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# Immigration Options and Professional Requirements for Foreign Health Care Workers

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SUMMARY

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# Immigration Options and Professional Requirements for Foreign Health Care Workers

The United States has long relied on foreign nationals to supplement its health care workforce because of long-standing shortages of doctors in some underserved regions and of nurses nationwide. Despite federal efforts and programs, health care worker shortages persist and have been exacerbated, most recently, by the COVID-19 pandemic. While demand for health care professionals is expected to increase because of U.S. population aging, many health care workers are expected to retire over the same period. Given the considerable time and investment required to train health care professionals, some Members of Congress have introduced legislative proposals to facilitate the immigration and employment of foreign health care professionals.

Under current law, there is no immigrant (permanent) or nonimmigrant (temporary) visa dedicated specifically to health care professionals. Health care workers permanently immigrating to the United States often use the Immigration and Nationality Act's (INA's) *employment-based (EB) immigrant* preference categories and receive lawful permanent resident (LPR) status (i.e., green card). Physicians typically apply through the second preference (EB2) category, while nurses typically use the third preference (EB3) category. While some prospective EB immigrants can self-petition for EB green cards, most EB2 and all EB3 immigrants require U.S. employers to petition on their behalf. Because demand for EB green cards exceeds their annual statutory allotment, new prospective EB immigrants from major immigrant-sending nations can anticipate waiting years to acquire them.

Foreign health care workers who seek to work in the United States temporarily typically use the following *nonimmigrant* visa categories: H-1B, H-1B1, and E-3 for specialty occupation workers; J-1 for exchange visitors; TN for U.S.-Mexico-Canada Agreement professionals; O for persons with extraordinary ability; and H-2B for seasonal nonagricultural workers. Each category has its own selection process, eligibility criteria, numerical limits (in some cases), length of stay, and other requirements. During the 1980s and 1990s, Congress created two nonimmigrant visa categories for nurses that have since expired. The H-1A visa allowed foreign registered nurses (RNs) to work temporarily at facilities where the Department of Labor had determined there was a shortage of health care professionals. The subsequently created H-1C visa contained similar eligibility criteria as the H-1A visa. Between FY1990 and FY2012, the United States issued 36,743 H-1A visas and 1,042 H-1C visas to foreign health care workers.

Apart from immigration requirements, foreign health care workers are also subject to training and licensing requirements, which vary by specific profession. States are responsible for licensing health care providers, which generally includes verifying an applicant's required education, passage of required examinations, and acquisition of relevant clinical training. Foreign-trained providers must attend accredited programs by accepted international organizations and must generally meet certain educational requirements in order to take the licensure exam for the relevant profession.

During the past decade, some Members have regularly proposed legislation either to increase numerical immigration limits for health care workers or to otherwise facilitate their temporary and permanent immigration. Apart from the Senate-passed S. 744 in the 113th Congress, no such bills saw committee or floor action. Alternatively, Congress has granted the executive branch considerable authority to shape immigration policy. Past examples of relevant executive actions include classifying all health care providers and industry workers during the pandemic as *essential workers*, expediting employment authorization for health care workers, and prioritizing immigrant visa applications of health care workers responding to COVID-19.

Other congressional proposals have focused on harnessing unused and/or underused skills of foreign workers already residing in the United States, a phenomenon referred to as *brain waste* and affecting an estimated 250,000-plus workers across all professions, including health occupations. Some have proposed *place-based* immigration systems that would decentralize immigrant processing for some foreign-born workers. Such systems would assign admitted foreign nationals to live and work in specified locations such as a state, metropolitan area, or county. With the federal government maintaining its vetting and enforcement roles, a place-based system would allow states or municipalities to establish how many foreign nationals to accept, the criteria for their selection (e.g., those working in in-demand occupations), and the duration of their stays.

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# Introduction

This report reviews major permanent and temporary admissions options allowing foreign health care workers to work in the United States.[1] The United States has long relied on foreign nationals to supplement its workforce of health care professionals.[2] This reliance stems from a long-standing nationwide labor shortage for nurses and, to a lesser extent, for doctors (typically in certain underserved regions).[3] The demand for health care professionals is projected to increase in the next decade as baby boomers age into and beyond retirement.[4] In addition, many health care practitioners are expected to retire over the next decade.[5] COVID-19 has exacerbated worker shortages, straining heath care facilities and prompting many health care professionals to leave their jobs and in some cases their occupations altogether.[6]

