

November 9, 2020

The Honorable Eugene Scalia
Secretary
U.S. Department of Labor
c/o Office of Foreign Labor Certification
200 Constitution Avenue, NW
ETA Office #: N-5306
Washington, DC 20210

The Honorable Chad Wolf
Acting Secretary
U.S. Department of Homeland Security
2707 Martin L. King Avenue, SE
Washington, DC 20528

Re: Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States [DOL Docket No. ETA-2020-0006] and Strengthening the H-1B Nonimmigrant Visa Classification Program [DHS Docket No. USCIS-2020-0018]

Dear Secretary Scalia and Acting Secretary Wolf:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide comment on the U.S. Department of Labor's (DOL) Interim Final Rule (IFR) titled, "Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States" [DOL Docket No. ETA-2020-0006] and "Strengthening the H-1B Nonimmigrant Visa Classification Program" [DHS Docket No. USCIS-2020-0018]. The AMA believes the IFR will cause immediate and lasting harm in the ability to provide timely, accessible health care services in rural and medically underserved communities across the United States. Prior to the COVID-19 pandemic, the U.S. was already facing a rising shortage of physicians largely due to the growth and aging of the general population and the impending retirement of many physicians.¹ International medical graduates (IMGs) often serve in rural and medically underserved communities, providing care to many of our country's most risk citizens. Individuals with serious chronic medical conditions, including diabetes and other comorbidities, are at a higher risk of experiencing complications from COVID-19.² Our IMGs have played a large role in caring for those who are seriously ill from COVID-19, including those facing the lasting health complications following recovery from this disease. **The AMA strongly urges the DOL to rescind the IFR, effective October 8, 2020. If rescission is not possible, we urge the DOL to exempt physicians from the IFR. Additionally, the AMA strongly urges the DOL to continue to approve, and the U.S. Department of Homeland Security (DHS) to annually accept, without reservation, the wage data from the Association of American Medical Colleges (AAMC) Survey of Resident/Fellow Stipends and Benefits Report for our foreign medical residents.**³

¹ <https://www.aamc.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage>.

² <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>.

³ AMA Letter to the Administration in 2018, voicing our concern that the U.S. Citizenship and Immigration Services (USCIS) delays in H-1B visa processing due to increased inspection of prevailing wage data for incoming non-U.S. international medical graduates (IMGs) who have accepted positions in U.S. Graduate Medical Education (GME) programs. <https://searchlf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-6-5%2520Letter-to-Cissna-re-H1B-Visa-Wage-Data.pdf>.

The IFR Violates the Administrative Procedure Act

Agency Failure to Observe Procedure Required by Law in Violation of the Administrative Procedure Act

The AMA believes that the IFR represents unlawful rulemaking because no good cause exists for the DOL's failure to comply with notice and comment rulemaking.⁴ The Administrative Procedure Act (APA) authorizes an agency to issue a rule without prior notice and opportunity for public comment when the agency for good cause finds that those procedures are "impracticable, unnecessary, or contrary to the public interest." The DOL provided approximately 36 hours of advance notice between posting the IFR at the public inspection desk of the *Federal Register* on October 6, 2020, and publishing the IFR on the morning of October 8, 2020, which immediately changed the law governing the determination of prevailing wages. **The rule failed to provide reasonable notice for a policy change that would severely impact the medical community in the midst of a global pandemic, failed to take into account the harms to H-1B physicians, foreign medical residents, and the public, failed to consider the reliance interests of those individuals utilizing H-1B visas, and failed to afford the requisite opportunity for those interested to comment and submit written materials.**

The DOL provides two rationales for satisfying the APA's good cause criteria that are both severely flawed. First, the DOL argues that the shock to the labor market caused by high unemployment due to COVID-19 has "created exigent circumstances that necessitate swift action by the Agency to protect U.S. jobs." We disagree. The AMA believes that, although the unemployment caused by the COVID-19 pandemic is serious, the priority of the Administration in the midst of this public health emergency, as new cases and COVID-19 related deaths rise, should be ensuring the health of the American people. The AMA strongly believes that the DOL's IFR undermines this effort and is in violation of the APA's good cause criteria. Second, the DOL argues that, even absent the labor market conditions caused by the pandemic, the public should not be given the opportunity to comment on the wage level adjustments offered in the IFR as it would undermine the Agency's ability to remedy the issues the IFR is meant to solve. Again, the AMA disagrees. The AMA believes that given the increases in new COVID-19 cases and deaths, now more than ever the Administration should be easing the administrative burdens for IMGs and the employers that sponsor them, such as academic medical centers. As the number of hospitalizations rise in the U.S. due to COVID-19, the Administration should be ensuring that our foreign trained physicians and medical residents are prioritized during the visa process to enable the U.S. to, in the short-term, more effectively fight COVID-19 and, in the long-term, ensure the physician shortages in our rural and underserved communities have been remedied.

