DOCTOR, DOCTOR: REFORMING PHYSICIAN IMMIGRATION POLICY TO IMPROVE ACCESS TO HEALTHCARE

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ABSTRACT

The persistent shortage of physicians in the United States significantly impacts public health, particularly in medical shortage areas. This article investigates the role foreign medical graduates (FMGs) may play in mitigating this crisis and examines the limitations of current immigration policies, specifically the H-1B visa, J-1 visa waivers, and various avenues for legal permanent residence. It begins with an explanation of the current and pending crisis, outlines the temporary and permanent visa options currently available to FMGs, and concludes with a policy prescription designed to reform various visa processes and provides a number of targeted policies to attract and retain foreign physicians in order to mitigate the growing medical shortage.

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INTRODUCTION

The United States has long had a medical shortage that does not appear to be improving.[1] According to a report released by the Association of American Medical Colleges (AAMC) in March 2024, there is currently a shortage of more than 20,800 primary care physicians and 37,000 total physicians in the United States.[2] By 2036, that shortage is expected to increase to up to 40,400 primary care physicians and an estimated shortage of between 13,500 and 86,000 total physicians by 2036.[3] Primary care density, or the number of primary care physicians (PCPs) per total population, has been strongly correlated with mortality.[4] Studies have shown that people living in counties with less than one physician per 3500 people had a mean life expectancy that was approximately 311 days shorter than those living in counties with a higher PCP to person ratio.[5]

The federal government designates areas with physician shortages as Health Professional Shortage Areas (HPSAs) or Medically Underserved

1. *See* Press Release, Am. Med. Ass'n., *AMA President Sounds Alarm on National Physician Shortage* (Oct. 25, 2023), https://perma.cc/D59A-5XXR.
2. TIM DALL, RYAN REYNOLDS, RITASHREE CHAKRABARTI, CLARK RUTTINGER, PATRICK ZAREK & OWEN PARKER, *The Complexities of Physician Supply and Demand: Projections From 2021 to 2036*, ASS'N OF AM. MED. COLLS. vii (March 2024), https://perma.cc/93GG-45LM.
3. *Id.* at 55.
4. SANJAY BASU, RUSSELL S. PHILLIPS, SETH A. BERKOWITZ, BRUCE E. LANDON, ASAF BITTON & ROBERT L. PHILLIPS, *Estimated Effect on Life Expectancy of Alleviating Primary Care Shortages in the United States*, ANN. OF INTERN. MED. 920, 924 (2021).
5. *Id.*

Areas/Populations (MUA/Ps).[6] HPSAs are geographic areas, populations, or facilities with a shortage of primary, dental or mental health care providers.[7] Mental Health Professional Shortage Areas (MHPSAs) are areas within a HPSA with a shortage of mental health providers, and MCTAs are areas within a HPSA that have a shortage of maternity health care providers.[8] MUAs are geographic areas and populations with a shortage of primary care services, while MUPs have a shortage of primary care services for a specific population within a geographic area.[9]

As of January 2024, there were a little over one million practicing physicians in the United States.[10] Appendix A provides a breakdown of these physicians by state.[11] It also includes the number of active PCPs per state, as well as the number of people per one PCP.[12] For example, Idaho has the worst (highest) ratio with one PCP per 1,035 people, while Rhode Island has the best (lowest) ratio with one PCP per every 377 people. Nationally, the ratio is 1 to 640.[13]

Because of this shortage, Congress, the states, and medical providers have attempted to fill this gap with foreign physicians. While the H-1B visa has recently been hotly debated by members of President Trump's inner circle and the media alike, it has largely been framed as a visa used by IT firms attempting to take advantage of the system.[14] Yet the H-1B is used for much more than just the IT sector. In fact, the most common employment visa used by foreign physicians is the H-1B nonimmigrant visa.[15] Table 1 provides the distribution of approved occupational groups in fiscal year 2023, and while computer-related occupations account for 65% of all approved H-1Bs, medicine and health related occupations accounted for 4.3% of all approved H-1Bs.[16]

A 2025 study in the Journal of the American Medical Association (JAMA), Azaroff, et al. analyzed U.S. Census Data from 2024 and found that 29.2% of all physicians in the United States were foreign born (either naturalized citizens or nonimmigrants).[17]

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6. Health Res. & Servs. Admin., *What is Storage Designation?*, https://perma.cc/ML88-2NUK.
7. *Id.*
8. *Id.*
9. *Id.*
10. KFF, *Professionally Active Physicians*, https://perma.cc/KLN9-736M.
11. *Id.*
12. *Id.*
13. *Id.*
14. *See* Daniel Costa & Ron Hira, *Tech and Outsourcing Companies Continue to Exploit the H-1B Visa Program at a Time of Mass Layoffs,* WORKING ECON. BLOG (Apr. 11, 2023, at 3:41 p.m.), https://perma.cc/HLH9-L7J5; Julia Ingram, *H-1B Visa Power the Tech Industry. But Experts Say That's Not Necessarily Because of a Talent Gap*, CBS NEWS (Jan. 13, 2025, at 5:00 p.m. EST), https://perma.cc/W2LP-4GFS; Bill Whitaker, *Are U.S Jobs Vulnerable to Workers With H-1B Visas?,* CBS NEWS (Mar. 19, 2017, at 7:14 EDT) https://perma.cc/S3DC-Q7XW; Eric Fan, Zachary Mider, Denise Lu & Marie Patino*, How Thousands of Middlemen are Gaming the H-1B Program*, BLOOMBERG (Jul. 31, 2024), https://perma.cc/5WRE-DTYV.
15. *See infra* Section I.A.
16. DEPT. HOMELAND SEC., U.S. CITIZENSHIP AND IMMIGR. SERVS., CHARACTERISTICS OF H-1B SPECIALTY OCCUPATION WORKERS 12–13 (2024), https://perma.cc/3WGT-WB7A.
17. Lenore S. Azaroff, Steffie Woolhandler, Sharon Touw, David Bor & David U. Himmelstein, *Deporting Immigrants May Further Shrink the Health Care Workforce,* 333 JAMA 2018, 2019 (2025).

Despite a robust body of legal and social science scholarship on immigration generally, employment-based immigration, specifically healthcare immigration remains understudied, even as the U.S. faces a growing physician shortage.

While the legal and social science scholarship abounds with studies on immigration generally, there is a huge deficit in the scholarship on the issue of employment immigration, and an even greater deficit in the area of healthcare immigration at a time when there is also a shortage in the availability of healthcare generally in the United States.[18] Specifically, the legal scholarship only includes one law review article (discussed *infra),* one student article, and one student note.[19] This article illuminates and illustrates the policy shortcomings of the H-1B visa as a fix for the healthcare shortage in the United States.

In a recent issue of the West Virginia Law Review, Kit Johnson argued that the current and forecasted medical shortages in the United States are so great that immigration is necessary to fill those gaps.[20] Foreign/international medical graduates (FMGs/IMGs[21]) are foreign nationals who complete their medical degrees outside of the United States or Canada. They comprise approximately 25% of all physicians currently practicing in the United States.[22] In the past, the physician shortage has been ameliorated to some degree with the influx of foreign physicians. Yet of late, Congress has not only failed to pass either any significant and/or minor legislation to increase these foreign physician flows, but in some cases has made the availability of foreign physicians more difficult.[23]

Johnson also notes this "dearth of legal scholarship on the role immigration does and could play in ameliorating the problem of lack of access to medical care in rural areas."[24] This article is designed to continue the very important conversation she began. While her article focuses on rural shortages, this article extends her argument to discuss the physician shortage generally as it

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18. The nonlegal scholarship is largely in the context of economic work. *See* Kurt Lavetti, Carol Simon & William D. White, *The Impacts of Restricting Mobility of Skilled Service Workers: Evidence from Physicians*, 55 J. HUM. RES. 3, 1025-1067 (2020); Anthony T. Lo Sasso, *Regulating High-Skilled Immigration: The Market for Medical Residents,* 76 J. HEALTH ECON., Jan. 22, 2021, at 1–14; Heike Hennig-Schmidt, Reinhard Selten & Daniel Wiesen, *How Payment Systems Affect Physicians' Provision Behaviour – An Experimental Investigation*, 30 J. HEALTH ECON. 637, 637-646 (2011).

19. The law review articles include Kit Johnson, *An Immigration Solution for Improving Rural Healthcare,* 124 W. VA. L. REV. 741 (2022); Skyler G. Cruz, *Have Foreign Physicians Been Misdiagnosed? A Closer Look at the J-1 Visa*, 1 LOY. U. CHI. INT'L L. REV. 295 (2004); and Vania Cornelio, *Doctors Battling Borders: How U.S. Immigration Policies Are Exacerbating the Nation's Physician Shortage*, 53 SUFFOLK. U. L. REV. 65 (2020).

20. *See* Johnson, *supra* note 19, at 742.

21. Both phrases and their corresponding abbreviations are used interchangeably to refer to those immigrants who complete their medical degrees outside of the United States or Canada. This article will refer to these physicians as FMGs.

22. *ECFMG Certification Fact Sheet*, EDUC. COMM'N FOR FOREIGN MED. GRADUATES, https://perma.cc/3XD8-P4VZ (last visited Jun. 29, 2025).

23. *See* Maryam T. Stevenson, *Explaining the Comprehensive Immigration Stalemate in Congress*, 73 CATH. U. L. REV. 400, 444 (2024).

24. *See* Johnson, *supra* note 20, at 742.

exists throughout the United States in both urban and rural areas. Specifically, Section I of this article begins with an outline of all the current nonimmigrant visa options available to foreign physicians. Section II and III explains how Congress and the Department of Health and Human Services (HHS) have attempted to rectify the physician shortage in both the short and long terms, and how their attempts have fallen short. Section IV illustrates both the immigration process for an FMG and the policy shortcomings associated with the immigration process. Finally, Section V offers solutions using nonimmigrant (temporary) and immigrant (permanent visas). Specifically, I argue Congress should consider immigration reforms such as visa cap exemptions, extended H-1B eligibility, a dedicated physician visa category, financial incentives for U.S. physicians, and streamlined pathways to permanent residency to attract and retain foreign physicians.

I. VISAS AVAILABLE FOR FOREIGN MEDICAL GRADUATES

There are three traditional methods of entry for immigrants to the United States: nonimmigrant visas, immigrant visas, and asylum.[25] When an immigrant legally enters the United States, they must be screened by a consular officer and have an approved visa.[26] Nonimmigrant visas are temporary visas that are available for a specific reason (visitor, student, employment, etc.) for a statutorily prescribed period.[27] Immigrant visas provide lawful permanent resident status (also known as green cards) and allow a foreign national to live and work in the United States indefinitely.[28]

In order to be eligible for medical licensure in the United States, foreign medical graduates must complete graduate medical training (a residency or fellowship program) in the United States.[29] The Accreditation Council for Graduate Medical Education, the accrediting organization, requires all FMGs to obtain certification from the Educational Commission for Foreign Medical Graduates (ECFMG) prior to beginning a residency or fellowship program.[30] ECFMG certification is designed to ensure that foreign physicians possess at least the same medical knowledge and experience as physicians educated in the U.S. and Canada before they undertake supervised patient care in a residency or fellowship program.[31] It assesses medical knowledge through a series of exams that are taken by graduates of U.S. medical schools.[32] ECFMG certification is required prior to entering a residency or fellowship program,

25. RICHARD A. BOSWELL, ESSENTIALS OF IMMIGRATION LAW 97 (2009).
26. *Id*.
27. *Id*. at 98.
28. *Id*. at 125.
29. An exception exists for physicians who will be teaching, conducting research, or both with a public or nonprofit private educational or research institution or agency in the United States. 8 U.S.C. § 1182 (j)(2)(A); *see also infra* Section V.A.4.
30. *ECFMG Certification Overview*, EDUC. COMM'N FOR FOREIGN MED. GRADUATES, https://perma.cc/BCD2-5U6N. (last updated Jun. 18, 2025).
31. *Id*.
32. *ECFMG® Certification Factsheet*, *ECFMG (Feb. 3, 2025), https://perma.cc/7TP5-CPZG*.

applying for step 3 of the USMLE exam, and obtaining an unrestricted license to practice medicine in the U.S.[33]

Under current immigration law, foreign medical graduates can complete this training through either an immigrant visa (green card) or a nonimmigrant temporary visa. The majority of immigrants enter the U.S. through a nonimmigrant visa because state licensing laws restrict the green card route.[34] Generally speaking, legal permanent resident status is available through family and employment routes. The employment route for a physician requires medical licensure, and because foreign medical graduates must complete a residence or fellowship training program in the U.S. in order to be eligible for licensure to practice medicine,[35] FMGs are typically not eligible for an employment-based green card. As a result, green card options are typically limited to marriage to a U.S. citizen or some other family relationship, or in rare cases the diversity lottery visa or asylum. As a result, the majority of immigrants enter the U.S. through a nonimmigrant visa.[36] Outside of those circumstances, physicians are limited to the nonimmigrant temporary visa.

There are two nonimmigrant categories that are available for foreign medical graduates to complete their training – the H-1B visa and the J-1 visa.[37] Each of these visas will be discussed in greater detail below. Historically, the majority of FMG-sponsored training programs only sponsored J-1 visas, and as a result, the majority of FMGs completed their training on a J-1 visa.[38] Today, sponsors typically require or prefer one visa over another with approximately half of FMGs completing their training on an H-1B and the other half on a J-1.[39]

The first section outlines the history and parameters of the H-1B visa. Understanding the design and constraints of the visa is essential to evaluating why it continues to frustrate the efforts of hospitals, medical groups, and FMGs alike in responding to regional and national healthcare gaps.

A. *The H-1B Visa*

The H-1B visa, the only nonimmigrant visa available solely for skilled foreign professionals, is misaligned with the unique needs of foreign physicians, largely because it was designed with the tech industry in mind. Further, Congress' inability to amend the H-1B over time to deal with the documented healthcare shortages evidences the innate problems associated with the visa process available for foreign physicians.

