Written testimony of the International Medical Graduate Taskforce
Before the House Judiciary Committee's Subcommittee on Immigration and Citizenship
"Why Don't They Just Get in Line?: Barriers to Legal Immigration"

April 28, 2021

Introduction

Chairwoman Lofgren, Ranking Member McClintock, and members of the subcommittee, thank you for providing the opportunity to submit written testimony regarding the barriers to legal immigration that currently exist within our immigration system.

The International Medical Graduate (IMG) Taskforce is comprised of legal professionals dedicated to helping Americans in rural and other physician-shortage areas obtain the basic medical services they so desperately need and deserve. Our members represent universities, teaching hospitals, medical centers, clinics of all sizes, and the physicians seeking to work in these shortage areas. We advise physicians when they are undergoing their graduate medical education, help them obtain lawful nonimmigrant status so they may commence their careers, and ultimately assist them in attaining lawful permanent resident status and citizenship.

Through this work, our membership has seen how the immigration system burdens these physicians and their employers, which hurts the medically underserved communities in which the physicians wish to work. The United States is facing a growing physician shortage that has only gotten worse due to the ongoing pandemic. The Association of American Medical Colleges projected that there will be a total physician shortage of between 54,100 and 139,000 physicians by 2033.[1] Yet, instead of working to attract foreign physicians from abroad to help alleviate this shortage, our immigration system actively disincentivizes the hiring and long-term retention of such physicians. Below, we will outline the difficulties the current system poses for physicians.

Barriers for foreign physicians

Training and post-training employment

Foreign medical graduates make up approximately 24.7% of the population of those obtaining graduate medical education in the United States.[2] Generally, they complete their residency and/or fellowship training in either H-1B or J-1 status. About 20% of trainees are in H-1B status and 80% train in J-1 status.[3]

When training in H-1B status, trainees must be paid at or above the prevailing wage for physicians in their specialty in their area. The prevailing wage levels determined by the Department of Labor are often far higher than standard wages paid to residents and fellows

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[1] *The Complexities of Physician Supply and Demand: Projections From 2018 to 2033*, Association of American Medical Colleges 3 (June 2020),https://www.aamc.org/media/45976/download.
[2] *Physician Specialty Data Report: Active Physicians Who Are International Medical Graduates (IMGs) by Specialty, 2019*, Association of American Medical Colleges (2020), https://www.aamc.org/data-reports/workforce/interactive-data/active-physicians-who-are-international-medical-graduates-imgs-specialty-2019.
[3] Greg Siskind and Elissa Taub, *ABCs of Immigration: J-1 Visas for Graduate Medical Training*, Siskind Susser PC (Dec. 2, 2019), https://www.visalaw.com/abcs-immigration-j-1-visas-graduate-medical-training/.

because there is no "trainee physician" wage category. As such, training programs often must use private wage surveys, which can trigger Requests For Evidence ("RFEs") from U.S. Citizenship and Immigration Services ("USCIS"). Additionally, the H-1B status has a six year time limit, unless an employment-based permanent residence case has been commenced on the H-1B worker's behalf. As training positions are temporary, this is not feasible for H-1B trainees and they will need alternative non-immigrant status to work in the United States if they pursue specialty training in H-1B status.

Physicians pursuing training in J-1 status become subject to Section 212(e) of the Immigration and Nationality Act ("INA"). This requires them to return to their home country for a minimum of two years before they may change to H or L status in the United States, obtain an H or L visa, or obtain lawful permanent residence. Physicians may waive this requirement by 1) agreeing to work for three years in a Health Professional Shortage Area or Medically Underserved Area or in a Veterans Affairs facility, 2) demonstrating that they will be persecuted if they return to their home country, or 3) showing that their U.S. citizen family member(s) will experience extreme and unusual hardship if they are forced to fulfill the two year home residency requirement. Most physicians choose the first option and pursue a J-1 waiver through either an Interested Government Agency ("IGA"), such as the Appalachian Regional Commision ("ARC"), the Delta Regional Authority ("DRA"), and the U.S. Department of Health and Human Services ("HHS"), or through a state department of health participating in the Conrad State 30 waiver program ("Conrad Waiver").

IGA waivers are limited to specific regions, areas, and/or specialization. The Conrad Waiver program currently only allows 30 waivers per state or territory (DC, Guam, and Puerto Rico are all eligible for this program), meaning there are a maximum of 1,590 waiver slots in any given year. In 2020, there were 12,506 foreign medical graduates training in J-1 status.[4] As such, there are an insufficient number of waiver slots for all J-1 trainees, and many of them will need to return to their home countries, where they may choose to remain, rather than attempting to return to the United States after completing their two year home residency requirement.

