n.8, because "[t]he ultimate

objective of residency programs is to ensure that the residents will acquire the knowledge base and the experience to manage the common problems in their specialty and function independently." *Mount Sinai*, 2008 WL 2940669, at *3.

2. The structure of residency programs, and the experience of medical residents, comport fully with the educational function of residencies. Allopathic medical residency programs are certified by the ACGME, and osteopathic residents can attend ACGME accredited-programs, or programs accredited by the AOA. ACGME has made it absolutely clear that "[r]esidents are first and foremost students, rather than employees, and all accreditation standards and activities reflect this distinction." ACGME, *Memorandum* (Mar. 1, 2000) (www.acgme.org/acWebsite/reviewComment/rev_residentEmployee.asp).[6]

To be accredited, a residency program must have "[r]egularly scheduled didactic sessions" and "[d]idactic and clinical education must have priority in the allotment of residents' time." ACGME, *Common Program Requirements*, §§ IV.A.3, VI.A.3 (2007) (www.acgme.org/acWebsite/dutyHours/dh_dutyhoursCommonPR07012007.pdf). Residency programs must "undergo regular internal and external review to ensure that they abide by and comply with" all of ACGME's curricula and

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[6] Osteopathic residency programs are accredited by the AOA's Council on Postdoctoral Training, which has similarly made clear that "[t]he purpose of Osteopathic Graduate Medical Education (OGME) is to provide quality educational programs with proper mentoring and supervision of all trainees." AOA, *Basic Documents for Postdoctoral Training* 9 (2010) (www.do-online.org/pdf/sir_postdoctrainproced.pdf).

institutional requirements. *Mount Sinai*, 2008 WL 2940669, at *7. This means that "[s]ponsoring institutions must provide services and develop systems to minimize the work of residents that is extraneous to their educational programs." *Id.* at *9. As petitioners have amply documented, ACGME accreditation carries with it a host of requirements that are intended to ensure that residents are continually engaged in activities that further their education. *See* Pet. Br. 5-8, 26-28. And Medicare funding depends on maintenance of that accreditation. *See* 42 C.F.R. §§ 413.75(b), 415.152 (Medicare provides funding only for medical residency programs accredited by ACGME or AOA).

In line with the purpose of a residency, the experience of residents is educational. Generally, a medical student must first apply to various residency programs through the National Resident Matching Program ("NRMP"), a process much like applying for college. *Mount Sinai*, 2008 WL 2940669, at *5 (application process viewed "in the same way [as] high school students, when applying to college"). Unlike with a job search, a prospective resident ranks various residency programs based on her preference for medical specialty and location. Clark, *supra*, at 1753. Residency programs, in turn, rank residents and submit those rankings to the NRMP. The process culminates on the anxious and unforgettable "match day," when she learns the institution that chose to accept her into its residency program. *Mount Sinai*, 2008 WL 2940669, at *5; Pet. App. 61a.[7]

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[7] Some osteopathic specialties require a first year called an "internship," in which students are "trainees." AOA, *Postdoctoral Training*, at 8. Certified trainees are "matched"

Our new resident knows from the outset that her time as a resident is finite. In most cases, it lasts only three to five years, depending on the specialty. NRMP, *About Residency* (www.nrmp.org/res_match/about_res/index.html). A medical school, hospital or a supporting organization (formed to coordinate training oversight) will be the "sponsoring institution" that is ultimately responsible for her education. ACGME, *Institutional Requirements*, § II.B.1 (2003) (www.acgme.org/acWebsite/irc/irc_IRCpr703.pdf); AOA, *Postdoctoral Training*, § IV.A. She must anticipate a job search in the years ahead, because there is generally no expectation of receiving a job with the sponsoring institution or affiliated hospital. *Mount Sinai*, 2008 WL 2940669, at *5 (aspiring resident "does not view the process to be one of picking his first 'job'" because he is "not likely to stay on staff as an attending physician after completion of the[ ] residency."); *Mayo I*, 282 F. Supp. 2d at 1001 n.8 ("when they began their residencies, they had no expectation of being hired by the [Mayo] Foundation as a staff physician upon completion of their programs").

