AMA AMERICAN MEDICAL ASSOCIATION

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The Honorable Chad Wolf
Acting 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 Acting Secretary Wolf:

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) proposed rule titled, "Modification of Registration Requirement for Petitioners Seeking To File Cap-Subject H-1B Petitions" [DHS Docket No. USCIS-2020-0019].

The AMA believes the proposed rule will cause irreparable 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 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.[2] Our H-1B physicians 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 DHS to withdraw the proposed rule. If withdrawal is not possible, we urge DHS to exempt physicians from the proposed rule.**[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.

Every wage level of H-1B physicians already meets 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 proposed 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 214(g)(3), 8 U.S.C. 1184(g)(3), is ambiguous."[4] 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 is not silent regarding selection criteria, and the selection criteria does 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, then 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.[5] 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 statue 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.[6] 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

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

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

[6] https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf.

between 33,700 and 86,700.[7] As such, there is a growing need for a larger physician workforce that the 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 fulfill a vital and irreplaceable role. In some specialties, such as geriatric medicine and nephrology, IMGs make up approximately 50 percent of active physicians.[8] In other areas IMGs make up about 30 percent of active physicians including in areas of medicine such as infectious disease, internal medicine, and endocrinology.[9] 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.[10] DOL regulations additionally 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.[11] As such, there already exists stringent performance and pay thresholds 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 as such, often does not actually reflect an increased required wage for higher skill levels.

DHS proposes to 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 proposed rule, U.S. Citizenship and Immigration Services (USCIS), would rank and select the registrations received on the basis of the highest proffered wage. Within this model, the selection of applicants would be changed, and applications in OES wage level IV would be considered first with 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

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[7] 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.

[8] https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-who-are-international-medical-graduates-imgs-specialty-2017.

[9] *Id*.

[10] *See* 20 CFR 655.731(c)(3).

[11] *See* 20 CFR 655.732(a).

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 survey.[12] However, as determined by the recently imposed interim final rule "Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States,"[13] if valid sources of data are not available, the default wage under the BLS OES, is $208,000. It should be noted that, there are some significant issues related to the collection of survey data from employers.[14]

The BLS' OES wage survey is based off a voluntary, semi-annual mail survey of non-farm establishments.[15] "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."[16] Since this critical data is collected voluntarily, there is not an accurate depiction of physician wage levels across all specialties and all geographic areas. Moreover, as larger urban centers have greater resources to participate in this survey compared to smaller, lower income practices, the OES data collected is 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 and specifically disadvantage small practices in high need, medically underserved areas. Furthermore, due to the lack of data that is able to be collected by this voluntary survey, numerous physician specialties of all wage levels default to $208,000 a year.

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[12] 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.

[13] 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.

[14] See the AMA's comments on "Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States," https://searchlf.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.

[15] https://www.bls.gov/oes/oes_ques.htm.

[16] https://www.americanimmigrationcouncil.org/sites/default/files/research/wages_and_high-skilled_immigration.pdf.

See charts: [17]

BLS Wage Data For Family Medicine

Location	Post Rule Level 1 Wage	Post Rule Level 2 Wage	Post Rule Level 3 Wage	Post Rule Level 4 Wage
New York County - NY	208,000	208,000	208,000	208,000
Los Angeles County - CA	208,000	208,000	208,000	208,000
Miami-Dade County - FL	208,000	208,000	208,000	208,000
Cook County - IL	208,000	208,000	208,000	208,000
Harris County - TX	208,000	208,000	208,000	208,000
Maricopa County - AZ	208,000	208,000	208,000	208,000
Dallas County - TX	208,000	208,000	208,000	208,000
Clark County - NV	208,000	208,000	208,000	208,000
Lincoln County - AR	208,000	208,000	208,000	208,000
Chattahoochee County - GA	208,000	208,000	208,000	208,000
Trousdale County - TN	208,000	208,000	208,000	208,000
Lake County - TN	208,000	208,000	208,000	208,000
Dakota County - NE	208,000	208,000	208,000	208,000
Lee County - AR	208,000	208,000	208,000	208,000
Buena Vista County - IA	208,000	208,000	208,000	208,000
Buffalo County - SD	208,000	208,000	208,000	208,000
Big Horn County - MT	208,000	208,000	208,000	208,000

BLS Wage Data for Pediatrics

Location	Post Rule Level 1 Wage	Post Rule Level 2 Wage	Post Rule Level 3 Wage	Post Rule Level 4 Wage
New York County - NY	208,000	208,000	208,000	208,000
Los Angeles County - CA	208,000	208,000	208,000	208,000
Miami-Dade County - FL	208,000	208,000	208,000	208,000
Cook County - IL	208,000	208,000	208,000	208,000
Harris County - TX	208,000	208,000	208,000	208,000
Maricopa County - AZ	208,000	208,000	208,000	208,000
Dallas County - TX	208,000	208,000	208,000	208,000
Clark County - NV	208,000	208,000	208,000	208,000
Lincoln County - AR	208,000	208,000	208,000	208,000
Chattahoochee County - GA	115,440	135,512	155,605	175,677
Trousdale County - TN	208,000	208,000	208,000	208,000
Lake County - TN	208,000	208,000	208,000	208,000
Dakota County - NE	208,000	208,000	208,000	208,000
Lee County - AR	208,000	208,000	208,000	208,000
Buena Vista County - IA	208,000	208,000	208,000	208,000
Buffalo County - SD	208,000	208,000	208,000	208,000
Big Horn County - MT	208,000	208,000	208,000	208,000

[17] https://www.flcdatacenter.com/OESWizardStart.aspx.