Agency Action is Substantively Arbitrary and Capricious in Violation of the Administrative Procedure Act (5 U.S.C. § 706(2)(A))

The AMA believes that the IFR is unlawful because the DOL did not justify its unprecedented change to the prevailing wage determination. The DOL acted arbitrarily and capriciously by failing to consider the interests of the various industries impacted by this IFR, including IMGs who are now subject to what the AMA believes is a wholly irrational change in wage levels. Moreover, this IFR completely fails to consider how such changes impact H-1B physicians' ability to serve the communities that they care for. The AMA also believes that the DOL acted arbitrarily and capriciously by setting wages in such

⁴ 5 U.S.C. §§ 553(b), 706(2).

an irrational manner that there is not sufficient data to provide four wage levels for the over 15,000 jobs that will be impacted. By requiring all of these jobs to pay their H-1B employees at the same wage level regardless of the location of the job, experience or education level of the worker, nature of the duties performed or other important factors, this IFR fails to adequately determine a prevailing wage across all employment sectors and will harm not only the H-1B employees but also, the employers that budget to pay the actual prevailing wage for the location, profession, and experience of the employee. As a result, a rural physician must be paid the same as an anesthesiologist in a metropolitan area and both physicians would be paid the same as a labor specialist or a first-year lawyer.⁵

The IFR Immediately and Inappropriately Changes the Prevailing Wage Determination which Irreparably Harms the Entire Medical Community and the Patients they Serve

The IFR created by the DOL has drastically altered the distribution of the four-tiered wage system by increasing the required prevailing wage determinations that employers must pay to H-1B employees. The rule change was implemented over a 36-hour period and its immediate enforcement drastically changed wage requirements for foreign national physicians, many of which serve low-income, rural or other medically underserved areas that do not have the capability or resources to meet these new criteria.

Currently, the Immigration and Nationality Act (INA) requires employers attempting to hire H-1B physicians to pay the greater of “the actual wage level paid by the employer to all other individuals with similar experience and qualifications for the specific employment in question,” or “the prevailing wage level for the occupational classification in the area of employment.” The survey methodology utilized by the DOL to determine prevailing wage levels utilizes an individual’s experience, education, and skill level as determined by the DOL’s Office of Foreign Labor Certification’s National Prevailing Wage Center. This determination is authorized by the DOL based on the “best information available” and must consist of at least four levels of wages irrespective of occupation. However, there are some significant issues related to the collection of survey data from employers. The DOL’s wage survey is based on a voluntary, semi-annual mail survey of non-farm establishments.⁶ “Employers who respond to the [Occupational Employment Statistics Survey (OES)] OES survey do not provide data about individual employees. Instead, participating employers provide grouped data responses, categorizing employees into wage groups. The same wage groups are used for all occupations in all geographic areas.”⁷ Since this critical data is collected voluntarily, it is highly unlikely that there will be an accurate depiction of physician wage levels across all specialties and all geographical areas. Moreover, as larger urban centers have greater resources to participate in this survey compared to smaller, lower income practices, the OES data collected will likely be skewed towards a higher wage level. Therefore, the prevailing wage levels determined by the DOL will not be accurate and will specifically disadvantage practices in high need, medically underserved areas.

The four prevailing wage levels are assigned a percentile of the total wage rates for a given “Metropolitan Statistical Area,” and employers are not permitted to pay a salary below that assigned “prevailing wage.”

⁵ Labor relations specialists interpret and administer labor contracts regarding issues such as wages and salaries, healthcare, pensions, and union and management practices. <https://www.bls.gov/ooh/business-and-financial/labor-relations-specialists.htm#:~:text=Labor%20relations%20specialists%20draft%20proposals,and%20union%20and%20management%20practices>.

⁶ https://www.bls.gov/oes/oes_ques.htm.

⁷ https://www.americanimmigrationcouncil.org/sites/default/files/research/wages_and_high-skilled_immigration.pdf.

Without providing evidence-based reasoning, this rule increased wage levels over night and in some cases, employers had to increase their H-1B employees' salaries by nearly 50 percent. Prevailing wage levels were significantly impacted at all levels. Specifically, the entry-level wage (Level 1) was increased from representing the 17th wage percentile or higher than 17 percent of all wages for that specific position in that Metropolitan Statistical Area, to representing the 45th percentile. Subsequently, Level 2 (qualified) was increased from the 34th percentile to the 62nd percentile, Level 3 (experienced) from the 50th percentile to the 78th percentile, and Level 4 (fully competent) from the 67th percentile to the 95th percentile. The goal of these determinations was to provide consistency in wage levels amongst H-1B employees, while at the same time protecting American workers from labor outsourcing.

As a default wage, if the Bureau of Labor Statistics (BLS) OES data set does not have information regarding wage levels for the specific career field in a particular area, or if a wage is greater than \$63.00 per hour, the prevailing wage level defaults to \$208,000 per year. As you will see below, due to the voluntary nature of the OES, much of the required data for physician specialties was unable to be collected. As such, this rule change will artificially skew the prevailing wage of the labor market for physicians which will further exacerbate the current physician shortage.

The IFR will have Adverse Consequences for H-1B Physicians and their Employers

If there are no available U.S. workers to fill a position, then a firm's labor need goes unmet without substantial investment in worker recruitment and training. Accordingly, importing needed workers allows companies to innovate and grow, creating more work opportunities and higher-paying jobs for U.S. workers. As such, the H-1B nonimmigrant visa program allows U.S. employers to temporarily employ foreign workers in specialty occupations. A "specialty occupation" is defined by statute as an occupation that requires the theoretical and practical application of a body of "highly specialized knowledge," and a bachelor's or higher degree in the specific specialty, or its equivalent, as a minimum for entry into the occupation in the U.S.⁸

Since all physicians are required to complete education and training that far exceed an undergraduate degree, there can be no doubt that physicians meet the education requirement. Moreover, since physicians undergo anywhere between three and eight years of residency to expand their knowledge of a specific area of medicine the "highly specialized knowledge" requirement described by statute has also been met. As such, H-1B physicians clearly deserve the "specialty occupation" designation and are critical to filling a gap in our workforce that the U.S. cannot fill on its own.