Once her residency begins, our typical resident is assigned a faculty advisor to provide comprehensive educational advice and personal support. *Id.* at 1002. Residency programs follow a curriculum that is designed to provide residents with an educational foundation during the early years of their residency and an increased focus on their own specialty as they

after this first year through the AOA Match program into a "residency" where they will train in a specialty. The AOA has adopted ACGME's core competency requirements, based on a "national consensus on what residents should know and be able to do," although the osteopathic competencies integrate osteopathic principles and practice. *Id*. at 9.

progress. Residents generally must follow a prescribed schedule that is developed by the specialty board under the aegis of the accrediting body. It is consistent for all residents in a given year of their specialty, though residents, like other students, have some choice regarding "electives." *See*, *e.g.*, ACGME, *Program Requirements for Graduate Medical Education in Child and Adolescent Psychiatry* 2 (2007) (www.acgme.org/acWebsite/downloads/RRC_progReq/405pr07012007.pdf). While a resident might undertake rotations at multiple participating hospitals or other institutions, her sponsoring institution holds ultimate responsibility for her education. ACGME, *Institutional Requirements*, § II.B.1 ("The Sponsoring Institution retains responsibility for the quality of [graduate medical education] even when resident education occurs in other institutions.").

The central feature of a residency is extensive clinical training that involves direct patient care. "[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. *See Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 507 (1994) ("Because participants learn both by treating patients and by observing other physicians do so, [graduate medical education] programs take place in a patient care unit (most often in a teaching hospital), rather than in a classroom."). The resident, however, always works under the "watchful eye" of faculty physicians. Pet. App. 64a; *Mayo I*, 282 F. Supp. 2d at 1018 ("a resident learn[s] by doing a medical task under the direct and personal guidance" of a faculty

member, who, "the whole time," is "looking over [the resident's] shoulder").

During "morning reports," our typical resident will discuss with faculty, other medical residents and medical students the diagnosis and management of patients in a ward. ACGME, *Core Competencies* (www.acgme.org/acWebsite/RRC_280/280_coreComp.asp). During "teaching rounds," she and other residents see patients and participate in diagnosis and treatment discussions, constantly under evaluation by faculty physicians who engage her and other residents in bedside exercises, drawing out and explaining salient educational points of each patient's condition. *Mayo I*, 282 F. Supp. 2d at 1003, 1016-17. The residents are providing care to patients, of course, but doing so is "inherent in the educational process," and because the goal is to make the resident capable of caring for patients "twenty-four hours a day and seven days a week, it is impossible to separate 'education' from 'patient care.'" *Id*. at 1014-15.

In addition to patient care activities, our typical resident must also keep a busy schedule of mandatory, integrated didactic education. Each rotation has a written curriculum, and residents participate in conferences and lectures throughout the week. Pet. App. 63a; *Mayo I*, 282 F. Supp. 2d at 1004. Over her three years or more, she will be required to participate in over 900 events, including core curriculum conferences, primary care conferences, grand rounds (a form of weekly lectures), morbidity and mortality conferences and journal clubs. *Mayo I*, 282 F. Supp. 2d at 1004; Pet. App. 41a n.10, 63a. That is approximately one formal didactic event per day, year-round, for three years.

And she finds herself continually mindful of the most emblematic part of student life: evaluation. She is evaluated by the faculty physicians supervising her rotations. *Mayo I*, 282 F. Supp. 2d at 1004; Pet. App. 63a-64a. She takes written tests, periodic program examinations, and national specialty board examinations. *Id*.; Pet. App. 22a. Residents who do not meet prescribed goals will not be promoted, and may be put on probation or dismissed. Pet. App. 64a n.17.

Finally, once our resident successfully completes her program, she graduates and receives a certificate that entitles her to take a certification exam of a medical board in her specialty. *Mount Sinai*, 2008 WL 2940669, at *2 n.4, 3; *Mayo I*, 282 F. Supp. 2d at 1004. She also is eligible to be fully licensed by the state where she will practice medicine. Only then does the next hurdle—finding a real job—await.