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33. *Id.*
34. *See* Gregory Siskind, *Visa Options For Graduate Medical Training*, *in* IMMIGRATION OPTIONS FOR PHYSICIANS, 29 (Margaret A. Catillaz, Rita Kushner & Stephanie L. Browning, eds., 2d ed. 2004).
35. INA § 212(j)(2)(A).
36. *See* Siskind et al., *supra* note 34.
37. *See* 60 FR 62021-22 (Dec. 4, 1995), which withdrew the bar to H-1B for medical residents.
38. *See* GREG SISKIND & ELISSA J. TAUB, THE PHYSICIAN IMMIGRATION HANDBOOK 11 (8th ed. 2024).
39. *See id.*

1. *Legislative History*

The original H-1 visa was created by the 1952 Immigration and Nationality Act.[40] It was available to foreign nationals who were "of distinguished merit and ability and who [were] coming temporarily to the United States to perform temporary services of an exceptional nature requiring such merit and ability."[41] As such, until the H-1 was revised and the H-1B was created in 1990, there was no nonimmigrant visa category available exclusively for skilled workers. By the late 1980s, the information technology (IT) industry was emerging, shortages in the healthcare fields were beginning to emerge, and Congress was suddenly faced with a new lobby in support of some type of visa to accommodate these shortages with qualified foreign workers.[42]

As a result, Congress created a number of categories for skilled workers, as well as a number of new visa categories for entertainers, artists, and athletes in the O and P categories in the Immigration Act of 1990.[43] In that Act, Congress redefined the H-1B as a category for "specialty occupation"[44] workers, defined as those with a minimum of a bachelor's degree or its equivalent in work experience, and created an annual cap of 65,000 on the number of visas issued.[45] Specifically, they bifurcated the H-1 into the H-1A and H-1B categories, creating for the first time a nonimmigrant visa for foreign workers in a "specialty occupation", with the H-1A solely for nurses and the H-1B for all other specialty occupations, and/or a fashion model of "distinguished merit and ability."[46]

The inclusion of fashion models (who incidentally are not required to hold a bachelor's degree) in the H-1B category is problematic for a number of reasons. First, the annual cap of 65,000 is insufficient for meeting the national demand for foreign workers as well be discussed in greater detail in part one of this section. Second, the inclusion of fashion models in the same cap as

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40. Immigration and Nationality Act (INA) of 1952, ch. 477, Pub. L. No. 82-414, 66 Stat. 163 (amended 2023). Note also that the H-1B, E, and L, and in some cases the O-1 visas are known as dual intent visas and allow the foreign national to have the intention to permanently immigrate to the United States.

41. *Id.*

42. *See* Susan Martin, B. Lindsay Lowell & Micah Bump, *Skilled Immigration to America: U.S. Admission Policies in the 21st Century* in SKILLED IMMIGRATION TODAY, 138 (Jagdish Bhagwati and Gordon Hanson, eds. 2009).

43. Immigration Act of 1990, Pub. L. No. 101-649; § 162(a)(1), (2), 104 Stat. 4978, 5009-10. Note that while the new O and P visa categories were designed to address labor concerns by excluding entertainment professionals that previously fell under the H-1 category, they "inadvertently omitted" fashion models from any visa category. *See* House Report 110-699. When the omission was noticed, Congress added fashion models to the H-1B category (and subsequently under the annual numerical cap of 65,000) under the Miscellaneous and Technical Immigration Amendments of 1991, rather than to the P category (which really would have made more sense).

44. Specialty occupation is defined as a position that requires "the [t]heoretical and practical application of a body of highly specialized knowledge" and a bachelor's degree or higher, or its equivalent, for entry into the field. 8 U.S.C. § 1101(a)(15)(h)(i)(b); INA § 101(a)(15)(H)(i)(b); *See also* 8 C.F.R. § 214.2 (h)(4)(ii).

45. *See* § 162(a)(1), (2).

46. *See id.*

physicians illustrates a fundamental misalignment between U.S. immigration law and market demands, particularly in critical sectors such as healthcare.

Initially, Congress excluded entertainment professionals from the H-1B visa for the sake of addressing growing labor concerns. However, in doing so, they "inadvertently omitted" fashion models from any category. When this omission was noticed, Congress added fashion models back to the H-1B category (and subsequently under the annual numerical cap) rather than to the O or P category (which really would have made more sense).[47] So effectively, the H-1B visa and the annual cap of 65,000 visas was available exclusively for skilled workers – and fashion models!

As mentioned, the H-1B originally was designed to create a mode of entry for skilled workers (and fashion models) to the United States.[48] For the first seven years after the H-1B's creation, the annual cap was not met, making the inclusion of fashion models irrelevant. Once the cap was hit in 1997 and again in subsequent years, however, the inclusion of the fashion models in a visa category designed for skilled workers became more and more problematic as they were taking visa numbers away from skilled workers.[49] And even while the total numbers are small (in the 2000 to 2005 fiscal years, new employment approvals for fashion models ranged from 614 to 790 and declined in fiscal years 2005, 2006, 2007, and 2010 to 467, 438, 349, and 250 respectively) it remains the only subset of the H-1B that does not require a bachelor's degree or higher.[50] While these numbers may not be a high percentage of the overall allotment (less than one percent), we are still looking at hundreds of H-1B visas that could be allocated to physicians working federally designated medical shortage areas.

Once Congress realized this oversight, there were some attempts to correct the omission as Congress has introduced a number of bills to move fashion models to the O-1 visa beginning in 2005.[51] This is significant because the H-1B cap was hit for the first time in the 2004 fiscal year and it was hit again in the 2005 fiscal year (see Table 2).

a. H-1B Eligibility

Currently, the H-1B visa is available to foreign skilled workers with a minimum of a bachelor's degree or its equivalent and a sponsoring United States employer for work in a skilled occupation.[52] It is employer specific and is

47. *See* House Report 110-699. *See also* Miscellaneous and Technical Immigration Amendments of 1991.
48. *See* Martin et al., *supra* note 42.
49. *See* Frank Bass & Kartikay Mehrotra, *Models Strut into U.S. as Programmers Ask Visa God for Help*, BLOOMBERG (May 20, 2013 at 12:03 ET), https://perma.cc/DLV9-ENSX.
50. *See id.*; *see also* H.R. REP. NO. 110-699, at 3 (2008).
51. *See* H.R. 4354, 109th Cong. (2005); H.R. 750, 110th Cong. (2007); H.R. 4080, 110th Cong. (2007); H.R. 264, 111th Cong. (2009); H.R. 52, 113th Cong. (2013); H.R. 1525, 113th Cong. (2013); H.R. 1525, 114th Cong. (2015); H.R. 3647, 115th Cong. (2017).
52. 8 U.S.C. § 1184(i).

only valid as long as the foreign national is employed by the sponsoring employer.[53] The H-1B visa is available for an initial period of up to three years and is renewable for an additional period of three years, for a total of six years of eligibility.[54]

Typically, nonimmigrant visas are available only for a temporary period and the applicant must provide evidence to the consular officer issuing the visa that the applicant does not have the intention to permanently immigrate to the United States.[55] The H-1B visa, however, is a dual intent visa.[56] As a dual intent visa, it is one of only three nonimmigrant visas that allow the foreign worker to have the intention at the onset of the application process of immigrating permanently to the United States and does not require that the nonimmigrant maintain a foreign residence.[57] As such, applicants for the H-1B visa do not bear the burden of proving their intention to remain in the United States on a temporary basis.[58] This means H-1B visa holders can safely file applications for immigrant visas and legal permanent status and leave the U.S. to travel abroad reenter the U.S. without needing to prove to a border officer that they do not have an intent to remain in the U.S. permanently and/or filing for extensions of their current H-1B status while in the U.S.[59]

There has been a longstanding debate in both the legal and social science scholarship and the mainstream media as to whether foreign workers depress domestic wages.[60] In response to this, the Immigration and Nationality Act

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53. *Id.*

54. There are some exceptions that allow for eligibility beyond the six-year maximum, discussed in Section II.A.1.

55. *See Lauvik v. INS*, 910 F.2d 658, 660-61 (9th Cir. 1990).

56. The dual intent nature of the H-1B visa was established in the Immigration Act of 1990. *See also* RICHARD A. BOSWELL, ESSENTIALS OF IMMIGRATION LAW 131, (5th ed. 2020).

57. *Id.*

58. *Id.*

59. *Id.*

60. Arguments in favor of skilled immigration include the fact that skilled immigrants promote economic growth and American stature in the international market for science, research, and technology. JAMES G. GIMPEL & JAMES R. EDWARDS, THE CONGRESSIONAL POLITICS OF IMMIGRATION REFORM 69-71 (1999). Additionally, as skilled workers they typically are paid wages sufficient to pay taxes in the middle and higher tax brackets, and as a result, they typically do not seek governmental assistance. *Id.* Others, however, argue that foreign workers create the effect of displacing American workers by providing cheap labor. The framework for this research, created by Johnson's work on the effects of immigrants on the native population, put forth the gains from trade argument that if immigrants provide an aggregate bundle of labor and capital that differs from the labor and capital that the native population possesses, then the native population will benefit and gain from the inflow of immigrants. Harry G. Johnson, *Some Economic Aspects of Brain Drain*, PAKISTAN DEVELOPMENT REV., 379-411 (1967). More recently, many have found that the influx of foreign workers (and students) has negatively impacted domestic wages (*See* Norman Matloff, *Immigration and the Tech Industry: As a Labour Shortage Remedy, for Innovation, or for Cost Savings?*, MIGRATION LETTERS, 210-227 (2013); Norman Matloff, *On the Need for Reform of the H-1B Non-Immigrant Work Visa in Computer-Related Occupations*, UNIV. MICH. J. L. REFORM, 815-914 (2003); Sunil Mithas and Henry C. Lucas, Jr., *Are Foreign IT Workers Cheaper?: U.S. Visa Policies and Compensation of Information Technology Professionals*, MANAGEMENT SCIENCE, 745-765 (2010); Hal Salzman, Daniel Kuehn, and B. Lindsay Lowell, *Guestworkers in the High-Skill U.S. Labor Market: An Analysis of Supply, Employment, and Wage Trends*, EPI Briefing Paper, Economic Policy Institute (2013); Giovanni Peri and Chad Sparber, *Highly-Educated Immigrants and Native Occupational Choice*, Center for Research and Analysis of Migration Working Paper (2008); Eric Weinstein, *How and Why*

("INA") requires that the hiring of a foreign national worker on an H-1B visa not adversely affect the wages and working conditions of comparably employed U.S. workers.[61] The wages offered to the foreign worker be at least the prevailing wage for the occupational classification in the area of employment, or the wage paid by the employer to workers with similar skills and qualifications, whichever wage is higher.[62]

The prevailing wage rate is the average wage paid to similarly employed workers in a specific occupation in the county of proffered employment.[63] It is calculated by the Department of Labor's (DOL) Bureau of Labor Statistics on a semi-annual basis.[64] Employers must attain this rate by submitting a prevailing wage request through the DOL's National Prevailing Wage Center or another legitimate source of data information, such as the Online Wage Library, a website maintained by the State of Utah under contract with the DOL's Office of Foreign Labor Certification.[65]

Employers found violating this requirement can be fined heavily by the DOL and may be banned from hiring foreign workers in the future.[66] In practice, audits of H-1B sponsoring employers have increased steadily as a result of a 2017 Executive Order.[67]

b. Subsequent Congressional Changes to the H-1B Visa

As mentioned, Congress created an annual cap of 65,000 H-1Bs available each year in the original Act.[68] In 1997, the annual cap was reached for the first time and it became clear that the annual cap was insufficient to meet

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Government, Universities, and Industry Create Domestic Labor Shortages of Scientists and High-Tech Workers, National Bureau of Economic Research (1998)).Others, however, have shown that that there is very little evidence that immigration affects the wages of American workers (*See* Magnus Lofstrom and Joseph Hayes, *H-1Bs: How Do They Stack Up to U.S. Workers?,* IZA Discussion Paper 6259 (2012); Giovanni Peri and Gianmarco I.P. Ottaviano, *Rethinking the Effects of Immigration on Wages*, HWWI Research Paper 2006); Julian J. Simon, THE ECONOMIC CONSEQUENCES OF IMMIGRATION (1989); Elaine Sorensen, Frank D. Bean, Leighton Ku, and Wendy Zimmerman, IMMIGRANT CATEGORIES AND THE U.S. JOB MARKET (1992)). In fact, Peri and Ottaviano showed that while immigration has had a negative wage effect on Americans without a high school diploma, it has had the opposite effect on American workers with at least a high school diploma where immigrants complement rather than replace American workers, resulting in wage increases. Giovanni Peri and Gianmarco I.P. Ottaviano, *Rethinking the Effects of Immigration on Wages*, HWWI Research Paper (2006). Additionally, Chiswick argues that the immigration of high skilled workers can increase the wages of low skilled workers, reducing income inequality and poverty, which in the long run returns capital to the domestic economy. Barry R. Chiswick, *High Skilled Immigration in the International Arena*, IZA Discussion Papers, No. 1782 (2005).

61. *See* 8 U.S.C. § 1182(n)(1)(A).

62. *Id.*

63. *See* 21st Century Department of Justice Appropriations Authorization Act of 2002, Pub. L. No. 107–273, 116 Stat. 1758; *See also Prevailing Wage Information and Resources*, U.S. DEP'T OF LAB., https://perma.cc/S2X8-TSJL. The prevailing wage is the average wage paid to United States citizens in a particular county for any particular job position, and is updated regularly by the Department of Labor, Bureau of Labor Statistics (BLS).

64. U.S. Dep't of Lab., *supra* note 63

65. *Id.*

66. *See* 20 C.F.R. §§ 655.810, 655.805, 656.31 (2023).

67. Exec. Order No. 13768, 82 C.F.R. 18; *see also* U.S. Dep't. of Homeland Sec., OIG-18-03, *USCIS Needs a Better Approach to Verify H-1B Participants*, (2017), https://perma.cc/9Y9M-URXM.