BLS Wage Data For Internal Medicine

Location	Post Rule Level 1 Wage	Post Rule Level 2 Wage	Post Rule Level 3 Wage	Post Rule Level 4 Wage
New York County - NY	208,000	208,000	208,000	208,000
Los Angeles County - CA	208,000	208,000	208,000	208,000
Miami-Dade County - FL	208,000	208,000	208,000	208,000
Cook County - IL	208,000	208,000	208,000	208,000
Harris County - TX	208,000	208,000	208,000	208,000
Maricopa County - AZ	208,000	208,000	208,000	208,000
Dallas County - TX	208,000	208,000	208,000	208,000
Clark County - NV	208,000	208,000	208,000	208,000
Lincoln County - AR	208,000	208,000	208,000	208,000
Chattahoochee County - GA	59,426	133,016	206,627	280,218
Trousdale County - TN	208,000	208,000	208,000	208,000
Lake County - TN	208,000	208,000	208,000	208,000
Dakota County - NE	208,000	208,000	208,000	208,000
Lee County - AR	208,000	208,000	208,000	208,000
Buena Vista County - IA	208,000	208,000	208,000	208,000
Buffalo County - SD	208,000	208,000	208,000	208,000
Big Horn County - MT	208,000	208,000	208,000	208,000

BLS Wage Data for General Surgery

Location	Post Rule Level 1 Wage	Post Rule Level 2 Wage	Post Rule Level 3 Wage	Post Rule Level 4 Wage
New York County - NY	208,000	208,000	208,000	208,000
Los Angeles County - CA	208,000	208,000	208,000	208,000
Miami-Dade County - FL	208,000	208,000	208,000	208,000
Cook County - IL	208,000	208,000	208,000	208,000
Harris County - TX	208,000	208,000	208,000	208,000
Maricopa County - AZ	208,000	208,000	208,000	208,000
Dallas County - TX	208,000	208,000	208,000	208,000
Clark County - NV	208,000	208,000	208,000	208,000
Lincoln County - AR	208,000	208,000	208,000	208,000
Chattahoochee County - GA	208,000	208,000	208,000	208,000
Trousdale County - TN	208,000	208,000	208,000	208,000
Lake County - TN	208,000	208,000	208,000	208,000
Dakota County - NE	208,000	208,000	208,000	208,000
Lee County - AR	208,000	208,000	208,000	208,000
Buena Vista County - IA	208,000	208,000	208,000	208,000
Buffalo County - SD	208,000	208,000	208,000	208,000
Big Horn County - MT	208,000	208,000	208,000	208,000

BLS Wage Data For OBGYN

Location	Post Rule Level 1 Wage	Post Rule Level 2 Wage	Post Rule Level 3 Wage	Post Rule Level 4 Wage
New York County - NY	208,000	208,000	208,000	208,000
Los Angeles County - CA	208,000	208,000	208,000	208,000
Miami-Dade County - FL	208,000	208,000	208,000	208,000
Cook County - IL	208,000	208,000	208,000	208,000
Harris County - TX	208,000	208,000	208,000	208,000
Maricopa County - AZ	208,000	208,000	208,000	208,000
Dallas County - TX	208,000	208,000	208,000	208,000
Clark County - NV	208,000	208,000	208,000	208,000
Lincoln County - AR	208,000	208,000	208,000	208,000
Chattahoochee County - GA	208,000	208,000	208,000	208,000
Trousdale County - TN	208,000	208,000	208,000	208,000
Lake County - TN	208,000	208,000	208,000	208,000
Dakota County - NE	208,000	208,000	208,000	208,000
Lee County - AR	208,000	208,000	208,000	208,000
Buena Vista County - IA	208,000	208,000	208,000	208,000
Buffalo County - SD	208,000	208,000	208,000	208,000
Big Horn County - MT	208,000	208,000	208,000	208,000