Foreign physicians who obtain J-1 waivers become personally exempt from the annual numerical limitation or cap on H-1Bs, but those who train in H-1B status or fulfill the two year home residency requirement are not exempt from the cap, and must either find cap-exempt employers to sponsor them or go through the annual H-1B lottery to secure H-1B status. Some of the facilities that might be considered the most deserving of an H-1B cap exemption - those in physician shortage areas, those serving vulnerable populations, etc. - often do not qualify as H-1B cap exempt. This again limits how many American-trained physicians can actually work in the United States following their training and often is not serving the interests of the American public.

Permanent residence

The two most common paths to permanent residency for physicians are through the PERM Labor Certification process ("PERM") or the Physician National Interest Waiver petition ("PNIW"). For physicians completing a J-1 waiver commitment, either process can be commenced while the physician is within the three year commitment period.

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[4] *ECFMG J-1 Sponsorship: Number of Exchange Visitor Physicians Sponsored 2010–2020 Calendar Years*, ECFMG (Jan. 13, 2021), https://www.ecfmg.org/resources/2020-EVSP-Data-Sponsored.pdf.

With a PERM, the employer must demonstrate through an extensive recruitment process that no able, qualified, or willing US worker is available to take the position. Once the advertisements have been placed for the required time and any applicants are properly vetted for the offered position, the PERM application is filed with the Department of Labor ("DOL"). Once the PERM is certified, a Form I-140, Immigrant Petition for Alien Worker can be filed with USCIS, The I-140 establishes the baseline for why an individual is eligible to file a green card, but the I-140 is only one part of the process. The second part of the green card application, Form I-485, Application to Register Permanent Residence or Adjust Status, can be filed with USCIS following the end of the three year J-1 waiver commitment (if applicable), as soon as the individual is eligible to apply for a green card.

With a PNIW, the physician must agree to work for a minimum of 40 hours per week in a medically underserved area for a total of five years. To obtain a PNIW, physicians first must obtain a letter of support from an IGA or the state health agency that oversees the state in which the physician will work. They then submit that letter of support to USCIS as part of their I-140 petition. Depending on the country in which they were born, the physician may also concurrently submit their I-485 application with the I-140 petition, but they will not be adjusted to permanent resident status until after their five year commitment is complete.

INA § 202(a)(2) provides that nationals of no one country can receive more than 7% of all green cards issued in a given year. As such, individuals born in countries with large emigrant populations, such as India and China, have to wait several years before they are eligible to apply for a green card. Both of the above-listed pathways are considered within the EB-2 category. Indians in the EB-2 category face immensely long waits for a green card – recent projections place the waiting time at several decades.[5] While awaiting their green cards, Indian physicians must renew their H-1B status every three years. H-1B sponsors must be able to control the employment of their H-1B employees, making it extremely difficult for H-1B physicians to open their own clinics.

Likewise, H-1B physicians need visas to travel, putting them at risk of administrative processing when they travel abroad. Additionally, the children of H-1B physicians can only maintain dependent status until they turn 21, at which point they must obtain an alternative nonimmigrant status, return to home countries in which they have not lived for a decade or more, or become undocumented. A recent study estimates that there are between 14,710 and 16,189 US-trained Indian physicians currently working in the United States who are awaiting adjustment of status.[6] Our current immigration system discourages each of these physicians from remaining in the United States and treating the U.S. citizens who need their help the most.

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[5] *See, e.g.,* Stuart Anderson, *Immigration Bill Shows Need To End Employment-Based Immigrant Backlo*g, FORBES, Mar 1, 2021,12:21 PM, https://www.forbes.com/sites/stuartanderson/2021/03/01/immigration-bill-shows-need-to-end-employment-based-immigrant-backlog/?sh=1bb5a4f1271a; David J. Bier, *Immigration Wait Times from Quotas Have Doubled: Green Card Backlogs Are Long, Growing, and Inequitable*, CATO INSTITUTE: POLICY ANALYSIS, June 18, 2019, https://www.cato.org/publications/policy-analysis/immigration-wait-times-quotas-have-doubled-green-card-backlogs-are-long#projected-future-wait-times.

[6] Kiran Koushik Nagarajan ET AL., *Prevalence of US-trained International Medical Graduates (IMG) physicians awaiting permanent residency: a quantitative analysis*, 10(6) J CMTY. HOSP. INTERNAL MED. PERSP. 537, (2020).

Conclusion

The COVID-19 pandemic has demonstrated the importance of a robust system of health care providers to the nation's ability to function. We are pleased that the House Judiciary Subcommittee on Immigration and Citizenship is discussing the barriers that prevent foreign-born physicians from being able to easily participate in our healthcare system and provide much-needed health care to our citizens. Several bills have been proposed in this Congress and in previous sessions that would address many of the above-discussed problems, including the U.S. Citizenship Act of 2021, the Healthcare Workforce Revitalization Act, the Fairness for High Skilled Workers Act (116th Congress), and the Conrad State 30 & Physician Access Act (116th Congress). We urge the Members of the Subcommittee to support the reforms proposed in these bills, as they will have an important and positive impact on our ability to attract and retain foreign physicians in the United States to alleviate our physician shortage.