3. While the educational opportunities of the residency are rich, the funding for residents is comparatively modest. One does not enter a residency for the stipend, but "for successful completion of the program." *Davis* v. *Mann*, 882 F.2d 967, 974 (5th Cir. 1989); *see also Mayo I*, 282 F. Supp. 2d at 1017. Unlike many of her peers in other professions, who may earn large, competitive salaries upon receiving a professional degree, our resident receives a stipend calculated to maintain "a minimum standard of living." *Mount Sinai*, 2008 WL 2940669, at *6; Pet. App. 22a. The stipend for the average first year resident is approximately $45,000, significantly less than the post-residency market salary for a physician working independently in private practice. GAO, Report GAO-09-438R, at 4 (May 4, 2009) (www.gao.gov/new.items/d09438r.pdf)

(2008 figures); *Mount Sinai*, 2008 WL 2940669, at *34 (stipends "represent[] a far cry from the salaries drawn by fully trained and licensed physicians"); Pet. App. 17a. The stipend is not tied to the number of days or hours that she works, *Ctr. for Fam. Med.*, 2008 WL 3245460, at *10, and at any given institution is uniform within programs for all students during a given year of training, and across all specialties. *Mayo I*, 282 F. Supp. 2d at 1005.

Once licensed after completing at least one year of residency, our typical resident or her classmates might consider the frowned-upon practice of using scarce off-hours to "moonlight" in an emergency room to make some extra money. ACGME, *Policy on "Moonlighting" by GME Resident* (June 27, 2000) (www.acgme.org/acWebsite/GME_info/gme_PPmanual902.pdf) (moonlighting "clearly competes with the opportunity to achieve the full measure of the educational objectives of the residency"); AOA, *Postdoctoral Training*, § 7.H (prohibiting first-year moonlighting and requiring approval in other years). Were she to do so, she would learn that this experience differs sharply from her residency. Her work would be limited to repetitive treatment of low-priority, low-acuity problems such as earaches, sore throats and lacerations. *Mayo I*, 282 F. Supp. 2d at 1017. She would not benefit from the educational interaction with a faculty supervisor or other residents as she does during her residency time; she moonlights strictly "for the purpose of earning income." *Id*.

II. THE 40-HOUR RULE ARBITRARILY DENIES RESIDENTS "STUDENT" STATUS SIMPLY BECAUSE THEY RECEIVE TOO MUCH EDUCATION.

As shown above, and as courts that have considered the factual realities of residency programs have held, residents' activities are all part of an educational regimen and they are therefore students. But even though amici believe that every resident sponsored by accredited institutions should qualify for the FICA student exemption, that is not the question in this case. Rather, the question is whether the Treasury Department can categorically preclude all residents and their sponsoring institutions from even *attempting* to make that showing, merely because they spend more than a specified amount of time on those educational activities. The challenged regulations themselves expressly recognize that medical residencies "have an educational, instructional, or training aspect." 26 C.F.R. § 31.3121(b)(10)-2(e) (example 4). Yet, by administrative fiat, this fact "does not affect [the] conclusion" that residents are ineligible to claim the exemption merely because they devote more than 40 hours per week to their required activities. *Id*.

This categorical exclusion is invalid because it is contrary to the plain meaning of the statutory term "student," and is in any event arbitrary and capricious agency action. 5 U.S.C. § 706(2)(A). The regulations establish the perverse rule that residents can never qualify as students merely because they receive *too much* education. Someone receiving exactly the same kind of education as a resident, but spending only 39 hours per week on those activities, would be able to prove that he or she was a "student"

eligible for the exemption. But someone receiving even an hour more of that education—or, in the case of residents, twice as much—is categorically ineligible from even attempting to make that showing.

Words in a revenue act are interpreted in their "ordinary, everyday senses," *Comm'r* v. *Soliman*, 506 U.S. 168, 174 (1993), and the ordinary, everyday definition of a "student" is a person who engages in "study" by applying the mind "'to the acquisition of learning, whether by means of books, observation, or experiment.'" Pet. Br. 22 (quoting *Oxford Universal Dictionary* 2049-50 (3d ed. 1955)). Under that definition, a "student" does not cease to be one simply because she spends a large amount of time learning. The statute has no ambiguity on that point. Congress carefully limited the statute to "students" who are "enrolled and regularly attending classes" at a school, college or university, 26 U.S.C. § 3121(b)(10), but placed no limit on how much a "student" may "work" in order to claim the exemption.

Medical residents have a schedule that interweaves clinical training, centered on "rounds," with integrated didactic training such as conferences, lectures and research. Yet the regulations absolutely preclude them from ever being considered students merely because that education occurs in a "work" setting and exceeds a fixed, arbitrary number of hours set forth by bureaucratic decree. Even if it did not conflict with the statute, that is exactly the kind of "decisive but unreasoned" determination that is the very definition of arbitrary agency action. *See United States* v. *Carmack*, 329 U.S. 230, 243 n.14 (1946) ("arbitrary" means "'[f]ixed or arrived at through an exercise of will or by caprice, without consideration or adjustment with reference to

principles, circumstances, or significance[;] * * * decisive but unreasoned") (quoting *Webster's New International Dictionary* (2d ed. 1945)).