68. Immigration Act of 1990, Pub. L. No. 101-649; § 162(a)(1), (2), 104 Stat. 4978, 5009-10.

U.S. employer demand. As a result, the following year, Congress both temporarily and permanently[69] increased the annual cap in various ways through various pieces of legislation between 1998 and 2004. The increased demand from the IT industry during the dot com bubble of the 2000s largely explained the need to increase the cap.[70] Table 2 below lists each of these Acts and they are discussed in greater detail in the section below.

From 2005 to 2008, more applications for H-1B visas were filed with USCIS than ever before.[71] The federal fiscal year begins on October 1 each year and per USCIS regulation, applications for H-1B visas can be filed up to 180 days prior to the employee's start date.[72] Because the fiscal year begins on October 1, this is the earliest an employee's start date can be. As such, applications for H-1B visas can be filed as early as April 1 for each fiscal year (180 days before October 1). Beginning in 2004 through 2009, the annual cap was hit earlier and earlier until 2007 when the 2008 fiscal year cap was actually hit on the first day applications were accepted.[73] Table 2 provides the date the H-1B cap was reached each year since 2005 when Congress stopped increasing the cap.

As mentioned, Congress first increased the H-1B cap in 1998 in response to demand in the American Competitiveness and Workforce Improvement Act (ACWIA).[74] Among other things, the Act increased the annual cap of 65,000 to 115,000 available visas for the fiscal years 1999 and 2000, and then decreased to 107,500 in 2001, and decreased again in 2002 by reverting to the original 65,000.[75]

ACWIA also created a new filing fee of $500 for initial applications to be earmarked for job training, low-income scholarships, and grants for mathematics,[76] engineering, or science enrichment courses.[77] It created provisions to protect U.S. workers from layoff and provisions for employers who become H-1B dependent.[78] ACWIA also made changes in enforcement and penalties for employers who violate the law.

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69. While the total 65,000 cap has not been permanently increased, Congress has created some exceptions from the annual cap which effectively allows for greater H-1B numbers to be granted. These exceptions are discussed in this section.

70. *See* All Things Considered, *Bill Gates Targets Visa Rules for Tech Workers*, NPR, at 01:08 (Mar. 12, 2008), https://perma.cc/MYA6-MJDB.

71. *See infra* Table 3.

72. U.S. Citizenship and Immigr. Servs., *I-129, Petition for a Nonimmigrant Worker*, (June 30, 2025), https://perma.cc/FBS9-GU7Z.

73. Per USCIS regulation, if USCIS receives a sufficient number of applications to reach the H-1B cap on the first business day applications can be filed, applications will be received for two consecutive business days and a random lottery will select the appropriate number of applications to fulfill the annual cap. As such, the annual cap was actually hit on the first day in both the 2008 and 2009 fiscal years.

74. American Competitiveness and Workforce Improvement Act of 1998, Pub. L. No. 105-277, 112 Stat. 2681.

75. *Id.* § 411.

76. *Id.* § 414.

77. *Id.*

78. *Id.* § 412. An H-1B dependent employer is an employer with twenty-five or fewer full-time employees of which more than seven are H-1B employees; or an employer with between twenty-six and fifty full time employees of which more than twelve are H-1B employes; or an employer with at least

In 2000, three pieces of legislation were passed by Congress, two minor and one significant bill. First, Congress passed a single bill to increase the previous $500 filing fee for job training and scholarships to $1000.[79] Another minor act, the Visa Waiver Permanent Program Act, included a provision that created an exemption from filing an amendment application when the employer engages in corporate restructuring.[80] Congress also passed the American Competitiveness in the Twenty-First Century Act of 2000 (AC-21).[81] The Act retroactively increased the previously apportioned cap numbers allocated in ACWIA to the number of H-1B visas that was actually issued the prior 2000 fiscal year[82] and prospectively increased the cap to 195,000 in fiscal years 2001, 2002, and 2003.[83]

AC-21 also created exemptions from the annual cap for institutions of higher education as defined by section 101(a) of the Higher Education Act of 1965 (20 U.S.C. 1001(a)), nonprofit entities related to or affiliated with a nonprofit educational entity as defined by section 101(a) of the Higher Education Act of 1965 (20 U.S.C. § 1001(a)), and nonprofit or governmental research organizations as defined by 8 C.F.R. § 214(h)(19)(iii)(C).[84] It also allowed for H-1B extensions beyond the six year maximum mentioned above for foreign nationals with a pending immigrant visa application who cannot file an adjustment of status application for a green card due to a lack of immigrant visa availability when the annual immigrant visa quota had been met.

AC-21 also provided portability provisions allowing H-1B employees wanting to change employers to be immediately eligible to do so once a change of employer application is filed with USCIS, rather than having to wait several months for an approval.[85] So if, for example, a physician received a better offer, his new potential employer could file a change of employer H-1B application for him. Once it is received by USCIS, that physician could begin work with the new employer before the approval actually goes through.[86] In the event the application is denied, the physician must either return to his original sponsoring employer (and consequently hope that his previous employer takes him back) or he is immediately out of legal status. AC-21 also instituted new government filing fees to be paid by the sponsoring employer to go towards public programs, including educational

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fifty-one full time employees of which at least fifteen percent of them are H-1B employees. *See* 8 U.S.C. § 1182(n)(3)(A); 20 C.F.R. § 655.736(a) (2006).

79. Immigration and Nationality Act—Amendments, Pub. L. No. 106-311, 114 Stat. 1247 (2000).

80. Visa Waiver Permanent Program Act, Pub. L. No. 106-396, 114 Stat. 1637 (2000).

81. American Competitiveness in the Twenty-First Century Act of 2000—Immigration Services and Infrastructure Improvements Act of 2000, Pub. L. No. 106-313, 114 Stat. 1251.

82. *Id.* In 2000, USCIS actually issued more H-1B visas than Congress had allotted. As a result, Congress retroactively passed AC-21 to cover the visas that were issued beyond the cap.

83. *Id.*

84. *Id.*

85. *Id.*

86. If, however, the physician is working on his three-year Conrad 30 waiver obligation (*see* discussion *infra* Section IV), he actually must prove that an extenuating circumstance exists in order to be eligible for a change of employer.

grants, low-income scholarships, programs to provide technical training skills, crime prevention, and computer education.[87]

As mentioned above, the H-1B visa was available for a maximum of six years. Congress created an exception in AC-21 for foreign nationals who were unable to obtain a green card due to the annual per country quota.[88] Attached as a short rider to the 21st Century Department of Justice Appropriations Authorization Act of 2002, H.R. 2215 extended H-1B status beyond the previously apportioned six year maximum for foreign nationals who had filed either an application for labor certification (the first of a series of applications for one category of employment-based legal permanent residence) at least 365 days prior to the end of the six year period, or an application for an immigrant visa. This extension was available even for foreign nationals with a visa number available because the annual immigrant visa quota for their home country had not been met. Essentially, this exception allowed for indefinite visa extensions without requiring a foreign national to become a legal permanent resident. Additionally, it established the prevailing wage requirement for employers and banned the displacement of United States workers for H-1B foreign nationals.

The H-1B Visa Reform Act of 2004 (H.R. 4818) was attached as an amendment to the Omnibus Spending Bill passed by the House. The significance of H.R. 4818 was that it set forth compliance standards for the H-1B visa, reinstituted and increased the previously sunset filing fee for job training and scholarships at $1500, created a new $500 Fraud Prevention and Detection fee for initial applications filed by employers per foreign worker, and more importantly created a second cap and exemption from the annual 65,000 cap for up to 20,000 foreign nationals who have obtained at least a Master's degree from an educational institution in the United States. In effect, this cleared 20,000 from the annual cap and raised the total cap to 85,000.

Finally, S.2302 was the last piece of successful H-1B legislation passed during this era. It was created to supplement the previously created Conrad 20 program that allowed physicians who entered the United States on a J-1 waiver to complete a medical residency or fellowship training program with a two-year home residency requirement to obtain a waiver if they agree to work in a federally designated medical shortage area for a period of three years.[89] The Conrad 30 program requires that the physician obtain an H-1B visa in order to complete this three-year obligation. S.2302 (coincidentally also introduced by Senator Conrad of the Conrad 20 program) created a cap exemption for these physicians.

87. *Id.*
88. *See* discussion *infra* Section III.F.
89. *See* discussion *infra* Section II.A.

c. H-1Bs for Foreign Physicians

For foreign physicians, the H-1B is a three-year nonimmigrant visa that allows the beneficiary to work in a specialty occupation.[90] It requires employer sponsorship, an employment contract, and an M.D. or license to practice medicine from a foreign state, passage of all three steps of the U.S. Medical Licensing Examination, passage of the English language proficiency test conducted by ECFMG, ECFMG certification, and medical licensure by the state licensing board (or other authorization to practice medicine in the state).[91]

The H-1B is employer specific, which means that in order for an FMG to be eligible for an H-1B, their training program must sponsor them.[92] Employer sponsorship requires that the employer receive approval of a Labor Condition Application (LCA) by the DOL,[93] file the application as petitioner, pay all fees associated with the petition, including government filing fees and attorney's fees, agree to pay a prevailing wage, and provide an employment agreement with specified work locations. The sponsoring employer must also either receive a cap number or demonstrate that they are exempt from the annual cap.[94] Recall that most medical training programs are cap exempt as either institutions of higher education or academically affiliated nonprofit institutions.[95] With regard to the employee's requirements, the FMG must have completed all three steps of the USMLE, a medical license if required by the state, and ECFMG certification. The application itself typically takes several months.

B. *The J-1 Visa*

1. *Legislative History*

The J-1 visa is a nonimmigrant visa available for exchange visitors.[96] In 1948, Congress created the exchange visitor program in the United States

90. A specialty occupation is one that requires at least a bachelor's degree.

91. *See* Miscellaneous and Technical Immigration and Naturalization Amendments of 1991, Pub. L. No. 102-232, 105 Stat. 1733; 8 U.S.C. § 1182; 8 U.S.C. § 1101; 8 C.F.R. § 214.2(h)(4) (2025).

92. 8 C.F.R. § 214.2(h)(1)(i) (2025).

93. The LCA is an attestation on the part of the employer to pay the foreign employee at least the prevailing wage (discussed *supra*), that the foreign worker will not adversely affect the working conditions of employees similarly employed, that there is not a strike, lockout, or work stoppage in the course of a labor dispute at the time the application is filed, and that notice of the filing will be given to current employees through a bargaining representative or physical posting at the work site. In order to file the LCA, the employer must first obtain a prevailing wage determination (discussed *supra*) and contractually attest to the Department of Labor that they will pay either the prevailing wage or the actual wage paid to similarly employed workers, whichever is higher. Once these conditions are met, the Department of Labor will certify the LCA. Note that the grant of the H-1B visa is not conditional on a labor market test, or proof that a U.S. worker be immediately qualified and available for the position. That requirement exists only at the green card stage (discussed *infra*). The attestation is simply a contractual obligation to pay the worker the proffered wage in the LCA.

94. 8 C.F.R. § 214.2(h)(8) (2025).

95. *See supra* Section I.A.

96. 9 FAM 402.5-6(C); 22 C.F.R. § 62.1 (2015).

Information and Educational Exchange (Smith-Mundt) Act.[97] The Smith-Mundt Act allowed for "students, trainees, teachers, guest instructors, professors and leaders in fields of specialized knowledge or skill" to participate in an exchange program and were admitted to the United States as nonimmigrant visitors for business.[98] The law was passed largely in the wake of the Second World War to encourage foreign nationals to obtain positive experiences and views of the American people and spread those positive views throughout the world.[99]

In 1952, Congress passed the Immigration and Nationality Act (INA), a bipartisan comprehensive immigration bill that changed the immigration system.[100] Concerned that some exchange visitors were not returning home to spread goodwill as originally intended by the program, the bill included a provision that subjected exchange visitors to a two-year home residency requirement upon the completion of their training program before they could be eligible to change to a different visa status.[101]

In 1956, Congress passed amendments to the Smith-Mundt Act to close a loophole that allowed exchange visitors to leave the U.S. and reenter under a different nonimmigrant or immigrant category prior to completing their two-year home residency requirement.[102] Specifically, the Act prohibited an exchange visitor from applying for an immigrant visa or an H nonimmigrant visa and also created a waiver of the home residency requirement when an interested government agency (IGA) and the Secretary of State find a waiver to be in the public interest.[103]

The INA was amended in 1961 with the Mutual Educational and Cultural Exchange (Fulbright-Hayes) Act, which created a J-1 visa in order to "increase mutual understanding between the people of the United States and the people of other countries by means of educational and cultural exchange. . . ."[104] The new J-1 visa retained the two-year home residency requirement and the limitation on acquiring permanent residency or an H visa prior to completion of the two-year home residency requirement until the applicant had been physically present in their home country, country of last residence, or another foreign country.[105] It is available for a variety of different categories of training and has a specific category for physicians engaged in graduate medical training.[106] The Fulbright-Hayes Act also

97. Smith-Mundt Act, Pub. L. No. 80-402 (1948).
98. *Id*.
99. *Id*.
100. Immigration and Nationality Act (INA), Pub. L. No. 82-414 (1952) (amended 2023) (to date the policy is still referred to as the INA).
101. Some exceptions exist. *See* INA § 212(e).
102. Act of June 4, 1956, Pub. L. No. 84-555 (amending the Smith-Mundt Act).
103. *Id*.
104. Mutual Educational and Cultural Exchange Act of 1961, Pub. L. No. 87-256.
105. *Id*. Note that the applicant could complete their home residency requirement in another country only if the U.S. Department of State found it to be within the purpose of the J-1 program.
106. *Id*; *see also* 22 C.F.R. § 62.27.

created waivers of the home residency requirement in limited cases of exceptional hardship to a U.S. citizen or permanent resident spouse or child(ren).[107]

In 1970, Congress amended the INA again in order to limit the home residency requirement only to those exchange visitors who received public funding from either their own home government or the United States government, and/or those who were engaged in a field of specialized knowledge or skill that was in demand in their home country.[108] A number of additional waivers of the home residency requirement were also created upon a favorable determination by the U.S. Department of State that the exchange visitor's return to their home country would impose exceptional hardship on a U.S. citizen or lawful permanent resident spouse or child, that the exchange visitor would be subject to persecution, a finding that remaining in the U.S. would be in the public interest, and/or a "no objection" statement from the exchange visitor's home country in cases where the home country provided public funding.[109] The amendments also limited the fulfillment of the home residency requirement to the foreign national's home country or country of last residency only.[110]

The Smith-Mundt Act, and consequently the J-1 visa, requires sponsorship by an exchange visitor program.[111] Sponsorship is evaluated by the Program Designation Branch of the Office of Exchange Visitor Services within the USIA's Office of General Counsel.[112] Only the ECFMG is authorized by the USIA to sponsor J-1 visas for FMGs in clinical training programs.[113] Clinical training programs may include academic medical centers or universities and the program must involve patient care and may include observation, consultation, teaching, and/or research.[114]

In 1976, Congress enacted the Health Professionals Education Asnce Act (HPEAA) which made foreign physicians participating in a clinical residency/fellowship training program subject to the two-year home residency requirement.[115] Under existing law at that time, only federal agencies acting

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107. *See* 22 C.F.R. §62.27.