Health care workers comprise roughly one-seventh of all U.S. workers and represent an industrial sector that is among the fastest growing in the country.[7] As of 2017, nearly one in four health care industry workers who directly cared for patients were foreign-born, as were nearly one in three

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[1] In this report, the terms *health care workers*, *health care professionals*, and *health care practitioners* are synonymous. Also in this report, the terms *foreign national* and *alien* are synonymous, defined in the Immigration and Nationality Act (INA) as persons who are not U.S. citizens or nationals (INA §101(a)(3), 8 U.S.C. §1101(a)(3)). *Foreign health care workers* is not defined in statute. Federal regulations that address required certification for foreign health care workers (except physicians) include licensed practical nurses, licensed vocational nurses, registered nurses, occupational therapists, physical therapists, speech language pathologists and audiologists, medical technologists (clinical laboratory scientists), physician assistants, and medical technicians (clinical laboratory technicians). See 8 C.F.R. §212.15(c). For a profile of foreign health care practitioners in the United States, see Jeanne Batalova, *Immigrant Health-Care Workers in the United States*, Migration Policy Institute, May 14, 2020.

[2] See, for example, Paulina Cachero, "From AIDS to COVID-19, America's Medical System Has a Long History of Relying on Filipino Nurses to Fight on the Frontlines," *Time*, May 30, 2021; Leah E. Masselink and Cheryl B. Jones, "Immigration Policy and Internationally Educated Nurses in the United States: A Brief History," *Nursing Outlook*, vol. 62 (2014), pp. 39-45; Laura Santhanam, "New Study Shows 1 in 6 U.S. Health Care Workers Are Immigrants," PBS, December 5, 2018; Yash M. Patel et al., "Proportion of Non-US-Born and Noncitizen Health Care Professionals in the United States in 2016," *JAMA*, vol. 320 (2018), pp. 2265-2267; and Alex Nowrasteh and Michelangelo Landgrave, *Immigrant Health Care Workers by Occupation and State*, Cato Institute, May 13, 2020.

[3] In this report, the term *labor shortage* refers to a demand for workers that exceeds the supply of workers. Causes cited for these shortages of nurses and doctors include U.S. population growth, population aging, increased retirement of health care practitioners, increased insurance coverage, worker burnout, insufficient nurse training and physician residencies, and immigration restrictions. See, for example, U.S. Congress, House Committee on the Judiciary, Subcommittee on Immigration and Citizenship, *The Role of Immigrant Physicians in the U.S. Healthcare System*, Chairman Nadler Statement, 117th Cong., 2nd sess., February 15, 2022; Dylan Scott, "Why the US Nursing Crisis Is Getting Worse," *Vox*, November 8, 2021; Xiaoming Zhang et al., "United States Registered Nurse Workforce Report Card and Shortage Forecast: A Revisit," *American Journal of Medical Quality*, vol. 33 (2018), pp. 229-236; and Keren Landman, "Why Well-Qualified Medical School Graduates Can't Get Jobs—Despite Doctor Shortages," *Vox*, March 25, 2022.

[4] U.S. Bureau of Labor Statistics, *Occupational Outlook Handbook*, "Healthcare Occupations," April 18, 2022. For more information, see also U.S. Department of Health and Human Services (HHS), Health Resources and Services Administration, "Projecting Health Workforce Supply and Demand," November 2022.

[5] HHS, National Center for Health Workforce Analysis, *Brief Summary Results from the 2018 National Sample Survey of Registered Nurses*, 2019.

[6] See, for example, Kriti Prasad et al., "Prevalence and Correlates of Stress and Burnout Among U.S. Healthcare Workers During the COVID-19 Pandemic: A National Cross-Sectional Survey Study," *eClinicalMedicine*, vol. 35 (2021), pp. 1-9; Karen Gilchrist, "Covid Has Made It Harder to Be a Health-Care Worker. Now, Many Are Thinking of Quitting," CNBC, May 30, 2021; Gretchen Berlin et al., "Assessing the Lingering Impact of COVID-19 on the Nursing Workforce," McKinsey and Company, May 11, 2022; Nick Ehli, "Short-Staffed and COVID-Battered, U.S. Hospitals Are Hiring More Foreign Nurses," NPR, January 6, 2022; and Nicole Narea, "The US Needs Foreign Doctors and Nurses to Fight Coronavirus. Immigration Policy Isn't Helping," *Vox*, March 30, 2020.