The 40-hour rule also devalues the medical profession's judgments about what is required to properly educate physicians. "Few professions require more careful preparation by one who seeks to enter it than that of medicine" because "[i]t has to deal with all those subtle and mysterious influences upon which health and life depend." *Dent* v. *West Virginia*, 129 U.S. 114, 122 (1889). And while "[e]very one may have occasion to consult [a doctor] * * * comparatively few can judge of the qualifications of learning and skill which he possesses." *Id*. It is the considered judgment of amici and others in the medical profession that residents require extensive clinical training before they can be fully certified to practice independently. That presently requires residents to devote up to 80 hours per week to their education, rather than the 39 or fewer that would qualify them as students under the regulations. ACGME, *Duty Hours Language* (www.acgme.org/acWebsite/dutyHours/dh_Lang703.pdf). The Secretary of the Treasury has expertise in financial areas, but he is plainly not one of the "comparatively few" people, *Dent*, 129 U.S. at 122, who is qualified to judge the number of hours of clinical education needed to ensure that physicians are fully qualified to practice independently. Nor has he even tried, instead establishing a categorical 40-hour rule regardless of circumstances.

In fact, when Congress has specifically considered the circumstances of medical residencies, it has concluded that residents are engaged in education rather than simply patient care. Medicare (and in

some states, Medicaid) provides substantial funds to residency programs for the direct and indirect costs of what Congress specifically described as "medical education." 42 U.S.C. § 1395ww(h); 42 U.S.C. § 1395ww(d)(5)(B); *see* 42 C.F.R. §§ 412.105, 413.75-83 (Medicare); Tim M. Henderson, *Medicaid Direct and Indirect Graduate Medical Education Payments: A 50-State Survey* (April 2010) (Medicaid). And when Medicare defines a resident for purposes of funding the graduate medical education program, it does so on the basis of the position (full time equivalent, or FTE) and area of the hospital where the resident trains, not on the number of hours spent in training. *See* 42 C.F.R. § 413.78.

"Congress was concerned that teaching hospitals would incur greater costs in treating patients than would non-teaching hospitals." *Rhode Island Hosp.* v. *Leavitt*, 548 F.3d 29, 32 (1st Cir. 2008). The costs are higher because, among other reasons, "the mere presence of interns and residents in an institution puts extra demands on other staff and leads to the existence of higher staffing levels" and "[t]he process of graduate medical education results in very intensive treatment regimens." Department of Health & Human Services, *Hospital Prospective Payment for Medicare: A Report to Congress* 49 (1982). The group of residents accompanying a faculty member on rounds is not necessary for patient care, but it is necessary for their education. And that educational component is inextricably intertwined with everything residents do. Thus, contrary to the Treasury Department's arbitrary rule, Congress has recognized that medical residents are not merely ordinary "full-time employees," 26 C.F.R.

§ 31.3121(b)(10)-2(d)(3)(iii), but rather are real students engaged in educational activities.

The IRS itself has effectively admitted that, but for its 40-hour rule, medical residents can and do qualify for the FICA student exemption when their actual circumstances are allowed to be considered. On March 2, 2010, the agency announced that it would refund FICA taxes to all residents and teaching hospitals who had filed claims for refunds of FICA taxes before April 1, 2005, the effective date of the regulations at issue here. *See* I.R.S. News Release IR-2010-25 (Mar. 2, 2010) (www.irs.gov/pub/irs-tege/nr-2010_25.pdf); Opp. Cert. 14 n.2. This determination covered all existing claims throughout the country, not merely those of specific parties who had prevailed in court. Because the IRS is always bound by the governing statute, it could not have paid those refunds unless the statute allowed residents to qualify as students.

The statute has not been amended, yet the agency now persists in denying all subsequent claims solely on the authority of its blanket 40-hour rule. The only thing that has changed is the IRS's interpretation, which the agency is seeking to impose without providing justification. That discrepancy shows that the rule conflicts with the statute. The same residents and sponsors who have proven their compliance with the statute when given a chance to present their specific circumstances are now arbitrarily prevented from doing so.