108. Act of Apr. 7, 1970, Pub. L. No. 91-225 (amending INA § 212(e)). The U.S. Department of State publishes an "exchange visitor skills list" which indicates whether a particular field of specialized knowledge and skill from a particular country subjects a J-1 visa holder to the home residency requirement. The most recent list was published in 2009. 74 FR 20108. *See also Exchange Visitors Skills List*, U.S. DEP'T OF STATE, https://perma.cc/VXT2-6R34 (last visited July 9, 2025).

109. Act of Apr. 7, 1970, *supra* note 108.

110. *Id*.

111. SISKIND & TAUB, *supra* note 38.

112. The United States Information Agency (USIA) is a federal agency established in August 1953 to oversee the exchange visitor program. It was temporarily renamed the U.S. International Communications Agency in 1978 by President Carter and renamed the USIA in 1982. It currently operates under the U.S. Department of State. *United States Information Agency*, FED. REG., https://perma.cc/H54U-GCJJ (last visited July 9, 2025).

113. *Instruction Sheet for Initial J-1 Applicants*, INTEALTH, https://perma.cc/HC4F-48MD (last visited Nov. 17, 2025).

114. GREGORY H. SISKIND, WILLIAM A. STOCK & STEPHEN YALE-LOEHR, THE J VISA GUIDEBOOK: THE COMPLETE RESOURCE FOR EXCHANGE VISITOR PROGRAMS AND PARTICIPANTS 2-10, 4-8 (1999).

115. Health Professions Educational Assistance Act of 1976, Pub. L. No. 94-484.

as IGAs could sponsor waivers of the home residency requirement for foreign physicians to help medically underserved rural areas. As a result, Congress created a waiver of the home residency requirement specifically designed for foreign physicians in the Immigration and Nationality Technical Corrections Act of 1994.[116] Initially called the Conrad 20 program after sponsor Senator Kent Conrad (D-ND), the program created a waiver of the two-year home residency requirement for any foreign physician who agrees to practice medicine in a health care facility located in a medical shortage area as designated by the U.S. Department of Health and Human Services for a period of three years. The waiver requires a sponsorship and a request from a state department of health (or its equivalent) to the U.S. Department of State.[117] Upon a favorable recommendation from the U.S. Department of State, a foreign physician may then apply for a change of status to an H-1B nonimmigrant visa to begin work.

2. *J-1 Eligibility*

The J-1 visa itself requires passage of Steps 1 and 2 of the USMLE exam, ECFMG certification, an offer letter from a residency or fellowship program, and a statement of need from the Ministry of Health of the country of last permanent residence.[118] The J-1 visa does not require passage of Step 3 of the USMLE. The J-1 is available for the duration of the training period for a maximum of seven years and may be extended in exceptional circumstances.[119] It does, however, have a two-year home residency requirement attached, which requires the foreign physician to return home for a period of two years unless they obtain a waiver.[120]

Because of the home residence requirement, FMGs are restricted from applying for an immigrant visa, permanent residence, or an H or L nonimmigrant visa.[121] That means that at the completion of their training, they have three options: (1) return to their home country or country of last permanent residence for the requisite two years; (2) pursue a waiver (discussed *infra)*; or (3) leave the United States and reenter on a visa other than an H or L.[122]

C. *Choosing Between the H-1B and the J-1 Visa*

In order to qualify to complete a medical training in an accredited graduate medical education program, an FMG must obtain ECFMG certification and

116. Immigration and Nationality Technical Corrections Act of 1994, Pub. L. No. 103-416.
117. *Id.*
118. *See* 9 FAM 402.5-6(C); 22 C.F.R. § 62.27.
119. 22 C.F.R. § 62.27.
120. INA § 212(e), 8 U.S.C. 1182(e).
121. *Id.*
122. SISKIND & TAUB, *supra* note 38, at 12.

pass USMLE Steps I and II. The FMG must also follow the medical licensure laws of the state where the FMG is practicing medicine.[123]

The choice between the H-1B and J-1 may come down to issues that are outside of the FMG's control. Clearly, the H-1B is the preferred nonimmigrant visa route for FMGs hoping to remain in the U.S. to practice medicine because it has no home residency requirement attached. That said, many programs refuse to sponsor an H-1B visa for a number of reasons, including cost and other obligations. Specifically, the DOL has promulgated a series of regulations that require the employer to pay all fees associated with the application, including government filing fees and attorney fees, as well as assume a series of obligations to sponsor the FMG for a visa.[124] Additionally, the J-1 is more cost effective for the FMG and does not require employer sponsorship as ECMFG is the J-1 sponsor.[125]

For the most part, there are two defining requirements that determine whether an FMG utilizes the H-1B or J-1 visa: passage of all three steps of the USMLE and whether the training program will sponsor an H-1B. Most states require medical licensure for both practicing physicians and residents/fellows in order to practice medicine in the state.[126] Some states, however, do not allow a physician to sit for Step 3 of the USMLE before graduate medical training begins.[127] Some foreign physicians choose not to take Step 3 prior to beginning their training. Additionally, the H-1B requires employer sponsorship – in this case the sponsorship of the residency program itself.[128]

While historically, the majority of FMGs completed their medical training on a J-1, that shifted in the mid-1990s when a number of teaching hospitals began sponsoring H-1Bs for medical training.[129] By the mid-2000s, nearly half of all FMGs completed their medical training on H-1Bs.[130]

The H-1B also allows for the FMG to have the intent to remain in the U.S. permanently, while the J-1 is not a dual intent visa.[131]The H-1B also allows for greater flexibility. Specifically, the H-1B allows for the FMG to have the ability to moonlight with USCIS approval while the J-1 does not allow for any additional employment authorization.[132] Additionally, there is greater flexibility with the H-1B in the event that the FMG needs to change program sponsors in the form of a 60 day grace period.[133]

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123. *Id*. at 9.
124. *Id*. at 36.
125. *Id*. at 11.
126. Gregory Siskind, *Visa Options For Graduate Medical Training*, *in* IMMIGRATION OPTIONS FOR PHYSICIANS, 35 (Margaret A. Catillaz, Rita Kushner & Stephanie L. Browning, eds., 2d ed. 2004). *See also infra* Section V.A.4.
127. SISKIND ET AL., *supra* note 126.
128. 8 C.F.R. § 214.2(h)(1)(i).
129. SISKIND & TAUB, *supra* note 38, at 11.
130. *Id*.
131. *Id*. at 17.
132. *Id*.
133. *Id*.

II. WAIVERS OF THE J-1 HOME RESIDENCY REQUIREMENT

Upon completing their medical training, the options vary for those who completed their training on an H-1B and a J-1. Those who are already on an H-1B can either return to their home country or find an employer to sponsor their employment on another H-1B. Recall that sponsorship of the H-1B requires that the employer pay all costs associated with the application, including both government filing fees and attorney's fees which can total several thousand dollars. Those who completed their training on a J-1 can return to their home country or country of last permanent residence for two years to complete their home residence requirement, obtain a waiver of the home residence requirement, or leave the United States and reenter on a nonimmigrant visa other than an H or L visa.[134]

The two-year home residence requirement is found in section 212(e) of the Immigration and Nationality Act.[135] It states

> No person admitted under section 1101(a)(15)(J) of this title or acquiring such status after admission... who came to the United States or acquired such status in order to receive graduate medical education or training, shall be eligible to apply for an immigrant visa, or for permanent residence, or for a nonimmigrant visa under section 1101(a)(15)(H) or section 1101(a)(15)(L) of this title until it is established that such person has resided and been physically present in the country of his nationality or his last residence for an aggregate of at least two years following departure from the United States.

Section 212(e) further describes the availability of several waivers of the two-year home residence requirement as follows:

> *Provided*, That upon the favorable recommendation of the Director, pursuant to the request of an interested United States Government agency (or, in the case of an alien described in clause (iii), pursuant to the request of a State Department of Public Health, or its equivalent), or of the Commissioner of Immigration and Naturalization after he has determined that departure from the United States would impose exceptional hardship upon the alien's spouse or child (if such spouse or child is a citizen of the United States or a lawfully resident alien), or that the alien cannot return to the country of his nationality or last residence because he would be subject to persecution on account of race, religion, or political opinion, the Attorney General may waive the requirement of such two-year foreign residence abroad in the case of any alien whose admission to the United States is found by the Attorney General to be in the public interest except that in the case of a waiver requested

134. *Id.* at 46.
135. INA § 212(e), 8 U.S.C. 1182(e).

> by a State Department of Public Health, or its equivalent, or in the case of a waiver requested by an interested United States Government agency on behalf of an alien described in clause (iii), the waiver shall be subject to the requirements of section 1184(l) of this title: *And provided further*, That, except in the case of an alien described in clause (iii), the Attorney General may, upon the favorable recommendation of the Director, waive such two-year foreign residence requirement in any case in which the foreign country of the alien's nationality or last residence has furnished the Director a statement in writing that it has no objection to such waiver in the case of such alien.[136]

As indicated in 212(e), IGA/Conrad 30, hardship, and persecution waivers are the only waivers of the home residency requirement that are available for FMGs.[137] All J-1 waivers must be approved first by the Department of State and then by USCIS, a process that can take several months.[138] Upon approval of the waiver, the FMG is then eligible to file an application for a nonimmigrant and/or immigrant visa.

A. *Conrad 30 Waivers*

Recall that the Immigration and Nationality Technical Corrections Act of 1994 created a waiver of the two-year home residency requirement for any foreign physician who was willing practice medicine in a health care facility located in a medical shortage area as designated by the U.S. Department of Health and Human Services for a period of three years.[139] The waiver, known as the Conrad 20 waiver, initially allowed for twenty waivers per state.[140] Congress subsequently amended the waiver by increasing each state's allotment to thirty, allowing each state to set aside up to five waivers (later increased to ten) for facilities not located in shortage areas but that nonetheless service patients that live in shortage areas, and expanding the availability of the waiver to specialists.[141] It is now known as the Conrad 30 program.

Section 214(l) of the Immigration and Nationality Act lists the requirements for a Conrad 30 waiver as follows:

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136. *Id.*

137. *See supra* Section I.B.

138. The final waiver is granted by USCIS upon favorable recommendation from the Department of State. *See* Dina v. Att'y Gen. of the U.S., 793 F.2d 473, 476 (2d Cir. 1986); Silverman v. Rogers, 437 F.2d 102, 107 (1st Cir. 1970); Matter of Tayabiji, 19 I&N Dec. 264, 264 (B.I.A. 1985).

139. Immigration and Nationality Technical Corrections Act of 1994, Pub. L. No. 103-416, sec. 220 (b), § 214(k)(1)(B), 108 Stat. 4305, 4319. *See supra* Section I.B.

140. Immigration and Nationality Technical Corrections Act of 1994 sec. 220(b), § 214(k)(1)(D).

141. 21st Century Department of Justice Appropriations Authorization Act, Pub. L. No. 107-273, sec. 11018(a), § 214(l)(1)(B), 116 Stat. 1758, 1825 (2002) (substituting "30" for "20"); Act of Oct. 8, 2008, Pub. L. No. 110-362, sec. 2, § 214(l)(1)(D)(ii), 112 Stat. 4013, 4013 (substituting "10" for "5"); Act of Dec. 3, 2004, Pub. L. No. 108-441, sec. 1(c)-(d), § 214(l)(1)(D), 118 Stat. 2630, 2630 (substituting "agrees to practice medicine" for "agrees to practice primary care or specialty medicine").

(1) a request by an interested federal or state agency;
(2) the FMG demonstrates an offer of full-time employment at a health facility or health care organization;
(3) the FMG agrees to begin employment within 90 days of receiving the waiver and agrees to continue to work for a total of three years unless the Attorney General determines extenuating circumstances warrant a change of employment for the duration of the three year period;
(4) the FMG agrees to provide full-time medical care in a facility located in a geographic area designated by the Secretary of Health and Human Services[142] as having a shortage of health care professionals or in a facility that serves patients who reside in said designations; and/or
(5) if the waiver is for specialty medicine in a designated shortage area, the request must justify that there is a shortage of specialists able to provide said medical services.