The United States is suffering from a major physician shortage, with forecasts of a widening gap that will continue to grow over the next decade. It is projected that by 2032, there will be about a 50 percent growth in the population of those ages 65 and older, compared with only a 3.5 percent growth for those ages 18 or younger.⁹ Partly due to this phenomenon, by 2033 the United States will experience a shortage of between 54,100 and 139,000 physicians. This number includes a projected primary care physician shortage of between 21,400 and 55,200, as well as a shortage of non-primary care specialty physicians of between 33,700 and 86,700.¹⁰ As such, there is a growing need for a larger physician workforce that the

⁸ See 8 U.S.C 1101(a)(15)(H)(i)(b), 1184(i).

⁹ <https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf>.

¹⁰ AAMC (2020, June) The Complexities of Supply and Demand: Projections from 2018 to 2033. Retrieved from AAMC: <https://www.aamc.org/system/files/2020-06/stratcomm-aamc-physician-workforce-projections-june-2020.pdf>.

U.S. cannot fill on its own, in part due to the fact that the U.S. physically does not have enough people in the younger generation to care for our aging country.

As such, H-1B physicians fulfill a vital and irreplaceable role. In some specialties, such as geriatric medicine and nephrology, IMGs make up approximately 50 percent of active physicians.¹¹ In other areas IMGs make up about 30 percent of active physicians including in more specialized areas of medicine such as infectious disease, internal medicine, and endocrinology.¹²

However, under the proposed rule, if the DOL did not have data for the H-1B physician’s specialty during the yearly review, which is highly probable since the DOL is missing a significant amount of data for physicians and their specialties, the H-1B physicians would need to be paid the default wage of \$208,000 a year, which would potentially, and unfairly, price out a significant number of physicians in the U.S.

For example, a level 1 family medicine physician, per 2020 DOL data had an average salary of between \$50,000 and \$118,000, with \$208,000 appearing when there was not enough information for the locality. However, per the IFR, these physicians that are renewing their visa, seeking new visas, or have pending visas without an approved prevailing wage would have to garner somewhere between a \$100,000 to a \$150,000 raise almost overnight. See chart ¹³

Location	Pre Rule Level 1 Wage	Pre Rule Level 2 Wage	Pre Rule Level 3 Wage	Pre Rule Level 4 Wage	Post Rule Level 1 Wage	Post Rule Level 2 Wage	Post Rule Level 3 Wage	Post Rule Level 4 Wage
New York County - NY	118,955	158,870	198,786	238,701	208,000	208,000	208,000	208,000
Los Angeles County - CA	61,776	106,912	152,027	197,163	208,000	208,000	208,000	208,000
Miami-Dade County - FL	113,277	161,491	209,706	257,920	208,000	208,000	208,000	208,000
Cook County - IL	102,253	153,795	205,317	256,859	208,000	208,000	208,000	208,000
Harris County - TX	105,290	161,970	218,670	275,350	208,000	208,000	208,000	208,000
Maricopa County - AZ	147,846	188,573	229,320	270,046	208,000	208,000	208,000	208,000
Dallas County - TX	126,298	169,853	213,387	256,942	208,000	208,000	208,000	208,000
Clark County - NV	109,179	150,738	192,317	233,875	208,000	208,000	208,000	208,000
Lincoln County - AR	208,000	208,000	208,000	208,000	208,000	208,000	208,000	208,000
Chattahoochee County - GA	138,008	185,827	233,667	281,486	208,000	208,000	208,000	208,000
Trousdale County - TN	107,099	149,926	192,733	235,560	208,000	208,000	208,000	208,000
Lake County - TN	49,837	93,912	138,008	182,083	208,000	208,000	208,000	208,000
Dakota County - NE	208,000	208,000	208,000	208,000	208,000	208,000	208,000	208,000
Lee County - AR	109,949	155,854	201,760	247,666	208,000	208,000	208,000	208,000
Buena Vista County - IA	208,000	208,000	208,000	208,000	208,000	208,000	208,000	208,000
Buffalo County - SD	134,430	178,298	222,186	266,053	208,000	208,000	208,000	208,000
Big Horn County - MT	208,000	208,000	208,000	208,000	208,000	208,000	208,000	208,000

Pediatric physicians, per 2020 DOL data had an average salary of between \$50,000 and \$170,000, with \$208,000 appearing when there was not enough information for the locality. However, per the IFR these physicians that are renewing their visa, seeking new visas, or have pending visas without an approved

¹¹ <https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-who-are-international-medical-graduates-imgs-specialty-2017>.