[7] U.S. Census Bureau, "Who Are Our Health Care Workers?," October 8, 2021.

housekeeping and maintenance workers in health care settings.[8] In addition, a large number of health care industry workers lack lawful immigration status, including an estimated 225,000 doctors, nurses, and home health aides. An additional estimated 190,000 individuals without lawful immigration status work in healthcare-related custodial and administrative roles.[9]

When employers of health care professionals struggle to find U.S. workers to fill their job openings, they may turn to foreign nationals because of the lengthy time required to train and license new health care practitioners in the United States.[10] Licensed practical nurses, for example, typically require one to two years of training, while registered nurses (RNs) often require four-year degrees. Some RNs extend their professional credentials with master's degrees, generally adding an additional one to three years. Physician training is significantly more extensive. To become a licensed physician, one must receive an undergraduate degree, graduate from medical school (typically after four years), and undergo post-medical school clinical training (i.e., a *residency*) for at least three years.[11] Given these requirements and the difficulty in finding U.S. workers who are qualified, available, and willing to fill these jobs, hiring foreign-trained health care professionals provides U.S. employers with an alternative way to meet staffing needs.

The Immigration and Nationality Act (INA) currently has no *immigrant* or *nonimmigrant* visa dedicated specifically to health care professionals.[12] During the 1980s and 1990s, foreign nurses could temporarily enter the United States to work under INA visa provisions that have since expired (see the "Expired Immigration Provisions" section). Currently, the INA contains provisions allowing a small number of physicians trained abroad, who enter the United States to complete their residencies, to work in underserved areas of the United States (see the "J-1 Visa: Exchange Visitor" section). Foreign health care workers seeking permanent or temporary U.S. employment must rely on INA provisions used for all foreign workers, irrespective of occupation. Such provisions often contain numerical caps that limit their use. The INA also contains provisions that make prospective immigrants and nonimmigrants inadmissible if they lack certain qualifications or seek work in the United States without proper authorization.[13]

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[8] Leah Zallman et al., "Care for America's Elderly and Disabled People Relies on Immigrant Labor," *Health Affairs*, vol. 38 (2019), pp. 919-926; and Nicole Prchal Svajlenka, "Undocumented Immigrants in Health Care Roles and Settings," Center for American Progress, February 2, 2021.

[9] Tom Jawetz, Center for American Progress, "Immigrants as Essential Workers During COVID-19," testimony before the U.S. House Judiciary Subcommittee on Immigration and Citizenship, September 2020; and Domininkas Mockus and Youngjoo Jung, "From Lawn Care to Home Care: Undocumented Immigration and Aging in Place," SSRN, November 17, 2022.

[10] A *license* is usually issued by a government agency and permits someone to work in a certain location (e.g., a state). In contrast, *certification* is not place-specific and is typically issued by a third party (i.e., a credentialing organization) that verifies that an individual has certain skills and has met certain criteria. State requirements for licensure are distinct from employer requirements for certifications.

[11] Some residencies may be longer depending on the medical specialty pursued. In addition, some physicians may seek fellowship training to further develop their medical specializations.

[12] *Immigrants* refers to foreign nationals lawfully admitted to the United States for permanent residence. In this report, the terms *immigrant*, *lawful permanent resident*, and *green card holder* are synonymous. *Nonimmigrants* refers to foreign nationals lawfully admitted to the United States for specified purposes and limited periods of time, including tourists, diplomats, students, temporary workers, and exchange visitors, among others.

[13] *Inadmissibility* refers to certain grounds by which a foreign national may be denied entry to the United States. These include health-related grounds, criminal history, public charge (i.e., indigence), lacking proper documents, and seeking employment without labor certification. See INA §212, 8 U.S.C. §1182. This section of the INA also contains specific provisions making unqualified physicians and uncertified foreign health care workers inadmissible. See INA §212(a)(5)(B) and (C), 8 U.S.C. §1182(a)(5)(B) and (C).

The federal government designates certain areas, populations, and health facilities as health professional shortage areas (HPSAs) and oversees programs, including immigration-related programs discussed in this report, to bring health care providers to these areas.[14]

Congress has responded to health care shortages by repeatedly introducing legislation to facilitate the immigration and employment of foreign health care professionals. Some proposals attempt to facilitate the immigration of foreign health care practitioners trained abroad, while others try to provide foreign nationals who complete their medical training in the United States with pathways to lawful permanent resident (LPR) status. Still others attempt to increase foreign nationals' U.S. labor force participation in health care occupations through policies such as credentialing and training.