The Conrad 30 program is largely operated by each individual state's Department of Health. In addition to the statutory requirements listed above, each Department has their own requirements for sponsorship, all of which include the requirements set forth by the U.S. Department of State.[143] Additionally, every state requires the employer to engage in some recruitment efforts to attempt to hire a U.S. physician in order to justify that there is an actual need for a waiver, and some states require filing fees, support letters, contract provisions in addition to those required by the Department of State, and/or a requirement that the waiver physician serve Medicare and Medicaid populations.[144]

Once the FMG secures an employment contract with a sponsoring employer, the employer must apply to the state Department of Health. Once they issue a request for a waiver, the state Department of Health forwards their support of a waiver to the U.S. Department of State's Waiver Review Division. If the Waiver Review Division issues the waiver, they forward a "Favorable Recommendation" to USCIS who has the final authority to issue the waiver. The waiver itself does not provide any legal status or work authorization. Once USCIS issues the waiver, the FMG is then eligible to file an application for a nonimmigrant and/or immigrant visa.

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142. HHS designated shortage areas are determined by the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA). HRSA measures shortages of medical professionals in two different categories: Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUAs/MUPs). HPSAs and MUAs/MUPs are generally designated for primary care, dental providers, and mental health providers. HPSAs are generally granted to a geographic area, population group, or specific health care facility, while MUA/Ps are generally granted to a whole county or group of continuous counties or census tracts in a county.

143. Travel.State.Gov, *Apply for a Waiver of the Exchange Visitor Two-Year Home-Country Physical Presence Requirement*, https://perma.cc/KXU8-H62P (last visited June 29, 2025).

144. SISKIND & TAUB, *supra* note 38, at 59-64.

B. *IGA (VA/HHS/ARC/DRA/SCRC) Waivers*

Recall that under Section 212(e) of the INA, a federal government agency may sponsor a waiver of the J-1 home residence requirement if the agency finds that the waiver is in the public interest.[145] The relevant regulations governing federal government agency waivers permit any U.S. government agency to request a waiver if the FMG is "actively and substantially involved in a program or activity sponsored by or of interest so such agency."[146] Currently, seven federal programs sponsor these waivers: the Appalachian Regional Commission (ARC), the Delta Regional Authority (DRA), the Southeast Crescent Regional Commission (SCRC), the Northern Border Regional Commission (NBRC), the Department of Health and Human Services (HHS), and the Department of Veteran Affairs (VA).[147]

Similar to Conrad 30 waivers, each federal agency has their own requirements pursuant to regulation for waiver eligibility. DRA waivers are only available for primary care and specialist physicians who will be working in facilities located in a HPSA, MHPSA, MUA, or MUP in counties that are located in states that are covered by the DRA.[148] Between 2019 and 2021, the DRA sponsored 440 physicians for an IGA waiver.[149] SCRC waivers were modeled after the DRA's program and are available for primary care and specialist physicians in a HPSA, MHPSA, MUA, or MUP in a county covered by the SCRC.[150] ARC waivers are available for primary care and specialist physicians but are limited to HPSAs in a country represented by the ARC.[151] The NBRC is the newest J-1 program and was modeled after the ARC.[152] It supports waivers for primary care physicians in a HPSA, MHPSA, MUA, or MUP.[153]

In addition to the regional programs listed above, the HHS and VA both operate a waiver program as well. The HHS program requirements are nearly identical to the Conrad 30 program, but HHS limits their waivers to physicians working in primary care.[154] The VA program is designed to allow VA

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145. 8 U.S.C. § 1182(e); *see also supra* Section II.B.

146. 22 C.F.R. § 41.63(c) (2024).

147. SISKIND & TAUB, *supra* note 38, at 69.

148. The DRA covers 252 counties in Alabama, Arkansas, Illinois, Kentucky, Louisiana, Mississippi, Missouri, and Tennessee. *See Delta Doctors*, DELTA REG'L AUTH., https://perma.cc/KEN2-SB88 (last visited July 3, 2025).

149. *Id.*

150. The SCRC covers counties in Alabama, Georgia, Florida, Mississippi, North Carolina, South Carolina, and Virginia. *See J-1 Visa Waiver Program Guidelines*, S.E. CRESCENT REG'L COMM'N, https://perma.cc/2S9N-VNUW (last visited July 3, 2025).

151. The ARC covers counties in Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, Ohio, Pennsylvania, South Carolina, Tennessee, Virginia, and West Virginia. *See J-1 Visa Waivers*, APPALACHIAN REG'L COMM'N, https://perma.cc/7RWH-STVM (last visited July 3, 2025).

152. The NBRC covers counties in Maine, New Hampshire, New York, and Vermont. *See NBRC J-1 Visa Waiver Program,* NORTHERN BORDER REG'L COMM'N, https://perma.cc/Y785-NQ2Z (last visited July 3, 2025).

153. *Id.*

154. *See* U.S. Dep't of Health and Hum. Servs., *HHS Exchange Visitor Program*, https://perma.cc/UP9Z-WLDU (last visited July 3, 2025).

facilities to fill internal shortage positions at local VA facilities.[155] The main difference between the VA waiver and those previously mentioned is the federal regulatory requirement that the VA facility be located in a federally designated HPSA or MUA is waived.

C. *Hardship and Persecution Waivers*

While most physicians obtain a Conrad 30 or IGA waiver, there are two alternate waivers that are available.[156] The hardship and persecution waivers of the home residency requirement are available to all J-1 visa holders that are subject to the home residence requirement. The hardship or persecution waiver is available if the applicant can establish that compliance with the home residence requirement

> would impose exceptional hardship upon his/her spouse or child who is a citizen of the United States or a lawful permanent resident alien, or that he or she cannot return to the country of his or her nationality or last residence because he or she will be subject to persecution on account of race, religion, or political opinion. . . .[157]

In practice the threshold for both hardship and persecution waivers is high. The hardship waiver is actually a two-step test and requires the applicant to establish that the J-1 visa holder's U.S. citizen or legal permanent resident spouse and/or child(ren) would both face *extreme* hardship if they were to relocate with the J-1 visa holder spouse/parent to their home country *and* they would suffer *extreme* hardship if they were to remain in the U.S. while their spouse/parent returned to their home country.[158] Examples of hardship factors include family composition, and economic, medical, political/security, psychological, and/or sociocultural hardships, and/or public policy concerns.[159] The persecution waiver is different than the analysis for asylum where the applicant must prove either that they are the victim of past persecution or has a well-founded fear of future persecution.[160] For a persecution waiver, the applicant can only prove that they "will be subject to persecution" if they returned to their home country, so any past persecution without a well-founded future fear is insufficient grounds for a waiver.[161]

Both the hardship and persecution waiver is filed initially with the U.S. Department of State's Waiver Review Division. If the Division issues a

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155. *See* Dep't of Veterans Affairs Directive 5005.01 Transmittal Sheet, Requests to Petition the United States Department of State for a Waiver of the 2-Year Home Residency Requirement on Behalf of an Exchange Visitor and Subsequent Employment Requirements (November 17, 2022).

156. SISKIND & TAUB, *supra* note 38, at 109.

157. 8 C.F.R. § 1212.7(c)(5).

158. Bruce A. Hake and David L. Banks, *The Hake Hardship Scale: A Quantitative System for Assessment of Hardship in Immigration Cases Based on a Statistical Analysis of AAO Decisions*, ILW.COM, https://perma.cc/4HFB-VYTB (last visited July 3, 2025); *see also* U.S. Citizenship & Immigr. Servs., *Policy Manual*, vol. 2, pt. D, ch. 4B, https://perma.cc/FLD9-7YWL (last visited July 3, 2025).

159. Hake & Banks, *supra* note 158; *see also* SISKIND & TAUB, *supra* note 38, at 110-13.

160. 8 C.F.R. § 208.13(b).

161. 8 C.F.R. § 1212.7(c)(8).

favorable recommendation, they forward the application to USCIS for final approval. Because the waiver does not provide any legal status or work authorization, once the waiver is approved, the physician may file an application for a change of status to a nonimmigrant visa that provides work authorization or an application for legal permanent residence.

D. *Alternate Options*

Recall from Section IIB that pursuant to the home residence requirement, FMGs are restricted from applying for an immigrant visa, permanent residence, or an H or L nonimmigrant visa.[162] Therefore, they have three options once they have completed their training: (1) return to their home country or country of last permanent residence for the requisite two years; (2) pursue a waiver (discussed *infra)*; or (3) leave the United States and reenter on a visa other than an H or L.[163]

If the FMG wants to remain in the United States without a obtaining a waiver, the only option for them is to leave the United States and reenter on a visa other an H or L. That typically leaves an O-1 or E-3. The O-1 visa was created in the same Act that created the H-1B visa.[164] It is available for foreign nationals with "extraordinary ability in the sciences, arts, education, business or athletics which has been demonstrated by sustained national or international acclaim. . .."[165] The O-1 is typically associated with big names in the arts and athletics. For example, David Beckham, Justin Bieber, and Rihanna are some examples of foreign nationals who came to the U.S. on an O-1.[166] The extraordinary ability standard may be met by

> receipt of a major, internationally recognized award, such as the Nobel Prize;. . . or at least three of the following forms of documentation: (1) documentation of the alien's receipt of nationally or internationally recognized prizes or awards for excellence in the field of endeavor; (2) documentation of the alien's membership in associations in the field for which classification is sought, which require outstanding achievements of their members, as judged by recognized national or international experts in their disciplines or fields; (3) published material in professional or major trade publications or major media about the alien, relating to the alien's work in the field for which classification is sought, which shall include the title, date, and author of such published material, and any necessary translation; (4) evidence of the alien's participation on a panel, or individually, as a judge of the work of others in the same or in an allied field of specialization to that for which classification is sought; (5) evidence of the alien's original scientific,

162. 8 C.F.R. § 1212.7(c)(9)(iii).
163. SISKIND & TAUB, *supra* note 38, at 12.
164. Immigration Act of 1990, Pub. L. No. 101-649, §§ 205, 207.
165. 8 U.S.C. § 1101(a)(15)(O)(i).
166. Ev Size, *Celebrity Immigrants and the Visas that Helped Them Get Famous*, MEDIUM (Feb. 1, 2019), https://perma.cc/AWF6-WS7B.

> scholarly, or business-related contributions of major significance in the field; (6) evidence of the alien's authorship of scholarly articles in the field, in professional journals, or other major media; (7) evidence that the alien has been employed in a critical or essential capacity for organizations and establishments that have a distinguished reputation; or (8) evidence that the alien has either commanded a high salary or will command a high salary or other remuneration for services, evidenced by contracts or other reliable evidence.[167]

Foreign physicians can often meet the requisite requirements for O-1 status as most can provide evidence of publications in research journals, peer review work, and a salary much higher than the prevailing wage.

The E-3 visa is available solely for Australian nationals to perform specialty services in a specialty occupation in the United States.[168] Note that there are some other nonimmigrant visa options for foreign physicians wanted to remain in the U.S. to perform research, but this article will not discuss them since its scope is patient care.

III. PERMANENT RESIDENCE

Up until now, this article has discussed nonimmigrant visa options available for foreign physicians wanting to complete medical training and begin work. The immigrant visa provides legal permanent residence and is traditionally known as a green card. There are a number of avenues for permanent residence: family-based immigration, employment-based immigration, asylum, and the diversity lottery. While family-based immigration, asylum, and the diversity lottery are certainly options, they are not available across the board to all foreign physicians. As the name suggests, family-based immigration requires a close qualifying family relationship to a U.S. citizen or permanent resident, asylum requires proof of past persecution or a well-founded future fear of persecution, and the diversity lottery is simply a lottery that is only available to citizens of countries with traditionally lower levels of immigration to the United States. As such, while they are paths that can be taken by a foreign physician when available, they are not the traditional routes for foreign physicians. This section will largely focus on the employment-based options that are available for foreign physicians.

A. *EB-2 PERM Labor Certification*

The most popular path for permanent residence is the labor certification process.[169] This process, also called the Program Electronic Review Management System (PERM) is designed to justify that there are no immediately qualified

167. 8 C.F.R. § 214.2(o)(3)(iii).
168. 8 U.S.C. § 1101(a)(15)(E)(iii).
169. SISKIND & TAUB, *supra* note 38, at 181.

and available U.S. employees for the position and as a result, the federal government should grant legal permanent residence to a foreign national so that they can provide the necessary work. It requires employment sponsorship and an extensive recruiting process that is designed to prove that there are no immediately qualified and available U.S. workers for the position. The process also requires the employer to justify that the employment of the foreign national will not adversely affect the wages and working conditions of similarly situated U.S. workers.

The application begins with a prevailing wage determination from the DOL. The requirements and duties associated with the job will determine the prevailing wage that the employer must pay, and will also determine whether the employer may disqualify an applicant because an employer may not disqualify an employee who is less qualified than the foreign national. Currently that determination takes approximately eight months.[170] If the employer can pay the prevailing wage, the next step of the process is the recruitment stage where the employer is required to post a job order listing the job requirements with the State Workforce Agency in the state where the physician will be working, an advertisement in the job cite city's major newspaper for two consecutive Sundays, and three additional forms of recruitment that can include the employer's website, other online job sites, a professional organization (i.e. the Journal of the American Medical Association or the New England Journal of Medicine), radio or television advertisements, campus placement offices (i.e. local medical school), and contracting with an employee recruitment firm. All of these activities must take place within a 180 day period prior to filing the application and only one of the recruitment steps may take place in the preceding 30 day period prior to filing.

Once the recruitment is complete, the employer is required to review all applications from qualified candidates. If there were no candidates, the application may be filed. If there were candidates who are qualified and immediately available, the employer must actually consider those candidates and either offer them a position or determine that those candidates are disqualified for a valid reason. Only then may the employer proceed with filing.

Once all of the applicants have been reviewed and either hired or disqualified, the employer must make ten attestations to the DOL on the PERM application (Form 9089).[171] As with the H-1B, all costs associated with a PERM must be paid by the employer.[172]

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170. U.S. Dep't of Lab., *Processing Times Update Schedule*, https://perma.cc/2SG6-MF9F (last visited January 11, 2025).

171. 20 C.F.R. § 656.10(c) (2006).

172. 20 C.F.R. § 656.12(b)-(c) (2007).

