

February 17, 2021

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

Re: Modification of Registration Requirement for Petitioners Seeking to File Cap-Subject H-1B Petitions [DHS Docket No. USCIS-2020-0019]

Dear Secretary Mayorkas:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide comments in opposition to the U.S. Department of Homeland Security's (DHS) final rule titled, "Modification of Registration Requirement for Petitioners Seeking to File Cap-Subject H-1B Petitions" [DHS Docket No. USCIS-2020-0019]. This rule was pushed through at the end of the Trump Administration, with the comment period opening on November 2, 2020, and closing on December 2, 2020.¹ On January 8, 2021, the Trump Administration finalized the rule without modifying the regulatory text proposed in the Notice of Proposed Rulemaking despite receiving close to 1,500 comments within the truncated comment period at the very end of the year.² The AMA applauds the Biden Administration for delaying the implementation of this rule and for reconsidering the negative impacts that this cap selection change would have on H-1B visa applicants.

The AMA believes that the final rule will cause irreparable and lasting harm in the ability to provide timely, accessible health care services to rural and medically underserved communities across the United States. Prior to the COVID-19 pandemic, the U.S. had already been facing a rising shortage of physicians largely due to the growth and aging of the general population and the impending retirement of many physicians.³ International medical graduates (IMGs) often serve in rural and medically underserved communities, providing care to many of our country's most at risk citizens. Individuals with serious chronic medical conditions, including diabetes and other comorbidities, are at a higher risk of experiencing complications from COVID-19.⁴ Our H-1B physicians have played a large role in serving on the front lines and 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 DHS to revoke the rule that was finalized under the Trump Administration and return to the previously employed cap selection process. If revocation is not possible, we urge DHS to exempt physicians from the rule.**⁵

¹ <https://www.federalregister.gov/documents/2020/11/02/2020-24259/modification-of-registration-requirement-for-petitioners-seeking-to-file-cap-subject-h-1b-petitions>.

² <https://www.federalregister.gov/documents/2021/01/08/2021-00183/modification-of-registration-requirement-for-petitioners-seeking-to-file-cap-subject-h-1b-petitions>.

³ <https://www.aame.org/news-insights/press-releases/new-findings-confirm-predictions-physician-shortage>.

⁴ <https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>.

⁵ 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://searchf.ama->

Every designated wage level of H-1B physicians already meet the specialty occupation requirements set out by the Immigration Nationality Act and should not be further limited by DHS' attempt to arbitrarily limit cap selection.

The H-1B visa program was established by Congress to provide an avenue for employers to hire a skilled foreign worker in a specialty occupation. The final rule is a clear violation of the Immigration and Nationality Act (INA), which prioritizes the selection of H-1B cap-subject petitions in the “order in which they are filed” and does not limit who is selected for the H-1B cap to those employers who pay the most. DHS asserts that “of course, this statutory provision, and more specifically the term filed as used in INA section 214(g)(3), 8 U.S.C. 1184(g)(3), is ambiguous.”⁶ However, the language utilized in this statute is clearly not ambiguous. The INA explicitly indicates that individuals subject to the numerical cap on issued H-1B visas will be processed on a “first-come, first-serve” basis. Therefore, preferentially choosing to admit candidates based on wage status does not fall in line with the provision set definitively within the INA. Moreover, DHS lacks the statutory authority to make such a change since the statute explicitly states selection criteria, and the selection criteria do not include additional wage level or skill level requirements above those already designated by the INA in prioritizing the selection of H-1B cap subject visas.

There are already rigorous standards in place that physicians must meet to receive an H-1B visa. Consequently, adding additional wage requirements, on top of the preexisting prevailing wage and performance standards, will only harm the U.S. health care system. If there are no available U.S. workers to fill a position, an employer’s labor need goes unmet without substantial investment in worker recruitment and training. Accordingly, importing necessary workers allows companies to innovate and grow, thus, creating more employment 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 bachelors or higher degree in the specific specialty, or its equivalent, as a minimum for entry into the occupation in the U.S.⁷ Accordingly, there is already a very high threshold that must be met to garner an H-1B visa.

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 set out by DHS provisions. Additionally, 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 is also met. As such, H-1B physicians clearly deserve the “specialty occupation” designation and these individuals are critical to filling a gap in our workforce that the U.S. cannot fill on its own.

