AMA
AMERICAN MEDICAL ASSOCIATION

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April 29, 2021

The Honorable Marty Walsh
Secretary
U.S. Department of Labor
c/o Office of Foreign Labor Certification
Employment and Training Administration (ETA)
Office #: N-5306
200 Constitution Avenue, NW
Washington, DC 20210

Re: Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States [DOL Docket No. ETA-2021-0003]

Dear Secretary Walsh:

On behalf of the physician and medical student members of the American Medical Association (AMA), I am writing to provide comments on the U.S. Department of Labor's (DOL) Final Rule (the Rule) titled, "Strengthening Wage Protections for the Temporary and Permanent Employment of Certain Aliens in the United States" [DOL Docket No. ETA-2021-0003]. The AMA believes the Rule 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 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 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 revise or rescind the computation of prevailing wage levels to ensure that the computation of wages effectively guarantees the employment of IMGs and does not adversely affect the wages of U.S. workers similarly employed. If rescission to pre-rule wage levels is not possible, we urge the DOL to exempt physicians from the rule. Additionally, the AMA strongly urges the DOL to continue to approve and to annually accept, 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.amaassn.org/letter/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-6-5%2520Letter-to-Cissna-re-H1B-Visa-Wage-Data.pdf.

The Rule Inappropriately Changes the Prevailing Wage Determination Which Irreparably Harms the Entire Medical Community and the Patients They Serve

The Rule 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 raises the salary requirements about 20 percent at each tier. This change, though slightly lower than the changes in the interim final rule, are still drastic and will radically alter wage requirements for foreign national physicians, many of whom 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 off a voluntary, semi-annual mail survey of non-farm establishments.[4] "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."[5] 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." Without providing evidence-based reasoning, this rule markedly increased wage 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 35th percentile. Subsequently, Level 2 (qualified) was increased from the 34th percentile to the 53rd percentile, Level 3 (experienced) from the 50th percentile to the 72nd percentile, and Level 4 (fully competent) from the 67th percentile to the 90th 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. However, these increases will be broadly implemented across all areas of the workforce without looking at specific circumstances of professions and within the physician community, and thus will likely do more harm than good.

H-1B Physicians Fill a Vital Role in the U.S. Workforce that Otherwise Could Not Be Filled

If there are no available U.S. workers to fill a position, then a firm's labor needs go unmet without substantial investment in worker recruitment and training. Accordingly, importing highly needed workers

[4] https://www.bls.gov/oes/oes_ques.htm.
[5] https://www.americanimmigrationcouncil.org/sites/default/files/research/wages_and_high-skilled_immigration.pdf.

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.[6]

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.[7] 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.[8] There is, therefore, 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. physically does not have enough people in the younger generation to care for our aging country. H-1B physicians play a vital and irreplaceable role in filling this void. In some specialties, such as geriatric medicine and nephrology, IMGs make up approximately 50 percent of active physicians.[9] 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.[10]

This wage increase, especially for IMGs, which were given less weight in how the DOL identified wage level ranges, is unnecessary.[11] The DOL already has safeguards in place beyond the education and knowledge requirements to protect the U.S. job market, including the requirement that a labor condition application cannot be filled without first proving that the employment of foreign workers will not adversely affect the wages and working conditions of U.S. workers that are similarly employed.[12]

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. However, despite the great need that our nation has, and the invaluable services that IMGs provide, this wage level increase will stop IMG physicians from being

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[6] *See* 8 U.S.C 1101(a)(15)(H)(i)(b), 1184(i).
[7] https://www.aamc.org/download/472888/data/physicianworkforceissues.pdf.
[8] 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.
[9] https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-who-are-international-medical-graduates-imgs-specialty-2017.
[10] *Id.*
[11] https://www.federalregister.gov/documents/2021/01/14/2021-00218/strengthening-wage-protections-for-the-temporary-and-permanent-employment-of-certain-aliens-in-the.
[12] *See* 8 U.S.C. 1182(a)(5)(A)(i)(II).

able to provide care in low income, rural, and small practices since these entities will not be able to support the large salary increase required by this rule.

The Rule Unfairly Discriminates Against H-1B Residents and 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 Rule, a Department at a National Processing Center (NPC) will determine whether a job is covered by a collective bargaining agreement that was negotiated at arms-length. However, in the event the occupation is not covered by such an 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,[13] the McNamara-O'Hara Service Contract Act,[14] an accepted independent authoritative source, or another legitimate source of wage data as determined by the DOL.