¹² *Id.*

¹³ <https://www.flcdatcenter.com/OESWizardStart.aspx>.

prevailing wage would have to garner a raise of somewhere between approximately \$30,000 to \$150,000. See chart:¹⁴

Location	Pre Rule Level 1 Wage	Pre Rule Level 2 Wage	Pre Rule Level 3 Wage	Pre Rule Level 4 Wage	Post Rule Level 1 Wage	Post Rule Level 2 Wage	Post Rule Level 3 Wage	Post Rule Level 4 Wage
New York County - NY	101,920	139,797	177,674	215,550	208,000	208,000	208,000	208,000
Los Angeles County - CA	101,150	131,331	161,533	191,714	208,000	208,000	208,000	208,000
Miami-Dade County - FL	97,365	126,734	156,104	185,474	208,000	208,000	208,000	208,000
Cook County - IL	73,798	131,581	189,363	247,146	208,000	208,000	208,000	208,000
Harris County - TX	74,443	112,923	151,403	189,883	208,000	208,000	208,000	208,000
Maricopa County - AZ	58,885	103,210	147,514	191,838	208,000	208,000	208,000	208,000
Dallas County - TX	121,389	168,771	216,154	263,536	208,000	208,000	208,000	208,000
Clark County - NV	208,000	208,000	208,000	208,000	208,000	208,000	208,000	208,000
Lincoln County - AR	111,176	156,229	201,282	246,334	208,000	208,000	208,000	208,000
Chattahoochee County - GA	90,376	106,621	122,866	139,110	115,440	135,512	155,605	175,677
Trousdale County - TN	143,083	186,805	230,506	274,227	208,000	208,000	208,000	208,000
Lake County - TN	55,578	113,755	171,912	230,090	208,000	208,000	208,000	208,000
Dakota County - NE	124,134	160,534	196,934	233,334	208,000	208,000	208,000	208,000
Lee County - AR	52,125	105,082	158,038	210,995	208,000	208,000	208,000	208,000
Buena Vista County - IA	77,459	131,602	185,765	239,907	208,000	208,000	208,000	208,000
Buffalo County - SD	172,390	207,459	242,528	277,597	208,000	208,000	208,000	208,000
Big Horn County - MT	208,000	208,000	208,000	208,000	208,000	208,000	208,000	208,000

These numbers are drastic and likely an under estimation, since the BLS’ OES is likely artificially inflated based on unreliable data sets as noted above. Moreover, unlike their resident counterparts, H-1B physicians are not part of a larger cohort and as such, are not as likely to be able to fund their own wage survey. Furthermore, they often do not benefit from the AAMC survey, mentioned below, as this specific survey focuses on residents and faculty. As such, the proposed rule will either cause these much-needed physicians to be priced out of a market that cannot afford to lose them, or will require employers to pay a wage that is much higher, which could cause fewer doctors to be hired overall during a time when we are facing a severe physician shortage.

The pressing and urgent need for physicians that our country has now, and will continue to have in the future, is specifically the reason that the H-1B visa program was created. These physicians are not “causing adverse effects on the wages and job opportunities of U.S. workers,” but rather are keeping the health of our nation afloat now more than ever.

The IFR Unfairly Discriminates Against H-1B Resident Physicians

The DOL believes that the BLS’ OES survey is the best source of wage data to determine prevailing wages in the H-1B program. However, because the OES survey does not capture the actual skills or responsibilities of the workers whose wages are being reported, the DOL can choose to rely on data outside the OES survey to establish the wage levels applicable to these nonimmigrant visa programs including for H-1B physicians and residents. Under the IFR, a Department at a National Processing Center (NPC) will continue to determine whether a job is covered by a collective bargaining agreement

¹⁴ *Id.*

that was negotiated at arms-length, but in the event the occupation is not covered by such agreement, an NPC will determine the wages of workers similarly employed using the wage component of the BLS OES, unless the employer provides an acceptable survey. An acceptable survey includes a current wage as determined by the Davis-Bacon Act,¹⁵ the McNamara-O'Hara Service Contract Act,¹⁶ an accepted independent authoritative source, or another legitimate source of wage data as determined by the DOL. However, if these other sources of data are not available, the default wage under the BLS OES, as noted above, is \$208,000.

Currently, if actively requested, H-1B physicians may petition for their salaries to be determined based on a collective bargaining agreement or on an acceptable survey, such as one that is privately funded or the annual AAMC Survey of Resident/Fellow Stipends and Benefits Report. However, these alternative, non-BLS surveys and agreements do not have to be accepted by the DOL. At least once a year, the DOL will determine what the prevailing wage for H-1B residents should be, and at that time the DOL can either choose to accept or reject the alternative surveys, including the often-used AAMC survey.

For example, in 2018 the U.S. Citizenship and Immigration Services (USCIS) requested additional evidence and denied visa applications that used wage data from the AAMC. Though this issue was eventually resolved, and the DOL accepted wage data from the AAMC this year, the acceptance of alternative data sets, even renowned and reliable ones, could be rejected without prior notice. This would have a devastating impact on H-1B resident physicians and their employers especially since the DOL does not provide wage data for medical residents in most cases. As such, under the proposed rule, if during the yearly review the DOL did not accept alternative surveys, or the H-1B residents were unable to fund or ask for the use of an alternative survey, H-1B residents would need to be paid the default wage of \$208,000 a year, which would have destructive consequences for the entire medical field.

¹⁵ The Davis-Bacon Act applies to contractors and subcontractors performing on funded or assisted contracts in excess of \$2,000 for the construction, alteration, or repair (including painting and decorating) of public buildings or public works. Davis-Bacon Act contractors and subcontractors must pay their laborers and mechanics employed under the contract no less than the prevailing wages and fringe benefits for corresponding work on similar projects in the area. The Davis-Bacon Act directs the Department of Labor to determine such prevailing wage rates. See <https://www.dol.gov/agencies/whd/government-contracts/construction>.