Currently, the U.S. 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 age 65 and older, compared with only a 3.5 percent growth for those age 18 or younger.⁸ Partly due to this phenomenon, by 2033 the U.S. 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 86,700.⁹ As such, there is a growing need for a larger physician workforce that the

[assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-6-5%2520Letter-to-Cisna-re-H1B-Visa-Wage-Data.pdf](https://www.fda.gov/oc/foia/assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-6-5%2520Letter-to-Cisna-re-H1B-Visa-Wage-Data.pdf).

⁶ <https://www.federalregister.gov/documents/2020/11/02/2020-24259/modification-of-registration-requirement-for-petitioners-seeking-to-file-cap-subject-h-1b-petitions>.

⁷ See 8 U.S.C 1101(a)(15)(H)(i)(b), 1184(i).

⁸ <https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf>.

⁹ 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. does not have enough people in the younger generation to care for our aging country.

H-1B physicians fill a vital and irreplaceable role. In some specialties, such as geriatric medicine and nephrology, IMGs make up approximately 50 percent of active physicians.¹⁰ In other areas IMGs make up about 30 percent of active physicians including areas of medicine such as infectious disease, internal medicine, and endocrinology.¹¹ Thus, H-1B physicians already are required to, and do, meet a very high threshold and fulfill a need that the U.S. cannot fill on its own.

Moreover, H-1B recipients already must be paid the prevailing wage, or an equivalent wage based on a U.S. Department of Labor (DOL) accepted survey or bargaining agreement. In addition, DOL regulations state that the wage requirement includes the requirement that employers offer benefits and eligibility for benefits to the H-1B nonimmigrant on the same basis, and in accordance with the same criteria, as the employer offers to similarly employed workers.¹² DOL regulations also provide that the employer must afford working conditions to the H-1B beneficiary on the same basis and in accordance with the same criteria as it affords to its U.S. workers who are similarly employed.¹³ As such there already exists stringent performance and pay thresholds already exist that must be met to even be considered for an H-1B visa. Placing additional wage barriers on the cap will garner no benefit and instead will harm U.S. patients and health care systems since it will make it harder for these vital physicians to obtain an H-1B visa and care for our U.S. communities in need.

DHS' criteria for determining the prevailing wage, and thus the wage threshold that must be met or exceeded by the proffered wage, is flawed and does not reflect an increased required wage for higher skill levels.

The final rule will abruptly and unnecessarily change the selection process for H-1B cap-subject petitions by prioritizing registrants based on the highest Occupational Employment Statistics (OES) prevailing wage level. DHS would further select beneficiaries earning the highest wages relative to their Standard Occupational Classification (SOC codes) and area(s) of intended employment independent of skill level and workforce need. The 2018 SOC code system is a federal statistical standard used to classify workers into occupational categories for the purpose of collecting, calculating, or disseminating data related to employment. Unlike the current lottery system, where applicants are randomly chosen if the number of applications exceeds the 65,000 H-1B visa cap, under the final rule, U.S. Citizenship and Immigration Services (USCIS), will rank and select the registrations received on the basis of the highest proffered wage. Within this model, the selection of applicants would be dramatically altered, and applications in OES wage level IV would be considered first with subsequent OES wage levels III, II, and I being considered in descending order. USCIS would rank the petition in the same manner even if, instead of obtaining an OES prevailing wage, a petitioner elects to obtain a prevailing wage using another legitimate source, or an independent authoritative source. Therefore, applicants would be considered solely based on the amount of money that they would be paid, rather than the utility that they would bring to the U.S. workforce.

Employers who adopt the prevailing wage determination for establishing wage levels of H-1B employees are dependent on data produced by the Bureau of Labor Statistics (BLS) OES survey. The BLS survey methodology utilized by the DOL to determine prevailing wage levels presumptively incorporates an individual's experience, education, and skill level as defined by the DOL's Office of Foreign Labor Certification's National Prevailing Wage Center. This determination is reflected in the BLS' OES

¹⁰ <https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-who-are-international-medical-graduates-imgs-specialty-2017>.

¹¹ *Id.*

¹² See 20 CFR 655.731(c)(3).