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 in 2020, the acceptance of alternative data sets, even well 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 to 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 potentially need to be paid a much higher wage than their U.S. counterparts which would have destructive consequences for the entire medical field.

In general, residents are paid a relatively similar base pay throughout their residencies, but this does vary based on geographic area and cost of living. Therefore, having approximately a 20 percent wage increase for IMG residents would be a major change and would likely mean that these individuals would have to

[13] The Davis-Bacon Act applies to contractors and subcontractors performing on federally 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 locally 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 locally prevailing wage rates. *See* https://www.dol.gov/agencies/whd/government-contracts/construction.

[14] 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.

be systematically paid significantly than more their U.S. resident counterparts. Such changes could make it next to impossible for IMGs to find resident positions.

Moreover, despite DOL acknowledging a plethora of commenters from across the physician and health care community asserting in the comments on the interim final rule that increased wages would lead to a shortage of health care workers (including bilingual workers and mental health professionals) and reduce the quality of and access to health care, the previous Administration did not make any reasonable changes to the wage levels, nor did it describe how this wage increase would actually meet market value for wages and not irreparably impair the medical community and its patients.[15]

Unlike their resident counterparts, H-1B physicians are not part of a larger cohort and not as likely to be able to fund their own wage survey. Furthermore, they often do not benefit from the AAMC survey, mentioned above, as this specific survey focuses on residents and faculty. Thus, the proposed rule will either cause these much-needed physicians to be priced out of a market that cannot afford to lose them or require employers to pay a wage that is much higher. This could cause fewer doctors to be hired overall during a time when facing a severe physician shortage.

Additionally, this rule does not take into account the current economic climate. According to a survey done by the Physicians Foundation, eight percent of physician respondents have closed their practices.[16] That could equate to as many as 16,000 practices closing nationally.[17] Another four percent said they plan to close their practices within 12 months as a result of COVID-19.[18] It is not just small practices that are feeling the strain "[m]ore than three dozen hospitals have already entered bankruptcy this year....More than a dozen in rural areas have also shut their doors according to the Cecil G. Sheps Center for Health Services Research at the University of North Carolina.[19] The American Hospital Association (AHA) put the total U.S. hospital count at 6,146 in its most recent report, a decrease of 64 from the previous year."[20] With the economics of health care currently in a perilous state, and with the recovery of the market uncertain, raising the wage levels about 20 percent, without justification as to why or how this meets true market value, will place additional financial strain on medical practices and may prevent IMGs from being hired.

The Rule Could Completely Collapse the Conrad 30 Program

The AMA has been vocal in its support of the Conrad 30 Waiver Program (Conrad 30) for over a decade.[21] Under Conrad 30,[22] J-1 IMGs[23] 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.[24]

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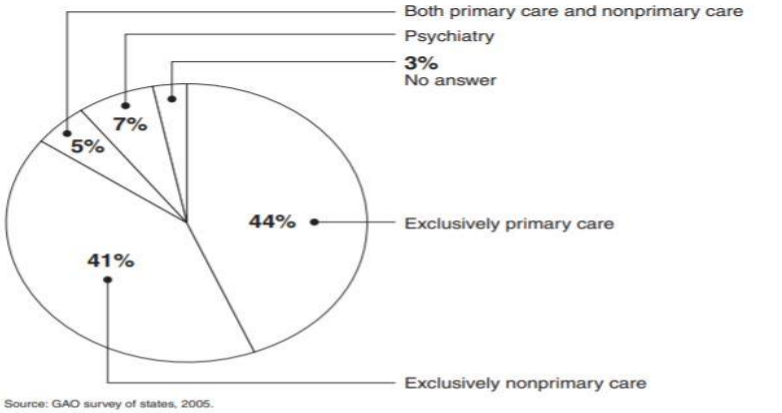
[15] https://www.federalregister.gov/documents/2021/01/14/2021-00218/strengthening-wage-protections-for-the-temporary-and-permanent-employment-of-certain-aliens-in-the.
[16] http://physiciansfoundation.org/wp-content/uploads/2020/08/20-1278-Merritt-Hawkins-2020-Physicians-Foundation-Survey.6.pdf.
[17] https://www.aha.org/aha-center-health-innovation-market-scan/2020-09-01-specialist-and-private-practices-take-severe.
[18] *Id.*
[19] *Id.*
[20] https://www.bloomberg.com/news/articles/2020-10-14/shaky-u-s-hospitals-risk-bankruptcy-in-latest-covid-wave.
[21] AMA letters in support of Conrad 30 Waiver Program Reauthorization: 2012, 2013, 2015, 2017, and 2019.
[22] https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program.
[23] 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).
[24] 8 U.S.C. §1182(l)(1)(C).