¹⁶ The McNamara-O'Hara Service Contract Act requires contractors and subcontractors performing services on prime contracts in excess of \$2,500 to pay service employees in various classes no less than the wage rates and fringe benefits found prevailing in the locality, or the rates (including prospective increases) contained in a predecessor contractor's collective bargaining agreement. See <https://www.dol.gov/agencies/whd/government-contracts/service-contracts>.

For example, for family medicine H-1B residents, if the BLS survey was used most year residents would go from making about \$73,000 a year to \$208,000 a year. See chart:¹⁷

Location	GME Pre Rule Level 1 Wage	GME Pre Rule Level 2 Wage	Rule Level 3 Wage	GME Pre Rule Level 4 Wage	Rule Level 1 Wage	Rule Level 2 Wage	Rule Level 3 Wage	Rule Level 4 Wage
New York County - NY	125,798	165,714	205,608	245,523	208,000	208,000	208,000	208,000
Los Angeles County - CA	208,000	208,000	208,000	208,000	208,000	208,000	208,000	208,000
Miami-Dade County - FL	31,928	48,381	64,813	81,266	44,512	101,296	158,101	214,885
Cook County - IL	133,619	154,565	175,490	196,435	208,000	208,000	208,000	208,000
Harris County - TX	58,510	101,421	144,310	187,221	208,000	208,000	208,000	208,000
Maricopa County - AZ	106,288	126,090	145,870	165,672	147,098	160,077	173,035	186,014
Dallas County - TX	77,147	126,568	175,968	225,389	208,000	208,000	208,000	208,000
Clark County - NV	73,549	117,853	162,178	206,482	208,000	208,000	208,000	208,000
Lincoln County - AR	73,549	117,853	162,178	206,482	208,000	208,000	208,000	208,000
Chattahoochee County - GA	75,275	82,722	90,168	97,614	86,798	101,192	115,565	129,958
Trousdale County - TN	73,549	117,853	162,178	206,482	208,000	208,000	208,000	208,000
Lake County - TN	73,549	117,853	162,178	206,482	208,000	208,000	208,000	208,000
Dakota County - NE	73,549	117,853	162,178	206,482	208,000	208,000	208,000	208,000
Lee County - AR	73,549	117,853	162,178	206,482	208,000	208,000	208,000	208,000
Buena Vista County - IA	73,549	117,853	162,178	206,482	208,000	208,000	208,000	208,000
Buffalo County - SD	73,549	117,853	162,178	206,482	208,000	208,000	208,000	208,000
Big Horn County - MT	73,549	117,853	162,178	206,482	208,000	208,000	208,000	208,000

A first-year general surgery H-1B resident would have an even more dramatic increase if the BLS survey data was used, requiring employers to raise wages for H-1B residents that are renewing their visa, seeking new visas, or have pending visas without an approved prevailing wage from about \$56,000 to \$208,000 almost overnight. See chart:¹⁸

Location	GME Pre Rule Level 1 Wage	GME Pre Rule Level 2 Wage	GME Pre Rule Level 3 Wage	GME Pre Rule Level 4 Wage	GME Post Rule Level 1 Wage	GME Post Rule Level 2 Wage	Post Rule Level 3 Wage	GME Post Rule Level 4 Wage
New York County - NY	58,282	104,208	150,134	196,061	208,000	208,000	208,000	208,000
Los Angeles County - CA	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Miami-Dade County - FL	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Cook County - IL	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Harris County - TX	56,534	118,518	180,502	242,486	208,000	208,000	208,000	208,000
Maricopa County - AZ	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Dallas County - TX	56,347	111,530	166,733	221,915	208,000	208,000	208,000	208,000
Clark County - NV	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Lincoln County - AR	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Chattahoochee County - GA	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Trousdale County - TN	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Lake County - TN	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Dakota County - NE	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Lee County - AR	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Buena Vista County - IA	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Buffalo County - SD	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000
Big Horn County - MT	56,222	107,245	158,246	209,269	208,000	208,000	208,000	208,000

¹⁷ <https://www.flcdatacenter.com/OESWizardStart.aspx>.

¹⁸ *Id.*

In 2019, the weighted mean stipend for all regions at the first post-MD year was \$57,863.¹⁹ Of the 153 institutions that submitted stipends data and responded to the question, the majority of the institutions (98.7 percent) reported that they pay the same base stipends to residents and fellows at each level across all specialties.²⁰ As such, the average year resident, including U.S. citizen residents, do not get paid anywhere close to \$208,000 a year. See chart:²¹

Table 1. Resident/Fellow Unweighted Stipends Nationwide, Dollar Change and Percent Change from Academic Year 2018-2019 to Stipends Effective July 1, 2019

	Year of Training	Institution Count	Mean Unweighted Stipend	25 th Percentile	Median	75 th Percentile
Stipends Effective July 1, 2019	1st Post-MD Year	154	\$57,191	\$54,083	\$56,912	\$58,965
	2nd Post-MD Year	155	\$59,339	\$56,196	\$59,022	\$61,785
	3rd Post-MD Year	155	\$61,636	\$57,836	\$61,350	\$64,098
	4th Post-MD Year	153	\$64,255	\$59,871	\$63,982	\$67,435
	5th Post-MD Year	149	\$66,787	\$62,171	\$66,318	\$70,000
	6th Post-MD Year	139	\$69,496	\$64,712	\$69,084	\$73,170
	7th Post-MD Year	126	\$72,515	\$67,365	\$71,847	\$75,942
	8th Post-MD Year	94	\$76,222	\$72,087	\$75,132	\$79,719