This report begins by describing the permanent and temporary immigration options available for foreign health care workers based overseas. It then reviews two temporary pathways that Congress established for foreign nurses that have since expired. It also describes U.S. training and licensing requirements for foreign health care practitioners. The report concludes with a review of selected legislative proposals from the 113th-117th Congresses as well as executive actions directed toward expanding permanent and temporary admissions for foreign health care workers. In addition to pathways for foreign national health care workers living abroad, this discussion encompasses proposals that would facilitate employment and/or immigration benefits among foreign-born health care professionals who already reside permanently in the United States.

# Permanent Immigration Options

Foreign nationals seeking to immigrate permanently to the United States can use several INA provisions to acquire LPR status (or *green cards*). These pathways include family-based immigration, employment-based (EB) immigration, the diversity immigrant visa, and refugee or asylee status.[15] The INA limits worldwide permanent admissions to 675,000 persons annually, but exemptions from this cap have pushed the actual number of annual green card recipients beyond 1 million in recent years.[16]

Foreign nationals seeking to immigrate permanently in order to work as health care professionals typically use the INA's employment-based provisions.[17] EB immigrants apply for LPR status through the first three (EB1, EB2, and EB3) of five EB *preference categories*. These three categories are hierarchical based on qualifications and needed skills.[18] The EB1, EB2, and EB3 categories are each limited to 40,040 immigrant visas annually, including accompanying spouses and minor children (**Table 1**). Physicians typically apply for LPR status through the EB2 preference category,[19] while nurses typically apply through the EB3 category. In some cases,

[14] For more information, see CRS Infographic IG10015, *Health Professional Shortage Areas (HPSAs)*.

[15] A foreign national living abroad who has not established a lawful residence in the United States must apply for an *immigrant visa*. Foreign nationals already residing legally in the United States obtain LPR status by *adjusting status* from nonimmigrant (temporary) status to LPR status. Foreign nationals with LPR status can then choose to become U.S. citizens through the naturalization process. For more information, see CRS Infographic IG10028, *Naturalization: The Process of Becoming a U.S. Citizen*.

[16] For additional information on permanent immigration, see CRS Report R42866, *Permanent Legal Immigration to the United States: Policy Overview*.

[17] For more information, see CRS Report R47164, *U.S. Employment-Based Immigration Policy*.

[18] The EB4 preference category is a hodgepodge of *special immigrants*, and the EB5 is for *immigrant investors*. The EB4 and EB5 categories are generally not relevant for health care workers and are not discussed further in this report.

[19] Unlike many foreign nurses, most foreign physicians are not licensed to practice independently at the point they first (continued...)

physicians may meet the EB1 criteria, and nurses may meet the EB2 criteria. While some prospective EB immigrants can self-petition, most EB2 and all EB3 immigrants require sponsoring U.S. employers to petition on their behalf.[20]

Apart from the annual numerical limits on EB immigrants, the INA also imposes a 7% *per-country ceiling*, or cap, that applies to each EB category. The 7% ceiling is not an allocation to individual countries but an upper limit established to prevent a small number of countries from monopolizing employment-based green cards. The INA contains reallocation provisions to help ensure that all employment-based visa numbers are fully utilized.[21] As a result, the 7% ceiling is exceeded regularly for countries that send the largest number of prospective EB immigrants, due to reallocations from other categories and countries.

**Table 1. Employment-Based Immigration System**

Total Worldwide Level of 140,000

| Category | Eligibility Criteria | Annual Numerical Limit |
|---|---|---|
| ***1st preference category (EB1):*** *"Priority workers"* | Priority workers: persons of extraordinary ability in the sciences, the arts, education, business, or athletics; outstanding professors and researchers; and certain multinational executives and managers | 28.6% of worldwide limit (**40,040**) plus unused 4th and 5th preference category visa numbers |
| ***2nd preference category (EB2):*** *"Members of the professions holding advanced degrees or aliens of exceptional ability"* | Members of the professions holding advanced degrees or persons of exceptional abilities in the sciences, the arts, or business | 28.6% of worldwide limit (**40,040**) plus unused 1st preference category visa numbers |
| ***3rd preference category (EB3):*** *"Skilled workers, professionals, and other workers"* | Skilled shortage workers with at least two years training or experience, professionals with baccalaureate degrees, and "unskilled" shortage workers | 28.6% of worldwide limit (**40,040**) plus unused 1st or 2nd preference category numbers; "unskilled" "other workers" limited to 10,000 |

**Source:** CRS summary of INA §203(b), 8 U.S.C. §1153(b).

**Note:** This table does not present the EB4 (special immigrants) and EB5 (immigrant investors) categories because they are generally not relevant for health care workers and are not applicable to this discussion. The EB4 and EB5 categories are each limited to 7.1% of the worldwide limit (9,940). Thus, the numerical limits of all five categories sum to 140,000. See 8 C.F.R. §204.5 for eligibility criteria for each EB category.