The Conrad 30 Program dates back to 1994 and, through subsequent reauthorizations, has resulted in bringing more than 15,000 physicians to high-need areas. By its own admission, the USCIS states that "[t]he [Conrad 30 Waiver] [P]rogram addresses the shortage of qualified doctors in medically underserved areas."[25] In light of the more than 31 million cases and the approximately 560,000 deaths due to COVID-19,[26] now more than ever the Administration should be supporting our IMG physicians.

Although 20 percent of the population resides in rural areas, fewer than 10 percent of U.S. physicians practice in those communities.[27] As a result, over 23 million rural Americans live in federally designated primary medical Health Professional Shortage Areas (HPSAs).[28] 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. The Conrad State 30 Program has helped address chronic physician shortages in rural America and other underserved areas for over two decades.[29] This program will only become more crucial as we face the long-term health impacts resulting from the COVID-19 pandemic.

Data show that resident physicians typically remain in the specialty in which they complete their training, in this case 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.

Specialties Practiced by Physicians for Whom States Requested J-1 Visa Waivers, Fiscal Year 2005[30]



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.

However, the Rule increases the minimum prevailing wage requirements by approximately 20 percent at every wage level. Such stringent alterations to the system for incorporating IMGs into our health care workforce presents significant barriers to rural and medically underserved areas attempting to utilize these physicians. With such large increases in prevailing wage requirements, rural sites with limited resources

[25] https://www.uscis.gov/working-in-the-united-states/students-and-exchange-visitors/conrad-30-waiver-program
[26] Data as of April 14, 2021. https://covid.cdc.gov/covid-data-tracker/#trends_dailytrendscases.
[27] https://www.aha.org/system/files/2019-02/rural-report-2019.pdf.
[28] 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.
[29] 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.
[30] https://www.govinfo.gov/content/pkg/GAOREPORTS-GAO-06-773T/pdf/GAOREPORTS-GAO-06-773T.pdf.

would likely be unable to fund IMG physicians who would otherwise be ready and capable to serve these patients. Thus, our high-risk patients who already suffer from limitations on access to primary and specialty care would be further disadvantaged.

The AMA believes the Rule 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 wage increase, may cause the elimination of the Conrad 30 Program.

The Rule Detrimentally and Disproportionately Impacts Rural and Other Medically Underserved Communities

For the medical field, these wage requirements come at a most inopportune time. Throughout the COVID-19 pandemic, the U.S. suffered the highest rates of COVID-19 cases worldwide.[31] The pandemic has put an incredible strain on our health care system and this crisis has drastically exacerbated physician shortages in many rural and medically 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.[32] Prior to COVID-19, the U.S. needed 14,945 physicians to remove the primary medical HPSA designation.[33] 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 recission of this rule becomes apparent.

Top States Where H-1B Physicians are Providing Care[34]	Number of Physician LCAs[35]	States with Increasing COVID-19 Cases[36]
New York	1467	5,023 new positive cases per day
Michigan	945	10,277 new positive cases per day
Illinois	826	3,184 new positive cases per day
Ohio	606	2,340 new positive cases per day
Pennsylvania	602	6,017 new positive cases per day
Texas	343	5,188 new positive cases per day
California	309	2,559 new positive cases per day
Indiana	244	952 new positive cases per day