¹³ See 20 CFR 655.732(a).

survey.¹⁴ However, as demonstrated by the recently imposed interim final rule “Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States,”¹⁵ there are some significant issues related to the collection of survey data from employers.¹⁶

The recently adopted final rule on “Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States,”¹⁷ raises the entry-level salary tier from the current 17th percentile to the 35th percentile. From there, the wage levels will be set at the 53rd, 72nd and 90th percentiles, up from the current top three levels at the 34th, 50th and 67th percentiles. This is a dramatic increase in the prevailing wage which is not necessarily representative of the actual market value of the services provided.

The BLS’ OES wage survey is based on a voluntary, semi-annual mail survey of non-farm establishments.¹⁸ “Employers who respond to the 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.”¹⁹ Since these critical data are collected voluntarily, there is not an accurate depiction of physician wage levels across every specialty or geographic area. Moreover, as larger urban centers have greater resources to actively participate in this survey process compared to smaller, lower income practices, the OES data collected are more likely to be skewed towards a higher wage level. Therefore, the prevailing wage levels determined by the DOL are not accurate due to the DOL’s inability to collect the required data for physician specialties and location which specifically disadvantages small practices in high need, medically underserved areas. The new prevailing wage changes will significantly harm the employers that budgeted to pay the actual competitive wage for the location, profession, and experience of the employee. If the new wage-based cap system is put in place it will further compound with the new prevailing wage requirements and make it impossible for underserved and small practices to garner the H-1B physicians that they desperately need.

Additionally, basing the H-1B cap system off of which applicant is paid the highest wage without considering that individuals within the same profession, training, and wage tier may be paid differently based on the geographic location that they are working will further skew the physician workforce away from rural areas and into urban coastal cities. By basing H-1B visas on the salary that an applicant is paid, a rural physician would have to be paid the same wage as an anesthesiologist in a metropolitan area in order to be competitive for a visa. The final rule, by creating a system that ranks H-1B visa applications based on the proffered wage, could potentially create a severely inflated wage market in order to gain H-

¹⁴ However, as the OES survey does not capture the actual skills or responsibilities of the workers whose wages are being reported, the DOL may choose to rely on a collective bargaining agreement or an acceptable survey outside the OES survey to establish the wage levels applicable to these nonimmigrant visa programs. An acceptable survey includes a current wage as determined by the Davis-Bacon Act the McNamara-O’Hara Service Contract Act an accepted independent authoritative source, or another legitimate source of wage data as determined by the DOL.

¹⁵ The OES survey designates four prevailing wage levels which are assigned a percentile of the total wage rates for a given “Metropolitan Statistical Area,” and clearly defines that employers are not permitted to pay a salary below that assigned “prevailing wage.” The DOL recently increased wage levels by a significant proportion. Specifically, the entry level wage (Level 1) now represents the 45th wage percentile or higher than 45 percent of all wages for that specific position in that Metropolitan Statistical Area. Subsequently, Level 2 (qualified) now represents the 62nd percentile, Level 3 (experienced) represents the 78th percentile, and Level 4 (fully competent) represents the 95th percentile.

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

¹⁶ See the AMA’s comments on “Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States,” <https://searchf.ama-assn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2020-11-9-Letter-to-Scalia-re-H-1B-DOL-Wage-Comment-Letter-2.pdf>.

¹⁷ <https://www.federalregister.gov/documents/2021/01/14/2021-00218/strengthening-wage-protections-for-the-temporary-and-permanent-employment-of-certain-aliens-in-the>.

¹⁸ https://www.bls.gov/oes/oes_ques.htm.

¹⁹ https://www.americanimmigrationcouncil.org/sites/default/files/research/wages_and_high-skilled_immigration.pdf.

1B physician slots. Acknowledging such circumstances, rural and other medically underserved areas are unlikely to be able to afford the inflated and inaccurate default wage and would remain devoid of critically needed physicians.

The final rule will either cause critically needed physicians to be priced out of a market that cannot afford to lose them or will force employers to pay a wage that is much higher than the competitive wage, which could cause fewer physicians to be hired overall, during a time when we are facing a severe physician shortage. If these provisions are implemented, the foundation for the system of determining whether an H-1B worker should be admitted into the U.S. workforce will become even more flawed and would eliminate many needed physicians during a global public health emergency.