Instead, according to the AAMC data, most residents will never make \$208,000 a year and in fact, the 75th percentile of year residents only make about \$79,000 a year. IMGs make up nearly one-fourth of all resident physicians within the United States.²² As such, the proposed rule has the potential to reduce the country’s physician workforce by approximately 25 percent, and unfairly price H-1B physician residents out of the market or require employers to shoulder the burden of paying an H-1B resident about three times more than their U.S. counterpart. Accordingly, the implications of this wage change for H-1B residents are dire, and the antithesis of DOL’s stated goal of changing prevailing wages “to better reflect the actual wages earned by U.S. workers similarly employed to foreign workers.”²³

¹⁹ <https://www.aamc.org/system/files/2019-11/Survey%20of%20Resident%20Fellow%20Stipends%20and%20Benefits%20Report%202019-2020.pdf>.

²⁰ <https://www.aamc.org/system/files/2019-11/Survey%20of%20Resident%20Fellow%20Stipends%20and%20Benefits%20Report%202019-2020.pdf>.

²¹ <https://www.aamc.org/system/files/2019-11/Survey%20of%20Resident%20Fellow%20Stipends%20and%20Benefits%20Report%202019-2020.pdf>.

²² <https://www.aamc.org/data-reports/workforce/interactive-data/acgme-residents-and-fellows-who-are-international-medical-graduates-imgs-specialty-2017>.

²³ <https://www.federalregister.gov/documents/2020/10/08/2020-22132/strengthening-wage-protections-for-the-temporary-and-permanent-employment-of-certain-aliens-in-the>.

The IFR could Completely Collapse the Conrad 30 Waiver Program

The AMA has been vocal in its support of the Conrad 30 Waiver Program (Conrad 30) for over a decade.²⁴ Under Conrad 30,²⁵ J-1 IMGs²⁶ must change their status to that of an H-1B physician in order to remain in the U.S. while working in an underserved area for a minimum of three years.²⁷ As mentioned above, under the IFR, the default wage for H-1Bs is \$208,000 per year. Consequently, a clinic may have to pay a H-1B physician immediately out of residency \$208,000 a year, which is dramatically higher than the market rate for these employees and much more than most rural hospitals and medical centers are able to pay.

The original version of the Conrad 30 federal bill dates back to 1994. Through subsequent reauthorizations, the program has resulted in bringing more than 15,000 physicians to high-need areas. By its own admission, USCIS states that, “[t]he [Conrad 30 Waiver] [P]rogram addresses the shortage of qualified doctors in medically underserved areas.”²⁸ With more than 8.8 million cases and 225,000 deaths, the U.S. continues its fight against COVID-19. In light of current circumstances, now more than ever the Administration should be supporting our IMG physicians.²⁹

Although 20 percent of the population resides in rural areas, fewer than 10 percent of U.S. physicians actually practice in those communities.³⁰ As a result, over 23 million rural Americans live in federally-designated primary medical Health Professional Shortage Areas (HPSA).³¹ Even in times when health care providers do not face serious shortages of medical equipment and supplies, too many rural Americans do not have adequate access to health care resources—and physicians in particular. With rural areas already experiencing a physician shortage, they will undoubtedly be disproportionately affected by the rising rate of COVID-19 infections. The Conrad 30 program has helped address chronic physician shortages in rural America and other underserved areas for over two decades.³² Some states even require that a certain percentage of patients—in some cases up to 51 percent of patients—served by program participants must be from underserved areas.³³ According to a 2005 Government Accountability Office report, 44 percent of J-1 physicians provided primary care services in underserved communities across this country. Since residents typically remain in the specialty in which they complete their training, in this case primary care, a majority of J-1 residents will remain primary care specialists as H-1B physicians and, in accordance with Conrad 30 requirements, will continue to practice in underserved areas.

²⁴ AMA letters in support of Conrad 30 Waiver Program Reauthorization: [2012](#), [2013](#), [2015](#), [2017](#), and [2019](#).

²⁵ <https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program>.

²⁶ Specifically, the Conrad 30 waiver program allows J-1 foreign medical graduates (FMGs) to apply for a waiver of the 2-year foreign residence requirement upon completion of the J-1 exchange visitor program. See INA § 214(l); 8 U.S.C. § 1184(l).

²⁷ 8 U.S.C. § 1182(l)(1)(C).

²⁸ <https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program>

²⁹ Data as of October 22, 2020. https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases.