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

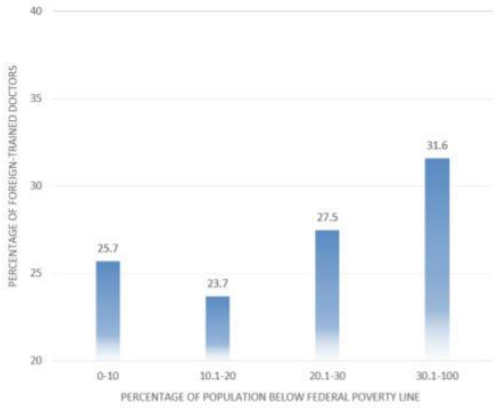
[31] As of October 28, 2020, according to https://coronavirus.jhu.edu/map.html, the U.S. had 8.8 million COVID-19 cases, the highest country/region/sovereignty globally.
[32] The U.S. Department of Health & Human Services, Bureau of Health Workforce Health Resources and Services Administration (HRSA), Bureau of Health Workforce, Fourth Quarter of Fiscal Year 2020, Designated HPSA Quarterly Summary. Data as of September 30, 2020. *See also*, https://bhw.hrsa.gov/shortage-designation/types.
[33] 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.
[34] 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.
[35] *Id.*
[36] Last checked on April 14, 2021: https://coronavirus.jhu.edu/testing/tracker/overview.

The AMA believes that the U.S. should promote an increase of IMGs to supplement our health care workforce 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 Rule on our most at-risk citizens in rural and medically underserved communities across this country that rely on H-1B physicians to provide much needed primary and specialty health care services.** For example, 69 percent of critical access hospitals were operating with negative income in 2015. This number has increased over time, with 75 percent running at a deficit in 2019.[37]

The 2019 State Physician Workforce Data Report found that, nationally, almost 25 percent of active physicians providing care in the U.S. were 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.[38] 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 to 139,000 physicians by 2033.[39] Therefore, as our physician shortage increases with every passing year, 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.[40] However, with many of these critical access hospitals running with a budget deficit, having to increase the salary of employees by around 20 percent may prove impossible, leading to either having to let much needed physicians go, or hiring fewer physicians to care for some of the most in need populations.

Foreign-trained Doctors Serving U.S. Population, by Poverty Level[41]



<u>The Rule violates the Administrative Procedure Act</u>

The AMA believes that the Rule represents unlawful rulemaking under the Administrative Procedures Act (APA) because no good cause existed for the DOL's failure to comply with notice

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[37] https://truthout.org/articles/covid-19-spikes-in-rural-areas-while-hospitals-face-financial-crisis/.
[38] https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf.
[39] 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.
[40] *Id*.
[41] https://www.americanimmigrationcouncil.org/sites/default/files/research/foreign-trained_doctors_are_critical_to_serving_many_us_communities.pdf.

and comment rulemaking.[42] The DOL provided two rationales for satisfying the APA's good cause criteria, both of which are severely flawed. First, the DOL argued that the shock to the labor market caused by high unemployment due to COVID-19 "created exigent circumstances that necessitate[d] 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 to continue ensuring the health of the American people. The AMA strongly believes that the Rule undermines this effort and is in violation of the APA's good cause criteria.

Second, the DOL argued in the interim final rule 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 Rule as it would undermine the Agency's ability to remedy the issues the Rule is meant to solve. Again, the AMA disagrees. With new strains and vaccine safety issues causing new challenges and with most of the world still struggling to secure effective vaccines, the pandemic is not yet behind us. 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 world still struggles to contain COVID-19 and physicians are in short supply everywhere, 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.

The AMA believes that the Rule is unlawful because the DOL did not justify its unprecedented change to the prevailing wage determination.[43] The DOL acted arbitrarily and capriciously by failing to consider the interests of the various industries impacted by this Rule, including IMGs who are now subject to what the AMA believes is a wholly irrational change in wage levels. Moreover, this Rule 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 significantly higher than the previous levels and providing no rationale for its reason of setting the new wage levels about 20 percent higher at every wage tier. The rule has not proven that this rise in wages meets the true prevailing market wage and does not address how the safeholds put in place to ensure that immigrants and nonimmigrants are paid a fair wage and do not price out local workers are inadequate. As such, the Rule violated the APA and should be rescinded.

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 well documented, and the COVID-19 pandemic has magnified these workforce issues and other structural problems. **We urge the Administration to prioritize supporting and protecting the health and well-being of the U.S. population by rescinding or revising the Final Rule by exempting physicians.** We welcome the opportunity to share our views further. If you have any questions, please contact Margaret Garikes, Vice President for Federal Affairs, by contacting margaret.garikes@ama-assn.org or calling 202-789-7409.

Sincerely,

James L. Madara, MD

[42] 5 U.S.C. §§ 553(b),706(2).
[43] 5 U.S.C. § 706(2)(A).