Prospective EB immigrants must navigate a multistep process involving several federal departments and agencies to become LPRs. Sponsoring employers of EB2 and EB3 immigrants

enter the United States. Instead, they typically enter the United States to obtain residency training, using the different visa types discussed in this report to do so.

[20] Most prospective EB immigrants acquire LPR status by adjusting status from within the United States after having worked for sponsoring employers. Self-petitioning is available to persons of extraordinary ability within the EB1 category (INA §204(a)(1)(E), 8 U.S.C. §1154(a)(1)(E)) and immigrants applying within the EB2 category who qualify for a national interest waiver (8 C.F.R. §204.5(k)(1)). A national interest waiver allows foreign nationals to petition for employment-based LPR status without obtaining labor certification from the Department of Labor. The INA does not define which jobs qualify for the waiver. It is typically granted to individuals "with exceptional ability and whose employment in the United States would greatly benefit the nation." For more information, see U.S. Citizenship and Immigration Services, "Employment-Based Immigration: Second Preference EB2," updated April 20, 2022.

[21] For more information, see CRS Report R46291, *The Employment-Based Immigration Backlog*.

initiate the EB immigration process by applying for foreign labor certification through the Department of Labor (DOL) (see the "LPR Labor Certification Process" section).[22]

Next, a petition for LPR status for each prospective immigrant is filed by the sponsoring U.S. employer with the Department of Homeland Security's (DHS's) U.S. Citizenship and Immigration Services (USCIS). For prospective immigrants residing overseas, the petition is forwarded first to the Department of State's (DOS's) National Visa Center (NVC) for pre-processing (i.e., collecting supporting documentation and required fees). The NVC holds the petition until an immigrant visa number becomes available. A DOS consular officer must then interview the prospective immigrant in his or her home country or country of residence before the individual can acquire an immigrant visa allowing him or her to seek admission at a U.S. port of entry. For prospective immigrants already residing lawfully in the United States, USCIS handles the status adjustment process. As with foreign nationals residing overseas, U.S.-based foreign nationals with approved immigrant petitions may apply to adjust status only if an immigrant visa number is immediately available.

Because the demand for EB green cards exceeds the annual statutory limit, a lengthy *employment-based queue* has resulted. The EB queue consists mostly of foreign workers and accompanying family members who are residing in the United States in a nonimmigrant (temporary) lawful status. Their immigrant petitions have been approved, but they cannot adjust to LPR status or receive immigrant visas until a visa number becomes available. New prospective EB2 and EB3 immigrants from major immigrant-sending nations such as India and China, in particular, can expect to wait years and sometimes decades to receive green cards.[23]

## LPR Labor Certification Process

Intending employers of EB immigrants applying through the EB2 and EB3 preference categories must first submit Form 9089 (*Application for Permanent Employment Certification*) labor certification applications with DOL.[24] When the employer subsequently files a Form I-140 (*Immigrant Petition for Alien Worker*) with USCIS, the approved labor certification application must accompany the Form I-140.

All labor certification applications for foreign nationals to become LPRs are processed through DOL's Program Electronic Review Management (PERM) process.[25] DOL must certify to USCIS that "there are not sufficient U.S. workers able, willing, qualified and available to accept the job opportunity in the area of intended employment, and that employment of the foreign worker will not adversely affect the wages and working conditions of similarly employed U.S. workers."[26] Employers must attest that they have met the mandatory recruitment requirements for all labor certification applications, including public advertisements of the job across a range of media. An employer must also obtain a valid prevailing wage determination (PWD) from DOL's National Prevailing Wage Center. The PWD ensures that wages offered to the prospective immigrant

[22] INA §212(a)(5), 8 U.S.C. §1182(a)(5).

[23] For more information on wait times of EB preference categories by origin country, see DOS's *Visa Bulletin*, published online each month at https://travel.state.gov/content/travel/en/legal/visa-law0/visa-bulletin.html. For background information, see CRS Report R46291, *The Employment-Based Immigration Backlog*.

[24] INA §212(a)(5)(A), 8 U.S.C. §1182(a)(5)(A).

[25] The stated goals of PERM are to streamline the labor certification process and reduce fraudulent filings. For more information, see DOL, Employment and Training Administration (ETA), "Permanent Labor Certification,", https://www.dol.gov/agencies/eta/foreign-labor/programs/permanent.