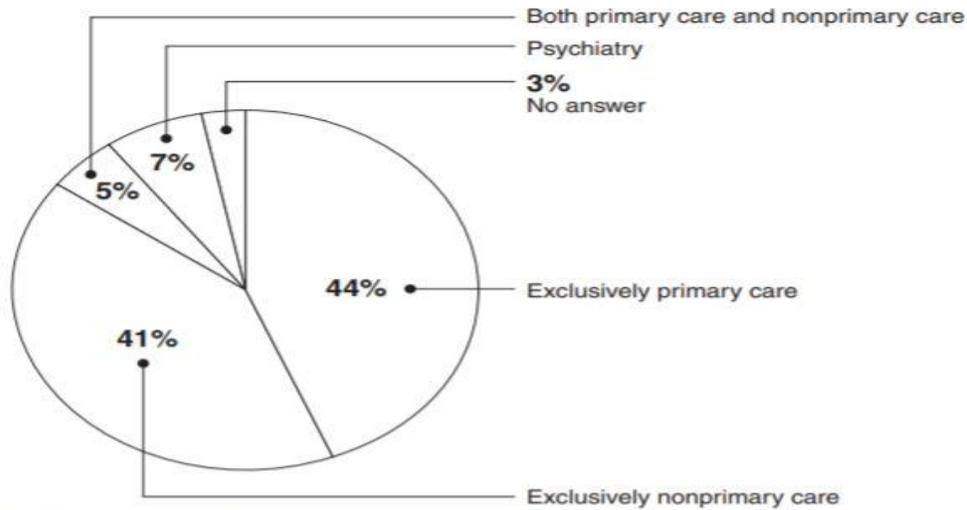
³⁰ <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>.

³¹ According to the U.S. Department of Health & Human Services, Bureau of Health Workforce Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Fourth Quarter of Fiscal Year 2020, Designated HPSA Quarterly Summary. Data as of September 30, 2020.

³² Conrad 30 participants must serve in a health care facility located in an area designated by the U.S. Department of Health and Human Services (HHS) as a HPSA, Medically Underserved Area (MUA), or Medically Underserved Population (MUP) or serving patients who reside in a HPSA, MUA, or MUP. See <https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program>.

³³ <https://dph.illinois.gov/topics-services/life-stages-populations/rural-underserved-populations/j1-waiver-program>.

Specialties Practiced by Physicians for Whom States Requested J-1 Visa Waivers, Fiscal Year 2005³⁴



Source: GAO survey of states, 2005.

Note: Percentages are based on 956 waivers requested by 52 states in fiscal year 2005. Puerto Rico and the U.S. Virgin Islands did not request waivers that year. Psychiatry is reported as a separate medical specialty because some states' J-1 visa waiver programs have requirements for psychiatrists that differ from those for other physicians.

The AMA believes the IFR will have a devastating impact on the ability for the Conrad 30 program to provide accessible health care to those in rural and other medically underserved communities, and due to the default wage requirement, may cause the elimination of the Conrad 30 program.

The IFR Detrimently and Disproportionately Impacts Rural and other Medically Underserved Communities

For the medical field, these wage requirements come at a most inopportune time, as the U.S. sustains some of the highest rates of COVID-19 cases worldwide.³⁵ The pandemic has put an incredible strain on our health care system and this crisis has drastically exacerbated physician shortages in many rural and underserved communities across the U.S.

HPSAs are used to identify areas, populations, groups, or facilities within the United States that are experiencing a shortage of health care professionals. According to the latest data released by the Health Resources & Services Administration (HRSA), 81.5 million people live in primary medical HPSAs in the U.S.³⁶ Prior to COVID-19, the U.S. needed 14,945 physicians to remove the primary medical HPSA

³⁴ <https://www.govinfo.gov/content/pkg/GAOREPORTS-GAO-06-773T/pdf/GAOREPORTS-GAO-06-773T.pdf>.

³⁵ As of October 28, 2020, according to <https://coronavirus.jhu.edu/map.html>, the U.S. had 8.8 million COVID-19 cases, the highest country/region/sovereignty globally.

³⁶ The U.S. Department of Health & Human Services, Bureau of Health Workforce Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Fourth Quarter of Fiscal Year 2020, Designated HPSA Quarterly Summary. Data as of September 30, 2020. See also, <https://bhwh.hrsa.gov/shortage-designation/types>.

designation.³⁷ However, the physician shortages identified by HRSA have become even more critical as COVID-19 has rampaged across the U.S.

If we compare the states where the most H-1B physicians are providing care and the states with some of the highest COVID-19 cases, the stark need for more physicians and the rescission of this IFR becomes apparent. For example, North Dakota has the highest per capita of COVID-19 cases and deaths of any state.³⁸ North Dakota also has the highest percentage of H-1B physicians in their workforce.³⁹

Top States Where H-1B Physicians are Providing Care ⁴⁰	Number of Physician LCAs ⁴¹	States with Increasing COVID-19 Cases ⁴²
New York	1467	2,499 new positive cases per day
Michigan	945	4,109 new positive cases per day
Illinois	826	6,362 new positive cases per day
Ohio	606	3,590 new positive cases per day
Pennsylvania	602	2,235 new positive cases per day
Texas	343	6,886 new positive cases per day
California	309	4,372 new positive cases per day
Indiana	244	3,618 new positive cases per day

Note: Abbreviation: LCA, labor condition application. Total certified physician LCAs by State. Physician LCAs certified in 2016.

As such, the AMA believes that the U.S. should promote an increase of IMGs and that current IMGs should not be hampered by additional unnecessary regulations in the midst of helping the U.S. fight COVID-19.

Even after the public health emergency ends, the AMA strongly urges the Administration to consider the long-term negative impact of this IFR on our most risk citizens in rural and medically underserved communities across this country whom rely on H-1B physicians to provide much needed primary and specialty health care services. The 2019 State Physician Workforce Data Report found that nationally, almost 25 percent of active physicians providing care in the U.S. are IMGs. Likewise, more than 20 million people live in areas of the U.S. where foreign-trained physicians account for at least half of all physicians.⁴³ According to new data released by AAMC, the United States' projected physician shortfall has increased from the 2019 predicted shortage of 121,900 physicians by 2032. The new study, projects shortfalls in primary care of between 21,400 and 55,200 physicians, and in specialty care of between

³⁷ The U.S. Department of Health & Human Services, Bureau of Health Workforce Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Fourth Quarter of Fiscal Year 2020, Designated HPSA Quarterly Summary. Data as of September 30, 2020.