The final rule makes the false assumption that higher skilled workers are always paid a higher wage and thus, devalues physicians in medically underserved areas.

The final rule is based on the false premise that individuals who earn more in their profession contribute more to the economy or society. The DHS specifically states prioritizing wage levels in the registration selection process:

incentivizes employers to offer higher wages, or to petition for positions requiring higher skills and higher-skilled aliens that are commensurate with higher wage levels, to increase the likelihood of selection for an eventual petition.... As a position's required skill level increases relative to the occupation, so, too, may the wage level, and necessarily, the corresponding prevailing wage. In most cases where the proffered wage equals or exceeds the prevailing wage, a prevailing wage rate reflecting a higher wage level is a reasonable proxy for the higher level of skill required for the position, based on the way prevailing wage determinations are made.²⁰

However, the prevailing wage is not directly tied to higher-skilled H-1B physicians. Even if we overlook the broken prevailing wage system, DHS has negated the true purpose of the INA and created a condition where employers would be able to buy their way into the H-1B visa cap selection system by offering a higher wage to the beneficiary regardless of skill. The DHS admits that "...while the proffered wage may not necessarily reflect the skill level required for the position in the strict sense of prevailing wage determination, the proffered wage still is a reasonable reflection of the value the employer has placed on that specific beneficiary." Based on this logic, an individual could be given preferential treatment despite having a lower skillset when compared to more qualified applicants. Thus, this would negate the stated purpose of garnering more high-skilled workers in the U.S. workforce. Additionally, larger, wealthier companies are much more likely to be able to pay augmented salaries to ensure that their future employee is able to successfully complete the H-1B visa process. In comparison, smaller, less affluent medical practices would not be able to compete with these large conglomerates, despite having a much greater physician workforce need. As such, U.S. patients that currently benefit from having H-1B physicians serve in their communities, may lose access to care as these physician slots are bought out by larger hospital systems, leaving mid to small size practices even more understaffed.

Moreover, it is incorrect to assume that skill level is definitively associated with wage amount. There are many situations where a highly skilled H-1B physician may choose to accept a lower wage, such as serving in an institution where they will expand their skillset, altruistic motives to provide for medically underserved communities, the potential to gain a green card in a shorter time span, and other motivators, including family. Therefore, the final rule creates a false assumption that would stop highly qualified, and

²⁰ <https://www.federalregister.gov/documents/2020/11/02/2020-24259/modification-of-registration-requirement-for-petitioners-seeking-to-file-cap-subject-h-1b-petitions>.

much needed, physicians from practicing in less affluent institutions across the U.S. Thus, as DHS acknowledged in the proposed rule that if the final rule is implemented it will likely stop employers from filling vacant positions that would have been engaged by H-1B workers.

The final rule creates a situation where either much needed physician positions remain vacant, only wealthy medical conglomerates are able to afford to sponsor H-1B physicians, or wages become so inflated that much fewer H-1B physicians can be hired. These outcomes are solely tied to money and are not tied to the actual skillset of the H-1B physician. Therefore, this contradicts the proposed rule's stated purpose of "attracting the 'best and the brightest' in the global labor market..."²¹

The final rule will have a devastating effect on Health Professional Shortage Areas and small medical practices, leaving U.S. patients without physicians.

If implemented, this final rule will have a direct and negative impact on U.S. employers and H-1B physicians by dramatically reducing access to the H-1B visa program for early-career professionals and their employers. U.S. Citizenship and Immigration Services has acknowledged that if this new regulation is implemented, no individuals who are paid a Level 1 wage would be selected to submit a H-1B cap-subject petition for the annual H-1B cap. These changes, if implemented, will effectively eliminate the H-1B program as an available visa option for new physicians seeking employment in an entry-level position.

Currently, IMGs compose nearly one-fourth of the U.S. physician workforce and one-fourth of the country's resident physicians in training. For the medical field, these visa cap requirements come at a most inopportune time, as the U.S. sustains some of the highest rates of COVID-19 cases worldwide and depends on these early career physicians to serve on the frontlines. 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. Even after the public health emergency ends, **the AMA strongly urges the Administration to consider the long-term negative impact of this final rule on our most at risk citizens in rural and medically underserved communities across this country who rely on H-1B physicians to provide much needed primary and specialty health care services.** Not only that, but if these early-career H-1B applicants believe that this new, arduous system will significantly prevent them from participating in the U.S. workforce, highly qualified physicians will choose to go to other countries rather than risk being unable to complete training requirements, build up a medical practice, or perform clinic duties.