[26] DOL, ETA, "Permanent Labor Certification." See also 20 C.F.R. §656.1.

reflect wages offered for similarly employed workers in the same geographic location as the job. The wage offered to the prospective immigrant must be at least 100% of the prevailing wage.

### Labor Certification Exemptions for Certain Health Care Workers

The INA contains two employment-based provisions that facilitate the immigration of health care professionals. First, the EB2 preference category provisions contain a *national interest waiver* for certain physicians. A national interest waiver exempts the foreign national from requiring a job offer from an employer (i.e., he or she can self-petition) or an employer from the requirement to obtain labor certification. Eligible physicians include those who agree to work full-time, usually for five years, in a Veterans Affairs health care facility or in areas designated by the Department of Health and Human Services (HHS) as having a shortage of health care professionals.[27] In addition, a federal agency or state public health department must have previously determined that such professionals' work (in such a facility or in such areas) is in the public interest.[28]

Second, DOL regulations contain a list of occupations, known as *Schedule A*, that the agency determines to be in such short supply that hiring non-U.S. workers would not adversely affect U.S. workers. Individuals hired to fill jobs in these occupations are exempt from the labor certification process. Schedule A currently lists nurses and physical therapists.[29]

# Temporary Immigration Options

As noted, nonimmigrants are admitted to the United States for temporary periods of time and specific purposes. Nonimmigrant visa categories are identified by letters and numbers based on the INA sections that authorize them.[30] The following section discusses several nonimmigrant options that foreign health care workers may use. At the end, **Table 3** provides a summary.

## H-1B, H-1B1, and E-3 Visas: Specialty Occupation Workers

Current law provides for the admission of temporary workers to perform services in specialty occupations. The INA defines *specialty occupation* as "an occupation that requires theoretical and practical application of a body of highly specialized knowledge, and attainment of a bachelor's or higher degree in the specific specialty (or its equivalent) as a minimum for entry into the occupation in the United States."[31] The main visa class for specialty occupation workers is H-1B. The H-1B1 and E-3 classes are associated with free trade agreements and are limited to citizens of Chile (H-1B1), Singapore (H-1B1), and Australia (E-3). Spouses and children can accompany principal H-1B and H-1B1 nonimmigrants on H-4 visas. Spouses and children accompanying principal E-3 nonimmigrants use E-3D visas.

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[27] DHS, USCIS, "Green Card Through a Physician National Interest Waiver (NIW)," October 25, 2018.

[28] INA §203(b)(2)(B)(ii), 8 U.S.C. §1153(b)(2)(B)(ii). Associated regulations include 8 C.F.R. §204.12 and 8 C.F.R. §245.18. For more information about health professional shortage areas, see CRS Infographic IG10015, *Health Professional Shortage Areas (HPSAs)*. For a physician, this employment would occur after completing a residency training program. Labor determinations are not undertaken for residency positions.

[29] Schedule A also lists certain persons deemed to be of exceptional ability in the sciences or arts, who are not relevant to this discussion. 20 C.F.R. §656.5(a).

[30] For more information on nonimmigrant categories, see CRS Report R45040, *Immigration: Nonimmigrant (Temporary) Admissions to the United States*.

[31] INA §214(i)(1), 8 U.S.C. §1184(i)(1). For H-1B1 workers, the definition of *specialty occupation* includes "body of specialized knowledge" rather than "body of *highly* specialized knowledge" (italics added). See INA §214(i)(3).

A prospective employers of specialty occupation workers (H-1B, H-1B1, and E-3) is required to file a Labor Condition Application (LCA) with DOL attesting that the employer will comply with program requirements related to fair wages and working conditions.[32] A prospective employer of H-1B workers must then submit a petition to USCIS—along with an approved LCA—to request workers.[33] USCIS adjudicates the petition to determine whether the prospective employee possesses the required qualifications for the position and visa class and whether other statutory and regulatory requirements have been met. If USCIS approves the petition, a prospective employee outside the United States applies for a visa at a U.S. consulate.[34]

Foreign nationals who have graduated from medical school and are coming to the United States to work in the medical profession may not be admitted in H-1B status unless they (1) are hired by public or nonprofit private educational or research institutions to teach or conduct research or (2) have passed the licensing examination administered by the Federation of State Medical Boards of the United States (also known as *passing the boards*) and demonstrate competency in English.[35]