B. *EB-2 Physician National Interest Waiver*

The Physician National Interest Waiver (PNIW) is basically an extension of the Conrad 30/IGA waiver in practice. It provides a path to legal permanent residence for foreign physicians who provide full time clinical care in a federally designated shortage area (including an MUA/MUP, HPSA, MHPSA, or a VA facility) for a period of five years to be completed within a six-year period.[173] It is available for both primary care physicians and specialists. Like the Conrad 30/IGA waiver, the PNIW must be supported by a state department of public health or a federal agency. While the application may be filed at any point, it will not be approved until after the physician has completed the full five-year service period. The work does not need to be completed at the same location and/or for the same employer for the full five-year period, as long as the physician is employed at *any* shortage area and has the support of the state department of public health and/or federal agency.

The PNIW does not require employer sponsorship and can be filed by the physician directly. It does, however, require an employment agreement that specifies that the physician will be working full time in a qualified shortage area for five years.

C. *EB-2 National Interest Waiver*

The traditional National Interest Waiver (NIW) is a waiver of the PERM labor certification.[174] It does not require employer sponsorship and is available for any foreign national who can demonstrate that a waiver of the labor certification is necessary because their work is in the public interest.[175] It requires an advanced degree (including a medical degree) or exceptional ability in the field.[176] Specifically, it is available to "qualified immigrants who are members of the professions holding advanced degrees or their equivalent or who because of their exceptional ability in the sciences, arts, or education interests, or welfare of the United States, and whose services in the sciences, arts, professions, or business are sought by an employer in the United States."[177]

D. *EB-1 Immigrants of Extraordinary Ability in the Sciences*

The EB-1 immigrant visa category covers immigrants of extraordinary ability in the sciences, arts, education, business, and athletics (EB-1A); outstanding professors and researchers (EB-1B); and international managers and executives (EB-1C). The EB-1A category for immigrants of extraordinary

173. 8 U.S.C. § 1153 (b)(2)(B) (1952); 8 C.F.R. § 204.12(a)-(c) (2000).
174. 8 U.S.C. § 1153 (b)(2).
175. *Id.*
176. *Id.*
177. *Id.*

ability in the sciences is the category applicable for practicing foreign physicians.

Just as the PNIW was an extension of the Conrad 30/IGA waiver, the EB-1 is similar to the O-1 nonimmigrant visa. It does not require employer sponsorship or an employment agreement. Instead, the applicant must provide evidence of a one-time international achievement, or three of the following ten categories:

> (1) evidence of receipt of lesser nationally or internationally recognized prizes or awards for excellence; (2) evidence of your membership in associations in the field which demand outstanding achievement of their members; (3) evidence of published material about you in professional or major trade publications or other major media; (4) evidence that you have been asked to judge the work of others, either individually or on a panel; (5) evidence of your original scientific, scholarly, artistic, athletic, or business-related contributions of major significance to the field; (6) evidence of your authorship of scholarly articles in professional or major trade publications or other major media; (7) evidence that your work has been displayed at artistic exhibitions or showcases; (8) evidence of your performance of a leading or critical role in distinguished organizations; (9) evidence that you command a high salary or other significantly high remuneration in relation to others in the field; or (10) evidence of your commercial successes in the performing arts.

While it is similar to the O-1, the standard for the EB-1 is higher. Granting the EB-1 visa is a subjective administrative adjudication by an immigration officer. In adjudicating these applications, USCIS has adopted a "final merits determination" when the applicant can establish three of the regulatory requirements, but the officer finds that the applicant has not demonstrated that they are at the top of their field.[178]

E. *Immigrant Investor*

Finally, an EB-5 investor visa may be a possibility for some foreign physicians, but likely not a viable option for many. It requires an applicant to invest $1.8 million (or $900,000 in high unemployment/rural areas) in a business (in this case, a medical practice) that creates ten full time jobs for U.S. workers. A foreign physician may either open their own practice, buy an existing practice, or invest in some other type of business through a regional center that in theory could have nothing to do with the medical field. While this is a viable option in a limited number of circumstances, it is far from a

178. Kazarian v. USCIS, 596 F.3d 1115, 1121 (9th Cir. 2010).

remedy that can function on a national scale to ameliorate the physician shortage.

F. *Annual Cap on the Immigrant Visa Categories*

In the Immigration Act of 1952, Congress created the immigration system that is largely still in place today.[179] The Act created the nonimmigrant and immigrant visa systems, and the visa preference and per country quota system that exists within the immigrant visa system.[180] Under visa preference, Congress gives preference to certain classes of immigrants by allowing more immigrant visa numbers each year.[181] The per country quota system grants 50% of each country's quota for the first preference category (EB-1), 30% for the second category (EB-2), 20% for the third category (EB-3), and any unused numbers go towards a country's fourth category (EB-4).[182]

In 1990, Congress created five categories of employment-based immigration and an annual quota for each category.[183] Currently, a total of 140,000 employment-based immigrant visas may be issued each year. Table 4 below illustrates the number of immigrant visas that may be issued in each preference category each year. The INA sets the worldwide limit for annual family sponsored immigration at 226,000 and the annual employment-based immigration at 140,000. The INA also sets the per country limit at seven percent of the annual for both family and employment-based immigration which is a total of 336,000. Per the seven percent limit, there is a total of 80,080 (and perhaps more in the EB-1 category if there are unused EB-4 and EB-5 numbers, and more in EB-2 if there are unused EB-1 numbers) EB-1 and EB-2 visas each year available.

IV. IMMIGRATING TO THE U.S. AS AN FMG: A CASE STUDY ILLUSTRATING THE SYSTEM'S FAILURES

As mentioned, there are two methods of legal entry into the United States, either through a nonimmigrant or immigrant visa. To enter the United States for the first time, applicants must apply outside of the United States at a United States consulate for either a temporary nonimmigrant or permanent immigrant visa. If they are granted an immigrant visa, they are allowed entry into the United States as a legal permanent resident. If they are granted a temporary visa, or a nonimmigrant visa, they will eventually need an immigrant visa in order to remain in the United States permanently. On a practical level, for many, the ultimate goal is United States citizenship.[184] Regardless of

179. 8 U.S.C. 1101.
180. 8 U.S.C. 1153(a).
181. *See id.*
182. *Id. See* also JAMES G. GIMPEL & JAMES R. EDWARDS, THE CONGRESSIONAL POLITICS OF IMMIGRATION REFORM 96 (1999) and Maryam T. Stevenson, *Explaining the Comprehensive Immigration Stalemate in Congress*, 73 CATH. U. L. REV. 414-415 (2024).
183. *See* Immigration Act of 1990, Pub. L. No. 101-649, 104 Stat. 4978.
184. The terms citizenship and naturalization are used interchangeably throughout this book.

method of entry, applicants must typically hold legal permanent resident status for at least five years plus meet a physical residency requirement prior to filing an application for citizenship.[185]

To illustrate the process of obtaining a nonimmigrant visa at a U.S. consulate abroad and going through the immigrant visa process, let us follow the experiences of Dr. Singh, a cardiovascular surgeon and researcher from India.[186] Dr. Singh wishes to immigrate to the United States to practice medicine because he believes he will be able to maximize on the research and medical facilities in the United States and further his own research on a new noninvasive surgical method for treating heart disease. Dr. Singh contacts an immigration attorney in the United States and learns that in order to practice patient care in the United States, he must first complete a residency or fellowship program in the United States.[187]

Dr. Singh completes all of the requirements set forth by the Educational Commission for Foreign Medical Graduates (ECFMG), the organization that assesses whether foreign medical graduates are ready to enter residency or fellowship programs and certifies their credentials. He obtains ECFMG certification and applies for the National Residency Match Program. He is matched in an excellent surgery residency at the Mayo Clinic. Because he has not yet completed Step 3 of the USMLE, Dr. Singh applies for and is granted a J-1 visa to complete his residency and moves to Rochester.[188] He completes one year of the program and applies for a cardiovascular surgery fellowship at Johns Hopkins. Because of his credentials, talent, and experience, Dr. Singh is accepted into the program and moves to Maryland.

In his last year of fellowship, Dr. Singh calls his immigration attorney to let her know that he is interested in practicing medicine in the United States upon completion of his fellowship. She tells Dr. Singh that because he completed his residency and fellowship on a J-1 visa, he has a two-year home residency requirement. Recall that Congress created a waiver of this requirement for physicians who agree to work and receive approval to work in a facility located in a medical shortage area as designated by the United States Department of Health and Human Services as a HPSA or MUA, or at a facility where a majority or patients reside in a HPSA/MUA.[189] Because the waiver in and of itself does not provide any legal status, Dr. Singh must apply

185. An exception is made for spouses of United States citizens, who must hold legal permanent resident status for three years before being eligible for citizenship.

186. All names and examples used throughout this article are completely fictional. Their stories are a combination of the real-life experiences of several actual personal former clients. Any resemblance to any one specific individual is purely coincidental.

187. An exception does exist for physicians of extreme renown who will be employed at a public university.

188. Recall that there are two visas available for foreign medical graduates to complete a residency or fellowship training program in the United States, the J-1, which requires a two-year home residency requirement upon completion, or the H-1B which requires that the applicant have completed all three steps of the USMLE exam. Like nearly half of all foreign medical graduates, Dr. Singh has not completed step 3 of USMLE, and as such, must complete his program on the J-1 visa.

189. *See supra* Section II.

for an H-1B visa to actually give him legal status to stay and work upon approval of the waiver.[190] Therefore, he will need to find an employer who is willing to sponsor him for both a J-1 waiver and an H-1B visa.

As it is his last year in his fellowship program, Dr. Singh is constantly contacted by physician recruiters. Upon the advice of his attorney, he begins asking recruiters if the potential employers will sponsor a J-1 waiver and H-1B visa. Due to a physician shortage in the United States, many potential employers will sponsor both and Dr. Singh secures an employment agreement with a private physician's group in Boston, Massachusetts. The employer contacts their immigration attorney to begin the J-1 waiver and H-1B paperwork.

Dr. Singh's attorney begins the process for a Conrad 30 waiver. Recall that the Conrad 30 waiver requires certification from the employing state's Department of Health and the United States Department of State.[191] The application must justify that the foreign physician will either work at a facility located in a federally designated medical shortage area or that a majority of their patients live in a federally designated medical shortage area on a full-time basis providing clinical care.[192]

Once the waiver is filed and approved, the first step of the H-1B application process requires Dr. Singh's potential employer to file a Labor Condition Application (LCA) with the DOL, attesting to pay the foreign employee at least the prevailing wage (discussed above), that the foreign worker will not adversely affect the working conditions of employees similarly employed, that there is not a strike, lockout, or work stoppage in the course of a labor dispute at the time the application is filed, and that notice of the filing will be given to current employees through a bargaining representative or physical posting at the work site.[193] In order to file the Labor Condition Application, the employer will need to obtain a prevailing wage determination, and contractually agree (attest) to the DOL that they will pay either the prevailing wage or the actual wage paid to similarly employed workers, whichever is higher.[194] Once these conditions are met, the DOL will certify the Labor Condition Application.[195] Note at this point that certification of the Labor Condition Application and/or the grant of the H-1B visa is not conditional on a labor market test, or proof that a U.S. worker be immediately qualified and available for the position. That requirement exists only at the green card stage (discussed below). The attestation is simply a contractual obligation to pay the worker the proffered wage in the Labor Condition Application.

190. *Id.*
191. *See supra* Section II.A.
192. *Id.*
193. *See supra* Section I.A.
194. *Id.*
195. *Id.*

Upon the DOL's certification, the employer will need to file an application for H-1B status with USCIS. All costs associated with the H-1B application must be paid by the employer, including both government filing fees and legal fees.[196] Upon approval, Dr. Singh may either apply for a visa at a United States consulate abroad, or since he is currently in the United States on a different status, he may request that USCIS change his status to H-1B. Once USCIS approves the change of status, he may begin work for the new employer.

Upon securing H-1B status, the process is far from over for Dr. Singh. Since he wants to remain in the United States permanently, he will need to begin the process for legal permanent residence, which is extremely time consuming and costly. Recall from Section IV that there are five different employment-based options that Dr. Singh could potentially choose from: PERM labor certification, PNIW, NIW, EB-1, or EB-5 investor visa.

Depending on the type of application he decides to pursue, his employer may have to sponsor his green card application and pay all costs (government and legal) associated with the application. In the best-case scenario, a foreign physician will be looking at least at an additional four to five years[197] and several thousand dollars before he actually has his green card in hand. However, because Dr. Singh is from India, only the EB-5 category at this time is current – meaning that due to per country limitations, there are immigrant visa numbers currently available to citizens of India in that category only. All of the other categories (EB-1 and EB-2 for PERM, PNIW, and NIW) are currently backlogged or oversubscribed, with a queue being formed with all of the applicants who were not able to receive a green card.[198] Because of this queue, visa numbers are only available for Indian nationals with a priority date of February 2022 for EB-1 or October 2012 for EB-2.[199] The priority date would be established in his case by the filing of the I-140 application or the filing of the labor certification application with the DOL. This means that there is currently a twelve year wait for a green card for an Indian national! Once he is awarded the green card, he will have another five-year wait before he can file an application for naturalization.

This lack of efficacy and efficiency of this process to permanent residence makes it exceedingly difficult, time consuming, and expensive for both the foreign national and the potential employer. Without permanent residence status, foreign nationals are often not eligible for various programs, including federal grant money, home mortgages,[200] and business travel outside the United States in certain circumstances. As such, without grant funding,

196. *Id.*

197. Because Dr. Singh has obtained a waiver, he must wait three years before he is eligible to apply for permanent residence. Applicants on an H-1B visa without the waiver can apply at any time.

198. *See* Bulletin for January 2025, *supra* note 210.

199. *Id.*

200. While there are no immigration related restrictions on obtaining home mortgages while on an H-1B visa, various mortgage programs often limit their funds to legal permanent residents.

Dr. Singh's plans to patent or purchase property are likely to be on hold for another five years until he can secure a green card. This twelve-year wait for a green card and seventeen-year wait for citizenship for a foreign physician with two fellowships who is working in a medical shortage area reflects the system's failure to prioritize talent in market areas that are in extremely high demand.