³⁸ *Id.*

³⁹ JAMA Network, Peter A. Kahn, MPH, ThM, et al., Distribution of Physicians With H-1B Visas By State and Sponsoring Employer, June 6, 2017. <https://jamanetwork.com/journals/jama/fullarticle/2620160?resultClick=1>.

⁴⁰ JAMA Network, Peter A. Kahn, MPH, ThM, et al., Distribution of Physicians With H-1B Visas By State and Sponsoring Employer, June 6, 2017. <https://jamanetwork.com/journals/jama/fullarticle/2620160?resultClick=1>.

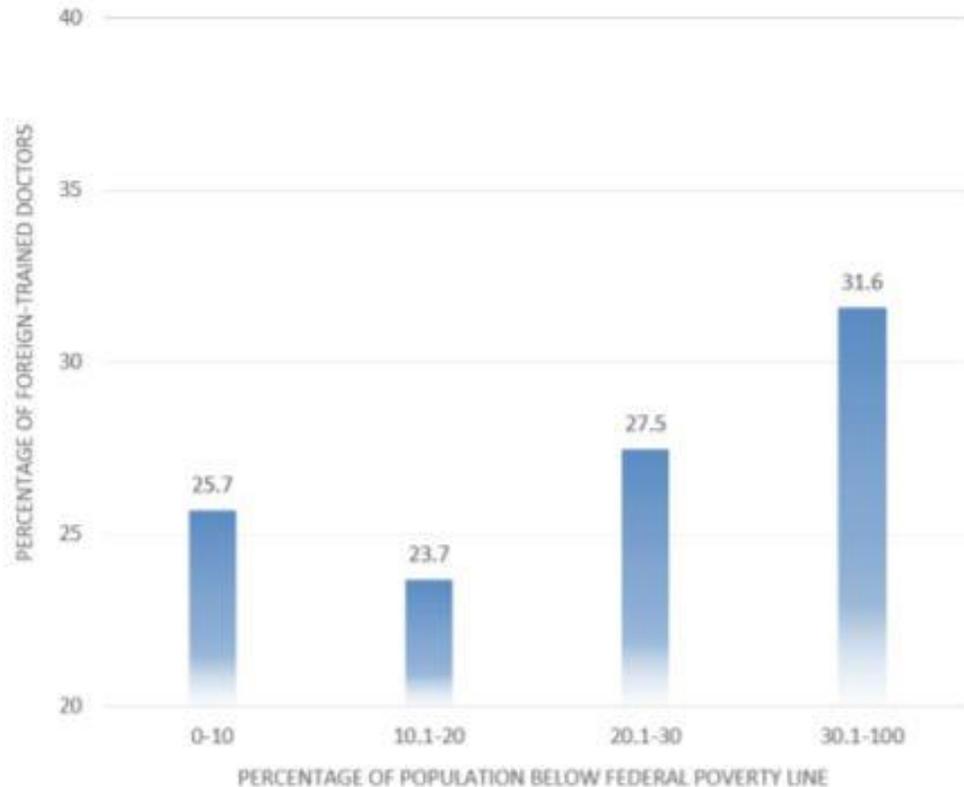
⁴¹ *Id.*

⁴² Last checked on October 30, 2020: <https://coronavirus.jhu.edu/testing/tracker/overview>.

⁴³ <https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained-doctors-are-critical-to-serving-many-us-communities.pdf>.

33,700 and 86,700 physicians by 2033. Therefore, IMGs will continue to play a critical role in providing health care, especially in underserved areas of the country with higher rates of poverty and chronic disease.⁴⁴

*Foreign-trained Doctors Serving U.S. Population, by Poverty Level*⁴⁵



The escalating physician shortage over the last 20 years, coupled with the COVID-19 pandemic, should serve as an alarm that the U.S. needs to increase its number of physicians to ensure we can care for patients in both the short- and long-term. **The AMA firmly believes that as we continue to face a mounting physician shortage in the U.S., the Administration should be promoting and easing the way for IMGs in the U.S. starting with the rescission of the current IFR, or exemption of physicians from the current IFR.**

We appreciate the opportunity to comment and we support the rule's policy objective to encourage the hiring and retention of qualified American skilled workers. However, the physician workforce shortage is documented, and the pandemic has magnified these workforce issues and other structural problems.

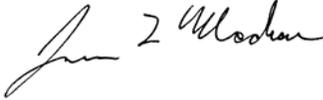
⁴⁴ *Id.*

⁴⁵ <https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained-doctors-are-critical-to-serving-many-us-communities.pdf>.

The Honorable Eugene Scalia
The Honorable Chad Wolf
November 9, 2020
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We urge the Administration to prioritize supporting and protecting the health and well-being of the U.S. population by rescinding this rule. We welcome the opportunity to share our views further. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, at 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,

A handwritten signature in black ink, appearing to read "Jim L. Madara". The signature is written in a cursive, flowing style.

James L. Madara, MD