Current law generally limits the number of new individuals who are annually provided H-1B status to 65,000. Since 2001, however, most petitions for H-1B workers are exempt from the limits because they are extending their status (and have thus already been counted against the cap) or they are working for universities or nonprofit research or government research facilities that are exempt from the cap.[36] Each year, up to 20,000 H-1B workers with master's or higher degrees from U.S. universities are also exempt from the cap.[37]

From FY2016 through FY2021, USCIS approved between 335,000 and 427,000 petitions for H-1B workers annually (**Table 2**). Although H-1B employees may work in a variety of fields, the majority are hired to work in science, technology, engineering, and mathematics (STEM) occupations, with about two-thirds working in computer-related occupations.[38] During the same five-year period, about 4% of approved employer petitions for H-1B workers were for workers in medicine and health occupations.

**Table 2. Approved H-1B Petitions, FY2016-FY2021**

| | Total Approved Petitions | | | Approved Petitions for Medicine and Health Occupations | | |
|---|---|---|---|---|---|---|
| | Total | Initial Employment | Continuing Employment | Total | Initial Employment | Continuing Employment |
| FY2016 | 357,211 | 105,090 | 252,121 | 14,178 | 4,979 | 9,199 |

[32] This process is known as *labor attestation* and is less rigorous than the labor certification process required for permanent employees and H-2 temporary workers. For more information, see CRS Report R47159, *Temporary Professional Foreign Workers: Background, Trends, and Policy Issues*.

[33] H-1B1 and E-3 classifications do not require an employer petition with USCIS unless the prospective employee is physically present in the United States and a change of status, concurrent employment, or an extension of stay is needed.

[34] If the prospective employee is already present in the United States, he or she applies to USCIS for a change of status.

[35] INA §212(j)(2), 8 U.S.C. §1182(j)(2). To obtain a residency position, an individual would have had to pass several steps of the board exams. In addition, residency programs generally require that providers demonstrate English proficiency through application and interview processes.

[36] INA §214(g)(5)(A)-(B), 8 U.S.C. §1184(g)(5)(A)-(B).

[37] INA §214(g)(5)(C), 8 U.S.C. §1184(g)(5)(C).

[38] See, for example, DHS, USCIS, *Characteristics of Specialty Occupation Workers: Fiscal Year 2019 Annual Report to Congress*, March 5, 2020. Annual reports from other recent years show similar occupational patterns.

| | Total Approved Petitions | | | Approved Petitions for Medicine and Health Occupations | | |
|---|---|---|---|---|---|---|
| | Total | Initial Employment | Continuing Employment | Total | Initial Employment | Continuing Employment |
| FY2017 | 373,392 | 96,167 | 277,225 | 14,884 | 4,696 | 10,188 |
| FY2018 | 334,961 | 87,894 | 247,067 | 12,965 | 4,771 | 8,194 |
| FY2019 | 389,378 | 132,986 | 256,392 | 15,233 | 5,763 | 9,470 |
| FY2020 | 426,710 | 122,886 | 303,824 | 15,192 | 5,446 | 9,746 |
| FY2021 | 407,071 | 123,414 | 283,657 | 14,070 | 5,802 | 8,268 |

**Source:** USCIS, *Characteristics of H-1B Specialty Occupation Workers*, [FY2016-FY2021], *Annual Report to Congress*. Total approved petitions come from Table 1b of the FY2020 and FY2021 reports, and approved petitions for medicine and health occupations come from each year's report. See notes.

**Notes:** USCIS altered the way it computes total approved petitions in FY2020. For the sake of consistency, this table presents the total approved petitions data for FY2016-FY2020 from the FY2020 report using the new method. In contrast, total approved petitions for medicine and health occupations data for FY2016-FY2019 come from each report using the old method, while the same figures for FY2020 and FY2021 were computed using the new method. In terms of computing the percentage of total petitions that involved medicine and health occupations, the change in methodology makes no difference if rounding to the nearest percentage (4% average). Data from FY2021 represents the most current available as of the date of this report. Data are not available for H-1B1 and E-3 specialty workers.