III. THE 40-HOUR RULE THREATENS TO IMPAIR ACCESS TO MEDICAL EDUCATION AND THE PROVISION OF MEDICAL SERVICES.

The arbitrary 40-hour rule may threaten the massive and urgent efforts to educate the next generation of physicians and meet the nation's healthcare needs. There are nearly 8,500 accredited residency programs in the U.S., providing education to over 107,000 residents. ACGME, *The ACGME's Approach to Limit Resident Duty Hours 2007-08* (www.acgme.org/acWebsite/dutyHours/dh_achievesum0708.pdf). Whether or not they could qualify for Congress's student exemption if given the chance, the IRS intends to tax every one of them. According to the government, these taxes amount to $700 million dollars every year. Pet. 20. These additional, unwarranted taxes imposed directly on education may have an impact on a resident's choice about what specialty to pursue, and the ability of the institutions that sponsor residency programs to provide that education.

FICA is a tax that hits medical residents particularly hard, given their extreme debt loads. The average medical school graduate has around $155,000 in educational debt. GAO, *supra*, at 4 (2008 data). The average stipend for a first year resident is about $3,729 per month, but monthly loan payments can reach over $1,700 per month, or about 48% of pre-tax income, subject to a limited number of partial loan deferral options. *Id*.[8] Under 2010 rates,

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[8] Even if all of a resident's debt is fully eligible for the federal graduated repayment plan, the resident still must spend about 10% of the stipend on student loan payments. *Id*.

about 7.65% of a resident's educational stipend—nearly 15% of an average resident's remaining income—must go to pay FICA taxes under the challenged regulations, and this is on top of federal, state and local income taxes. Social Security Administration, *Social Security & Medicare Tax Rates* (www.ssa.gov/OACT/ProgData/taxRates.html).

These significant costs may, at the margins, affect a resident's choices about what medical specialty to pursue. Facing mounting financial obligations, she may choose a more highly compensated specialty such as surgery, even if it is not otherwise a suitable fit or the specialty of her keenest interest. Or she may choose a practice with a shorter residency, at the expense of a specialization in which she would thrive and excel, for the sake of relieving financial pressures.

Teaching hospitals, medical schools and other sponsoring organizations are also vulnerable, as they must match FICA contributions. As a matter of simple math, hundreds of millions of dollars that must be paid in taxes every year represents hundreds of millions of dollars that cannot be spent on medical education or any of the other beneficial activities in which these educational institutions are engaged.

The long hours required for residency training have received intensive study in recent years, and yielded recommendations by ACGME and AOA that a reduction of in the number of hours of training and tasks can both increase the quality of residents' education and reduce medical errors. Many changes have already been made in this regard, including ACGME's recommendation of an 80-hour week in 2003. *See supra* at 21. But these changes and others

have required either increasing the number of fully trained physicians or expanding nursing staff, or enlarging the resident programs themselves, amounting to over $1.6 billion in additional costs. Teryl K. Nuckols, et al., *Cost Implications of Reduced Work Hours and Workloads for Resident Physicians*, 360 New Engl. J. Med. 2202 (2009) (changes needed to implement 80-hour limits estimated to cost each major teaching hospital about $3.2 million annually). The continuing imposition of $700 million of FICA taxes on institutions that sponsor residency programs and on residents can only slow the pace of reform by siphoning more resources from the education of residents.

Finally, these unwarranted taxes come at a time when there is a national doctor shortage—particularly in primary care—which will only be exacerbated by Congress's recent efforts to expand basic health-care coverage. The overall demand for physician services will increase an estimated 22% between 2005 and 2020, while the number of primary care physicians will increase by only 18% during this period. Darrell G. Kirch, *How To Fix The Doctor Shortage*, Wall St. J., Jan. 5, 2010, at A17. At current graduation and training rates, the nation could face a shortage of as many as 150,000 doctors in the next 15 years. Suzanne Sataline & Shirley S. Wang, *Medical Schools Can't Keep Up*, Wall St. J., Apr. 12, 2010, at A3. But the medical education timetable is at odds with the timetable for healthcare reform. Even if applications to medical schools rise, a bottleneck at the medical residency education stage is likely if there is not a corresponding expansion of residency positions. *Id*. Imposing an additional $700 million in taxes on residents and their schools may

decrease the ability of amici's members to meet those critical needs.

CONCLUSION

For the foregoing reasons, the judgment below should be reversed.

Respectfully submitted,

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