V. POLICY PRESCRIPTION

In previous years, the United States has accepted relatively high numbers of immigrants, and as Table 5 indicates, is the largest recipient of global immigrants.

A good economy, combined with employment opportunities in both the skilled and unskilled sectors are consistent with the traditional push and pull theory that predicts that man's desire to better himself would pull him to immigrating to the United States as a result of relatively good educational, employment, and other opportunities.[201] However, the push and pull theories also predict that increased delays, risks, and difficulties in obtaining visas to immigrate to the United States in recent years would result in a repelling effect, forcing would be immigrants to either remain where they are or look to other possible locations such as Canada, Australia, or New Zealand with fewer immigration barriers and marginally fewer opportunities. In order to remain competitive in the global market, and more importantly to meet current employment demands specifically in the health care industry, the United States will need to create pull factors to attract in the United States. These pull factors will need to include more than just a good economy and the promise of a better life, as other economically sound states such as those listed above provide actual incentives for skilled immigrants such as physicians.

In looking forward, policy makers will need to examine the pull factors created by countries that have passed more skilled worker friendly policies in an attempt to either provide similar or better incentives for immigrating to the United States. There are several options that Congress could consider to alleviate the medical shortage. Each is outlined below.

A. *H-1B Cap Exemptions and Allocations*

1. *Restart the Six Years of H-1B Eligibility After Training is Complete*

The six-year limit on H-1B eligibility can be problematic for some physicians who complete a longer training program on an H-1B. If, for example, a physician completes a three-year internal medicine residency and one year surgery fellowship on the H-1B, he only has two years remaining on the H-1B. If that physician is from India, he needs to have an application for labor

201. *See, e.g.,* Everett S. Lee, *A Theory of Migration,* 3 DEMOGRAPHY 47 (1966).

certification (the first of a series of applications for one category of employment-based legal permanent residence) at least 365 days prior to the end of the six-year period, or an application for an immigrant visa. The labor certification process begins with the prevailing wage determination from the U.S. Department of Labor and currently takes eight months to obtain. That leaves a four-month period to post the Job Order with the State Workforce Agency, complete all of the required recruitment activities, and file the labor certification application. While it can be done, if the prevailing wage takes any longer than eight months or there are any other delays in the process, the physician may lose out on the ability to extend their H-1B past the six years mark and without a visa number, they will be out of status in the next year with very little other visa options.

Congress can solve this issue in a couple of different ways. They can either restart the six-year clock of eligibility once the physician completes their training and begins work, effectively giving the physician six year of work eligibility, or they can create a different visa category for training and one for clinical practice (discussed in B.2.).

2. *Create a Separate H-1B Cap for Highly Skilled Workers*

Alternatively, Congress could create a separate numerical cap for highly skilled workers. There is precedent for this as Congress created a separate cap of 20,000 H-1Bs for foreign nationals that obtained a master's degree from a U.S. educational institution. Congress could now create a separate cap of 20,000 for foreign physicians and/or those foreign nationals that have a doctorate degree from any institutional, foreign or domestic.

3. *Exempt All Foreign Physicians Working in a HPSA/MUA from the H-1B Cap*

Congress could also simply create an exemption from the H-1B cap for physicians working in a HPSA/MUA. In 2004, Congress exempted foreign physicians with a J-1 waiver from the numerical cap. They could simply extend this to all foreign physicians working in a HPSA/MUA, including those who simply do not need a J-1 waiver. This may incentivize those physicians who fear the availability of a cap number to seek positions in a HPSA/MUA if they know they will not need to worry about the cap. This option may be more palatable and politically feasible than creating a new cap for highly skilled workers. This option may also work in tandem with the policy option below in part C.2.

4. *Change State Laws to Allow Foreign Physicians to Obtain Licensure Without Having to Complete a Training Program*

States have the power to determine licensure requirements within their jurisdiction. Until recently, all states required that an FMG complete a U.S.

accredited residency or fellowship program in order to be eligible for licensure. Beginning in 2023, however, fourteen states have passed legislation that allows FMGs the ability to obtain an unrestricted license to practice medicine without having to complete a U.S. medical training program.[202] This indicates a desire for states to circumvent some of the restrictions created by Congress. This is a very minor fix, but combined with some of the other suggestions provided here could make the process more appealing for foreign physicians, particularly those with many years of experience in their home countries.

B. *Structural Reforms*

1. *Create an Exemption from the Immigrant Visa Per Country Quota*

First, Congress should consider exempting foreign physicians from the annual per country quota. There are a number of benefits to this policy. First, this exemption will allow all physicians the opportunity to be immediately eligible for a green card or legal permanent resident status. Allowing an immediate visa number will go a long way in attracting foreign physicians to the United States. This may singularly be sufficient in solving the medical shortage problem discussed here, and there is already precedent for this as Congress already exempts a variety of categories of foreign physicians from the H-1B cap.[203]

2. *Create a Separate Nonimmigrant Work Visa for Foreign Physicians*

Alternatively, Congress can create a separate nonimmigrant visa for foreign physicians. First and foremost, this option will help with the negative optics associated with the H-1B visa as discussed in the introduction. There is already precedent for creating a new category as Congress has previously created a separate visa category for foreign nurses under the H-1C category. This new category could allow for unlimited extensions, which if passed as a standalone policy would effectively remedy the sixth-year extension problem for foreign nationals without a current visa number. Again, there is precedent for this as the O-1 visa allows for an initial eligibility period of three years with additional one-year extensions for as long as the adjudicating officer finds that the applicant is eligible. Additionally, the sixth-year extension allows for one-year extensions beyond the initial six-year period of eligibility. As such, this new visa category could allow for two three-year periods of eligibility with the option of additional one-year extensions as long as the adjudicating officer finds the applicant eligible.

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202. These states include Arkansas, Florida, Iowa, Idaho, Illinois, Indiana, Louisiana, Massachusetts, Minnesota, Nevada, Oklahoma, Tennessee, Virginia, and Wisconsin. *See* Fed'n of State Med. Bds., *States with Enacted and Proposed Additional IMG Licensure Pathways: Key Issue Chart* (Apr. 2024), https://perma.cc/SWQ9-JACA.

203. *See supra* Section I.A.1.

This new category could also be extended to apply to other highly skilled health care workers as well, including nurse practitioners, certified registered nurse anesthetists, physician assistants, nurse midwives, pharmacists, etc. in order to help alleviate some of the workload that physicians have in the medical shortage areas.

3. *Create a National Interest Waiver for Other Health Care Workers*

While this article focused entirely on foreign physicians and did not address visa options for support staff, Congress could also consider a Health Care National Interest Waiver (HCNIW) for nurse practitioners and/or physician assistants. While these positions may not exit in other countries, foreign nationals may pursue these programs of study while in the U.S. and they may become more attractive if there is a separate green card category for these types of jobs. Since these practitioners are already helping alleviate some of the workload of physicians and have the ability to prescribe medicine, creating a separate immigrant visa route for these practitioners could help further alleviate the shortage in HPSAs and MUAs.[204]

4. *Move Fashion Models Out of the H-1B Category and into the O-1 Category (Or Somewhere Else)*

Ridiculously, fashion models are still taking up H-1B cap numbers since Congress "inadvertently omitted" them from any other visa category.[205] It is time that Congress either creates a separate visa category for them or creates a separate category of admissibility in either the O or P categories. This will not only make the H-1B a true skilled worker visa, but it will allow that all 85,000 H-1Bs are allocated to foreign nationals that have at least a bachelor's degree.

5. *Amend the Conrad 30 Program*

There are several ways the Conrad 30 program could be amended to resolve the issues identified in this article. Congress could increase the cap or remove it altogether, giving the HHS the power to determine on a case-by-case basis whether a state has a market need for a greater number of waivers. This way, those states like California, Texas, and Florida that typically use all thirty of their waivers on the first day of the fiscal year would have the ability to continue receiving waiver physicians as long as federal guidelines dictate shortages still abound.

Congress should also allow all states to use some of their waivers for specialists. As noted above, shortages exist for primary care and all specialties throughout the states. Because states are limited to only thirty waivers, many

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204. Tanya Albert Henry, Am. Med. Ass'n, *Are Nurse Practitioners Easing Shortages in Underserved Areas?*, (May 9, 2024), https://perma.cc/48Q2-4CJX.

205. *See supra* Section I.A.

have prioritized primary care and as a consequence, patients are forced to travel long distances or in some cases simply do not have access to specialists at all. If Congress increased or removed the cap, they could allow for specialist waivers in tandem.

Additionally, Congress could choose to distinguish between urban and rural areas in order to prioritize or increase the number of physicians in rural areas. Congress could decrease the years of service for facilities located in rural areas and increase them in urban areas. For example, the service requirement in rural Alabama could be two years (instead of three), and the service requirement in Miami could be four years (instead of three).

6. *Exempt FMGs from the Labor Certification Requirement*

Schedule A is an exception from the Labor Certification process (much like the National Interest Waiver. The DOL predetermines certain occupations that "will not be adversely affected by the employment of aliens in Schedule A occupations."[206] Essentially the agency "pre-certifies" that there is insufficient U.S. workers who are "able, willing, qualified, and available" and that the wages and working conditions of U.S. workers in these positions will not be adversely affected by the inclusion of foreign workers.[207] Schedule A occupations are not required to go through the traditional recruitment process and instead are "pre-certified", which means they bypass the DOL application and may apply for an immigrant visa with USCIS initially.[208]

Currently, the DOL has classified physical therapists, professional nurses, and aliens of exceptional ability in the sciences or arts, including college and university teachers, and immigrants of exceptional ability in the performing arts.[209] Considering the HHS has already determined that there is a market shortage of physicians in the areas they have designated as shortages areas, Congress and/or the DOL should add foreign physicians to the current list of Schedule A occupations.

C. *Incentive Based Reforms*

1. *Institute a New H-1B Filing Fee to be Earmarked for Recruitment of U.S. Physicians in Rural Areas*

In 1998, Congress created a $500 filing fee to be earmarked for STEM scholarships, grants, and training for U.S. citizens to help decrease the reliance on foreign talent by incentivizing U.S. students to enter these fields.[210] That fee was subsequently increased twice and is currently $1500 for

206. *See* 20 C.F.R. § 656.5 (2025).
207. *Id*. *See* also U.S. Citizenship & Immigr. Servs., *Schedule A Design Petitions*, Vol. 6, Ch. 7, https://perma.cc/A7US-MEZN.
208. *See* U.S. Citizenship & Immigr. Servs., *supra* note 207.
209. *Id*.
210. *See supra* Table 3.

employers with more than twenty-five employees and $750 for employers with fewer than twenty-five employees.[211] Additionally, in 2024, the Department of Homeland Security (DHS) created an asylum program fee of $600 for employers with more than twenty-five employees or $300 for employers with twenty-five or fewer employees.[212] These fees are earmarked for the adjudication of refugee, asylum, and other related applications, and DHS estimated that the fee would generate approximately $313 million in revenue per year.[213]

Congress could create a filing fee earmarked in a similar fashion to provide grants for U.S. physicians willing to work in shortage areas. The National Health Service Corps, an agency falling under the Health Resources and Services Administration (and ultimately the Department of Health and Human Services) currently provides grants to physicians providing primary care services in primary care HPSAs of up to $75,000 in exchange for a full-time, two-year commitment or up to $37,500 in exchange for a half-time, two-year commitment.[214] The average medical school graduate has a total student loan debt of $264,519 (including both medical school and undergraduate school debt).[215] This is more than three and a half times what the agency currently provides as loan repayment grants. As such, Congress has an opportunity to do something similar but more impactful here. Much like ACWIA, Congress can create a filing fee to be earmarked for a fund to help attract physicians (U.S. physicians or otherwise) to shortage areas. In fiscal years 2019, 2020, 2021, 2022, and 2023, physicians accounted for a total of 8054,[216] 8236,[217] 7104,[218] 2523,[219] and 8521[220] H-1Bs respectively. The initial filing fee could be set at $2000 per employer, per application. Over this four-year period from 2020 to 2023, the fund would have made nearly $70 million. This fund could then be used to provide grants to provide student loan payoffs for physicians willing to work in a HPSA/MUA. The amount of the grant could increase exponentially the longer the physician works in a HPSA/MUA.

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211. *See id.*

212. *See* 8 C.F.R. § 106.2(c)(13) (2025).

213. U.S. Citizenship and Immigration Services Fee Schedule and Changes to Certain Other Immigration Benefit Request Requirements, 89 Fed. Reg. 6194, 6208 (Jan. 31, 2024) (to be codified at 8 C.F.R. pts. 103, 106, 204, 212, 214, 240, 244, 245, 245a, 264, 274a).

214. *NHSC Loan Repayment Program*, HEALTH RES. & SERVS. ADMIN., https://perma.cc/N5RC-B2P2 (last visited June 30, 2025).

215. Education Data Initiative, *Average Medical School Debt*, (last updated Aug. 28, 2024), https://perma.cc/YYF3-KPUB.

216. U.S. Citizenship & Immigr. Servs., *Characteristics of H-1B Specialty Occupation Workers*, 2019 DHS ANN. REP. TO CONG. 14 (2020), https://perma.cc/6LWF-43DL (last visited June 29, 2025).

217. U.S. Citizenship & Immigr. Servs., *Characteristics of H-1B Specialty Occupation Workers*, 2020 DHS ANN. REP. TO CONG. 49 (2021), https://perma.cc/2HQC-698D (last visited June 29, 2025).

218. U.S. Citizenship & Immigr. Servs., *Characteristics of H-1B Specialty Occupation Workers*, 2021 DHS ANN. REP. TO CONG. 49 (2022), https://perma.cc/R8E9-YATH (last visited June 29, 2025).

219. U.S. Citizenship & Immigr. Servs., *Characteristics of H-1B Specialty Occupation Workers*, 2022 DHS ANN. REP. TO CONG. 49 (2023), https://perma.cc/MZS6-GEJV (last visited June 29, 2025).