Although 20 percent of the country's population resides in rural areas, fewer than 10 percent of U.S. physicians actually practice in these underserved communities.²² As a result, over 23 million rural Americans live in federally designated primary medical Health Professional Shortage Areas (HPSAs).²³ 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 and Services Administration (HRSA), 81.5 million people live in primary medical HPSAs in the U.S.²⁴ Federally Qualified Healthcare Centers (FQHCs) are institutions who serve high-risk, medically underserved populations in HSPAs, but do not qualify for exemption from the DHS H-1B visa cap. "FQHCs are safety net providers that primarily provide services typically furnished in an outpatient clinic. FQHCs include community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and health center program 'lookalikes.' They also include outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization." To fill the physician gap, FQHCs utilize H-1B physicians to care for patients in

²¹ *Id.*

²² <https://www.aha.org/system/files/2019-02/rural-report-2019.pdf>.

²³ According to the Fourth Quarter of Fiscal Year 2020 Designated HPSA Quarterly Summary Data as of September 30, 2020.

²⁴ *Id.* See also, <https://bhwh.hrsa.gov/shortage-designation/types>.

these health care disparaged communities. Prior to COVID-19, the U.S. needed 14,945 physicians to remove the primary medical HPSA designation.²⁵ If the final rule is implemented, these FQHCs will be unable to obtain early-career H-1B physicians and will be unlikely to be able to compete with larger, more affluent organizations to offer a higher proffered wage in order to increase their chances of obtaining H-1B physician candidates and reducing the physician shortages identified by HRSA data.

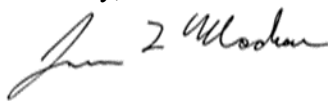
Moreover, FQHC facilities are often utilized by H-1B physicians participating in pipeline programs, such as Conrad-30,²⁶ to serve in during the beginning of their career. These physicians are recently graduated or have had limited experience and thus, fall within the first and second tiers of the prevailing wage determination. DHS admits that if the final rule is implemented, it is highly unlikely that any applicants from the first two tiers would even be considered. Therefore, the final rule will create a system that removes physicians that are willing and ready to practice in medically underserved areas and cuts off those that are most in need from receiving physician care.

FQHCs are not the only practice model likely to be harmed from by the final rule change. DHS estimates that in previous years, 80.1 percent of the population of who filed Form I-129 under the H-1B classification were small entities, yet the DHS asserts that no small entities would be significantly affected by the final rule. However, in 2018 nearly 57 percent of physicians worked in a practice with 10 or fewer physicians.²⁷ For these small facilities, losing a physician employee could be not only disruptive to the clinic's practice, but could catastrophically limit the amount of patients who are able to receive care.

In addition, as stated above, small and mid-sized practice groups would be severely limited in their ability to raise the proffered wage, thus preventing these entities from being competitive in the new prevailing wage prioritization process for H-1B cap slots. The loss of even one physician within small practices in rural and medically underserved areas could mean many individuals lose access to health care, something that we cannot afford, especially during a global pandemic.

The physician workforce shortage is well documented, and the pandemic has magnified these workforce issues and other structural problems. We appreciate the opportunity to comment and urge the Administration to prioritize supporting and protecting the health and well-being of the U.S. population by revoking this final rule. If that is not possible, we ask that DHS exempt H-1B physicians from this change to the cap system. We welcome the opportunity to share our views further. If you have any questions, please contact Margaret Garikes, Vice President, Federal Affairs at margaret.garikes@ama-assn.org or 202-789-7409.

Sincerely,



James L. Madara, MD

²⁵ Fourth Quarter of Fiscal Year 2020 Designated HPSA Quarterly Summary Data as of September 30, 2020.

²⁶ 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>.

²⁷ <https://www.ama-assn.org/about/research/employed-physicians-now-exceed-those-who-own-their-practices>.