BLS Wage Data For Urology

Location	Post Rule Level 1 Wage	Post Rule Level 2 Wage	Post Rule Level 3 Wage	Post Rule Level 4 Wage
New York County - NY	208,000	208,000	208,000	208,000
Los Angeles County - CA	208,000	208,000	208,000	208,000
Miami-Dade County - FL	208,000	208,000	208,000	208,000
Cook County - IL	208,000	208,000	208,000	208,000
Harris County - TX	208,000	208,000	208,000	208,000
Maricopa County - AZ	208,000	208,000	208,000	208,000
Dallas County - TX	208,000	208,000	208,000	208,000
Clark County - NV	208,000	208,000	208,000	208,000
Lincoln County - AR	208,000	208,000	208,000	208,000
Chattahoochee County - GA	208,000	208,000	208,000	208,000
Trousdale County - TN	208,000	208,000	208,000	208,000
Lake County - TN	208,000	208,000	208,000	208,000
Dakota County - NE	208,000	208,000	208,000	208,000
Lee County - AR	208,000	208,000	208,000	208,000
Buena Vista County - IA	208,000	208,000	208,000	208,000
Buffalo County - SD	208,000	208,000	208,000	208,000
Big Horn County - MT	208,000	208,000	208,000	208,000

The charts included above show significant discrepancies between the BLS prevailing wage—the information that would be used to determine wages relative to H-1B's Standard Occupational

Classification—and DHS' claim that higher skill level positions will be required to be paid higher wages. Despite assessing wage data among a variety of physician specialties across a range of geographic areas, a lack of accurate statistical evidence by the BLS OES survey has created a situation where a population of H-1B physicians are to be paid the same amount despite skill level or experience.

Moreover, the inability to accurately determine prevailing wage levels is not exclusive to the field of medicine; many other career fields have experienced similar discrepancies. By requiring all jobs to pay their H-1B employees at the same wage level, if there is inadequate data, regardless of the location of the job, experience or education level of the worker, nature of the duties performed, or other important factors, the DOL fails to adequately determine a prevailing wage. The required default wage across all employment sectors will harm not only the H-1B employees, but also, the employers that budget to pay the actual competitive wage for the location, profession, and experience of the employee. As a result, of the default wage, 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.[18]

Thus, in situations where there is minimal wage data, DHS will be unable to accurately and fairly adjudicate cap slots to H-1B applicants based on the proposed prevailing wage prioritization process. As seen in the charts above, if there are two H-1B applications, one from a Urologist newly graduated from their residency program and another from a Urologist with 12 years of experience, based on DHS' proposed prioritization method, the Department would be unable to differentiate between the two applicants when the default wage is utilized. Therefore, this system would not meet the goals set out by DHS to "better ensur[e] that new H-1B visas will go to the highest skilled or highest paid beneficiaries."[19]

Under the proposed rule, in order for a non-cap exempt applicant to meet the qualifications to receive an H-1B visa, employers must pay the prevailing wage as determined by the DOL, even if this wage is not reflective of the occupation's market value. If the DOL does not have data for the H-1B physician's specialty, which is highly probable, the H-1B physicians must be paid the default wage of $208,000 a year. For example, per 2020 DOL data, a level one family medicine physician had an average salary of between $50,000 and $118,000. However, due to a lack of data, many employers are now going to be required to pay level one family medicine physician H-1B employees the default wage of $208,000 which is not representative of the market. The proposed rule, by creating a system that ranks H-1B visa applications based on the proffered wage, buys into a system that is broken due to a lack of accurate data and could potentially create a severely inflated wage market in order to gain H-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 proposed rule will either cause much-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

[18] 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.

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

physician shortage. If these provisions are adopted, 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 proposed rule makes the false assumption that higher skilled workers are always paid a higher wage and thus, devalues physicians in medically underserved areas.

The proposed rule by DHS 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 positions 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, as shown above, the BLS OES prevailing wage often does not correspond 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 proposed 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 DHS proposed rule to garner 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 an incorrect assumption 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 proposed rule creates a false presupposition that would stop highly qualified, and much needed, physicians from practicing in less affluent institutions across the U.S. Thus, as DHS acknowledges, if this proposed rule is enacted it would likely stop employers from filling vacant positions that would have been engaged by H-1B workers.

As such, the proposed 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

[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.

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 proposed rule would have a devastating effect on Health Professional Shortage Areas and small medical practices leaving U.S. patients without physicians.

If implemented, this proposed 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 proposed changes would 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 depend 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 proposed 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 feel 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 those 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 these health care disparaged

[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://bhw.hrsa.gov/shortage-designation/types.

communities. Prior to COVID-19, the U.S. needed 14,945 physicians to remove the primary medical HPSA designation.[25] If the proposed rule is enacted, these FQHCs will be unable to obtain early-career H-1B physicians and are 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.

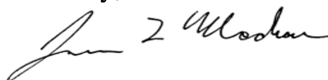
Moreover, FQHC facilities are often utilized by H-1B physicians participating in pipeline programs, such as Conrad-30,[26] to serve in during the beginning of their career. These physicians are recently graduated or have had limited experience and thus, fall within the first and second tiers of the prevailing wage determination. DHS admits that if the proposed rule is adopted, it is highly unlikely that any applicants from the first two tiers would even be considered. Therefore, the proposed rule would 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 this proposed 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 proposed 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 proposed 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 withdrawing this proposed rule. If that is not possible, we ask that DHS exempt H-1B physicians from this proposed 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 202-789-7409 or margaret.garikes@ama-assn.org.

Sincerely,



James L. Madara, MD

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[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.