220. U.S. Citizenship & Immigr. Servs., *Characteristics of H-1B Specialty Occupation Workers*, 2023 DHS ANN. REP. TO CONG. 49 (2024), https://perma.cc/V9QQ-Z225 (last visited June 29, 2025).

2. *Grant a Conditional Green Card for Physician National Interest Waivers*

Currently, a foreign physician can apply for legal permanent residence at any point after completing their home residence requirement or waiver. The two main avenues for legal permanent residence on the employment-based immigration side are labor certification and PNIW. The labor certification requires employer sponsorship while the PNIW allows for the foreign physician to self-petition. Additionally, the labor certification can be completed in less than a year, while the PNIW requires that a foreign physician work full time in a HPSA/MUA for a period of five years before being eligible for legal permanent residence status. There is not much of an incentive for a foreign physician to work in a HPSA/MUA for five years when they could simply file for legal permanent residence through the labor certification process after completing their waiver obligation.

Congress, however, currently grants a foreign spouse of a U.S. citizen that has been married less than two years a conditional green card. This is the only category of persons granted conditional green cards and the grant is only valid for two years. After being married for two years, the legal permanent resident and their U.S. citizen sponsoring spouse may file for removal of the condition. Basically, the government gives the foreign national permanent legal residence but will take the status back unless a condition is met (in this case either continuing to be married to the U.S. citizen spouse or proving that a now terminated marriage was a bona fide marriage at the time it was entered into).

If Congress allowed this conditional green card status for foreign physicians in the PNIW category, physicians might have an incentive to remain in their waiver positions and/or seek employment in HPSAs/MUAs if they know that they will be eligible for a green card in less time than it would take them to complete a labor certification.

CONCLUSION

This article examined the critical shortage of physicians in the United States particularly in underserved areas. It explored the role of FMGs in addressing these shortages and the challenges they face due to restrictive visa policies. It outlined existing immigration pathways for FMGs and their respective requirements and limitations and concluded with a number of policy recommendations, including visa reforms, exemptions from caps, and financial incentives to attract and retain foreign physicians in an attempt to alleviate the ever-growing medical shortages.

APPENDIX A

Physician to Population Ratios By State

State	Active Physicians[221]	Active PCPs[222]	Population[223]	Population: Active PCPs (Ratio)
Alabama	13,050	6,300	5,108,468	811
Alaska	1,917	1,080	733,406	679
Arizona	19,814	9,297	7,431,344	799
Arkansas	8,162	4,032	3,067,732	761
California	119,087	56,761	38,965,193	686
Colorado	15,088	7,576	5,877,610	776
Connecticut	17,178	7,687	3,617,176	471
Delaware	3,357	1,644	1,031,890	628
D.C.	8,313	3,495	678,972	194
Florida	62,346	30,115	22,610,726	751
Georgia	27,315	13,636	11,029,227	809
Hawaii	4,558	2,346	1,435,138	612
Idaho	3,327	1,898	1,964,726	1,035
Illinois	47,785	24,150	12,549,689	520

221. KFF, *Professionally Active Physicians*, https://perma.cc/LQ8U-YMRD (Data as of January 2024).

222. *Id.*

223. U.S. Census Bureau, *State Population Totals and Components of Change: 2020-2024*, https://perma.cc/FK55-VA3D (Data as of July 2023).

CONTINUED

State	Active Physicians[221]	Active PCPs[222]	Population[223]	Population: Active PCPs (Ratio)
Indiana	17,875	8,728	6,862,199	786
Iowa	9,593	5,008	3,207,004	640
Kansas	8,235	4,191	2,940,546	702
Kentucky	12,663	5,751	4,526,154	787
Louisiana	14,673	6,774	4,573,749	675
Maine	5,030	2,628	1,395,722	531
Maryland	26,472	11,891	6,180,253	520
Massachusetts	39,417	16,433	7,001,399	426
Michigan	44,314	20,824	10,037,261	482
Minnesota	19,461	9,342	5,737,915	614
Mississippi	7,272	3,550	2,939,690	828
Missouri	23,326	10,904	6,196,156	568
Montana	2,389	1,255	1,132,812	903
Nebraska	5,987	3,048	1,978,379	649
Nevada	6,898	3,425	3,194,176	933
New Hampshire	4,506	2,152	1,402,054	652
New Jersey	33,406	16,358	9,290,841	568
New Mexico	6,260	3,134	2,114,371	675
New York	101,861	45,887	19,571,216	427
North Carolina	31,043	14,565	10,835,491	744
North Dakota	2,268	1,284	783,926	611

CONTINUED

State	Active Physicians[221]	Active PCPs[222]	Population[223]	Population: Active PCPs (Ratio)
Ohio	46,816	21,558	11,785,935	547
Oklahoma	10,619	5,454	4,053,824	743
Oregon	12,885	6,381	4,233,358	663
Pennsylvania	57,570	26,681	12,961,683	486
Rhode Island	5,878	2,906	1,095,962	377
South Carolina	14,108	6,968	5,373,555	771
South Dakota	2,258	1,217	919,318	755
Tennessee	20,155	9,347	7,126,489	762
Texas	71,740	33,670	30,503,301	906
Utah	7,438	3,317	3,417,734	1,030
Vermont	2,489	1,192	647,464	543
Virginia	25,707	12,590	8,715,698	692
Washington	23,366	11,717	7,812,880	667
West Virginia	5,866	3,126	1,770,071	566
Wisconsin	18,805	9,063	5,910,955	652
Wyoming	1,245	706	584,057	827
Total	1,101,191	523,042	334,914,895	640

TABLE 1. OCCUPATIONAL GROUPS OF APPROVED H-1BS, FY 2023[224]

Occupational Group	Total Number	Percent
Computer-Related	251,084	65.0
Architecture, Engineering, and Surveying	36,773	9.5
Education	23,365	6.0
Administrative Specializations	19,503	5.0
Medicine and Health	16,684	4.3
Mathematics and Physical Sciences	10,586	2.7
Life Sciences	7,250	1.9
Managers and Officials	5,570	1.4
Miscellaneous Professional, Technical, and Managerial	4,648	1.2
Social Sciences	3,052	<1%
Art	1,694	<1%
Law and Jurisprudence	1,468	<1%

224. *Id*. at 13.

TABLE 2. THE H-1B CAP[225]

FY	Date H-1B Cap Was Reached
2004	February 17, 2004[226]
2005	October 1, 2004[227]
2006	August 10, 2005[228]
2007	May 26, 2006[229]
2008	April 3, 2007[230]
2009	April 7, 2008[231]
2010	December 21, 2009[232]
2011	January 26, 2011[233]
2012	November 23, 2011[234]
2013	June 11, 2012[235]
2014	April 5, 2013[236]
2015	April 7, 2014[237]
2016	April 7, 2015[238]

225. The table begins with 2004 because this is the first year the cap numbers were not increased by Congress.
226. Am. Immigr. Laws. Ass'n, *H-1B Cap Count History*, (Apr. 13, 2016), https://perma.cc/83T3-D57H.
227. *Id.*
228. *Id.*
229. *Id.*
230. *Id.*
231. *Id.*; Am. Immigr. Laws. Ass'n, *USCIS Announces FY2009 H-1B Caps Reached*, (Apr. 8, 2008), https://perma.cc/7Z2W-FAFH.
232. *H-1B Cap Count History*, *supra* note 226.
233. *Id.*
234. *Id.*
235. *Id.*
236. *Id.*
237. *Id.*
238. *Id.*

TABLE 2. CONTINUED

FY	Date H-1B Cap Was Reached
2017	April 7, 2016[239]
2018	April 7, 2017[240]
2019	April 4, 2018[241]
2020	April 5, 2019[242]
2021	February 16, 2021[243]
2022	February 28, 2022[244]
2023	August 23, 2022[245]
2024	December 13, 2023[246]
2025	December 2, 2024[247]
2026	March 31, 2025[248]

239. *Id.*

240. U.S. Citizenship & Immigr. Servs., *USCIS Reaches FY 2018 H-1B Cap* (Apr. 7, 2017), https://perma.cc/Y735-5PLK.

241. U.S. Citizenship & Immigr. Servs., *USCIS Reaches FY 2019 H-1B Cap* (Apr. 6, 2018), https://perma.cc/N2HW-F7ZE.

242. U.S. Citizenship & Immigr. Servs., *USCIS Reaches FY 2020 H-1B Regular Cap* (Apr. 5, 2019), https://perma.cc/52FU-RFLE.

243. U.S. Citizenship & Immigr. Servs., *USCIS Reaches Fiscal Year 2021 H-1B Cap* (Feb. 16, 2021), https://perma.cc/799E-KVYS.

244. U.S. Citizenship & Immigr. Servs., *USCIS Reaches Fiscal Year 2022 H-1B Cap* (Feb. 28, 2022), https://perma.cc/PPH3-KXFD

245. U.S. Citizenship & Immigr. Servs., *USCIS Reaches Fiscal Year 2023 H-1B Cap* (Aug. 23, 2022), https://perma.cc/VR3V-W3JG

246. U.S. Citizenship & Immigr. Servs., *USCIS Reaches Fiscal Year 2024 H-1B Cap* (Dec. 13, 2023), https://perma.cc/XG7Q-3YWF

247. U.S. Citizenship & Immigr. Servs., *USCIS Reaches Fiscal Year 2025 H-1B Cap* (Dec. 12, 2024), https://perma.cc/ZL7T-AYCW

248. U.S. Citizenship & Immigr. Servs., *FY 2026 H-1B Initial Registration Selection Process Completed* (Mar. 31, 2025), https://perma.cc/9763-GBYY

TABLE 3. TIMELINE OF PASSED H-1B LEGISLATION

Year	Legislation	Provisions
1990	S.358	Created the current H-1B visa.
	Immigration Act of 1990	Created an annual cap of 65,000 on H-1B visas.
		Requirement that employer obtain LCA certification from U.S. Dept. of Labor.
1998	H.R.4328 ACWIA / Omnibus Consolidated and Emergency Supplemental Appropriations Act, 1999	Increased the cap to 115,000 in 1999 and 2000, to 107,500 in 2001, and back to 65,000 in 2002.
		Created new filing fee of $500 for initial applications to be earmarked for job training, low-income scholarships, grants for mathematics, engineering, and/or science enrichment courses.
		New requirements for employers who become H-1B dependent.
		Provisions to protect U.S. workers from layoffs.
		Changes in enforcement and penalties.
2000	H.R.5362 / Pub. L. No. 106-311	Increased the $500 filing fee to $1000.
2000	S.2045 AC-21 / Kids 2000 Act	Increased the cap to 195,000 for 2001-2003.
		Created extensions beyond the 6 year period of eligibility for applicants with a filed immigrant visa application but no available visa number.
		Allowed for portability.

CONTINUED

Year	Legislation	Provisions
		Created cap exemptions for higher education and research institutions and their affiliates.
2000	H.R.3767 Visa Waiver Permanent Program Act	Created exemption from filing an amendment application when the employer engages in corporate restructuring.
2002	H.R.2215 21st Century DOJ Appropriations Authorization Act	Created additional extensions beyond the 6-year period for applicants who have filed a labor certification application 365 days prior to the end of their 6 year H-1B eligibility.
		Banned displacement of U.S. workers.
		Established prevailing wage requirement for employers.
2004	H.R.4818	Set new compliance standards.
	H-1B Visa Reform Act / Consolidated Appropriations Act, 2005	Created a new anti-fraud filing fee of $500.
		Reinstated and increased the previously sunset job training and scholarship fee to $1500 for employers with at least 25 employees and $750 for fewer than 25 employees.
		Created an additional new cap of 20,000 for applicants with a master's degree from a U.S. educational institution.
		Instituted procedures for a Dept. of Labor audit investigation.
		Changed the fee structure for job training, low-income scholarships, and grants.

CONTINUED

Year	Legislation	Provisions
2004	S.2302	Created cap exemption for physicians with an approved J-1 waiver who agree to work in a federally designated medical shortage area for 3 years through the Conrad 30 program.

TABLE 4. ANNUAL IMMIGRANT VISA CAP NUMBERS[249]

Employment-Based Immigrant Preference Categories	2025 Annual Cap[250]
EB 1 Priority Workers	40,040 + any unused EB 4 and 5 numbers
EB 2 Advanced Degree / Exceptional Ability	40,040 + any unused EB 1 numbers
EB 3 Skilled / Professional / Other Workers	40,040 + any unused EB 1 and 2 numbers
EB 4 Certain Special Immigrants	9,940
EB 5 Entrepreneurs / Job Creation	9,940

249. Under the preference system created in 1990, i*d. See also* U.S. Department of State Visa Bulletin, https://perma.cc/Z436-SF2G. *See also* Stevenson, *supra* note 23, at 414-415 (2024).

250. Congress has established an annual quota for the number of immigrant visas/legal permanent resident applications granted each year per country. When and if that quota is reached each fiscal year, all additional applications are rolled over and are adjudicated first in the next fiscal year. The quota is updated each month by the Department of State in their monthly visa bulletin. Each month, the Department of State assesses how many applications are approved (based on how many immigrant visas are issued) and issues a new priority date. For the EB-1, EB-2, and EB-2 categories, each receives 28.6% of the worldwide level of 140,0000 and the EB-4 and EB-5 categories each receive 7.1% of the worldwide level. These percentages are calculated in Table 4. *See also Visa Bulletin for January 2025*, U.S. DEP'T OF STATE, https://perma.cc/M75Z-GQ39 (last visited July 4, 2025).

TABLE 5. COUNTRIES WITH THE LARGEST NUMBER OF PERMANENT IMMIGRATION (2023)[251]

Country	Number of Immigrants
United States	1,200,000
United Kingdom	750,000
Germany	700,000
Canada	470,000
Spain	360,000

251. Migration Data Portal, *International migration flows*, https://perma.cc/B7MN-BNBF (last visited Nov. 17, 2025).