## J-1 Visa: Exchange Visitor

J-1 visas are issued as part of the Exchange Visitor Program, administered by DOS.[39] Foreign nationals entering on J visas include professors and research scholars, students, foreign medical graduates (FMGs), teachers, resort workers, camp counselors, summer work/travel participants, and au pairs who are participating in approved exchange visitor programs. FMGs may enter the United States on J-1 nonimmigrant visas in order to receive graduate medical education and training. Spouses and children can accompany principal J-1 nonimmigrants on J-2 visas. An average of 2,900 FMGs joined the J-1 physician program annually from CY2016 to CY2022.[40] FMGs must return to their home countries for at least two years after completing their education or training before they can apply for certain other nonimmigrant visas or LPR status that would allow them to work as physicians in the United States, unless they are granted waivers of the foreign residency requirement.[41] A J-1 physician can receive a waiver of the two-year home residency requirement if

- an interested government agency (IGA) or state department of health requests the waiver;[42]
- the FMG's return to their home country would cause extreme hardship to a U.S. citizen or LPR spouse or child; or

[39] DOS's Bureau of Educational and Cultural Affairs is responsible for approving the cultural exchange programs and designating sponsoring organizations. Regulations for J-1 physicians are found at 22 C.F.R. §62.27.

[40] See DOS, BridgeUSA, "Facts and Figures," https://j1visa.state.gov/basics/facts-and-figures/.

[41] INA §212(e), 8 U.S.C. §1182(e). This requirement was established to prevent *brain drain* and to allow newly trained medical workers to share what they learned in the United States with others in their home countries.

[42] Examples of interested government agencies include HHS and Veterans Affairs.

- the FMG fears persecution in the home country based on race, religion, or political opinion.

Most J-1 waiver requests are submitted by an IGA or state department of health and forwarded to DOS for recommendation. If DOS recommends the waiver, it will forward the waiver to USCIS for final approval. Upon final approval by USCIS, the physician's status is converted to that of an H-1B specialty occupation worker (see the next section). Spouses and children can accompany the H-1B workers by applying for H-4 visas. From FY2015 through FY2021, USCIS approved a total of 13,212 waivers for foreign physicians.[43]

Established in 1994 as a temporary program,[44] the *Conrad 30 Waiver Program* (also known as the *Conrad State Program*) allows each state to obtain up to 30 waivers per year on behalf of FMGs who have completed their required training. In return, the FMG must agree to work full-time for three years in an area in that state designated by HHS as having a shortage of health care professionals. Upon completion of this requirement, the doctor and his or her dependents are eligible to apply for permanent residence or H-1B or L-1 nonimmigrant status.[45] The objective of the Conrad 30 Waiver Program is to encourage immigration of foreign physicians to medically underserved communities. Congress has extended the program multiple times.[46]

States participating in the Conrad 30 Waiver Program sponsored 19,597 physician waivers in total from FY2001 through FY2021.[47] State officials who administer the program report that it is an important part of rural physician supply, as some states require that J-1 physicians be placed in rural HPSAs. While not all states track the retention of J-1 placements, states that do found that most recruited physicians intended to remain in their communities, though not necessarily at their same employer. In addition, a few states that did track their J-1 retention found that 40% of recruited physicians were employed at the same locations five years after their commitments ended.[48]

**Graduate Medical Education (GME)**

To work independently as a fully licensed physician in the United States, a medical school graduate must complete clinical training after completing medical school. Clinical training is formally called graduate medical education (GME) or, more commonly, *residency*. The federal government is the largest source of funding for GME, and residency positions are competitive. In recent years, there have been more residency positions available than graduates of U.S. based medical schools, which has enabled international medical graduates (IMGs) to obtain

[43] Data provided to CRS by USCIS on March 13, 2023.

[44] The Exchange Visitor Program was established by the Mutual Educational and Cultural Exchange Act of 1961 (P.L. 103-416) and amended by the Health Care Professions Act (P.L. 94-484).

[45] The L-1 visa for *intra-company transferees* allows U.S. employers to transfer employees from their affiliated offices overseas to their U.S. offices. L-1 visa holders may stay in the United States between one and three years initially and may extend their stays for up to seven years. L-1 visas are not numerically limited. Spouses and children of L-1 nonimmigrants may apply for L-2 visas.

[46] For background information, see archived CRS Report RS22584, *Foreign Medical Graduates: A Brief Overview of the J-1 Visa Waiver Program*.

[47] See 3RNet, "Conrad 30 State Totals from FY 2001 through FY 2021," https://www.3rnet.org/Portals/0/adam/Basic%20Content/QxXpO-cnfkeKBY1XymXi7Q/Content/Conrad%20Historic%20Totals%20-%202001%20to%20Present.pdf.

[48] Davis G. Patterson, Gina Keppel, and Sue M. Skillman, *Conrad 30 Waivers for Physicians on J-1 Visas: State Polices, Practices, and Perspectives*, WWAMI Rural Health Research Center, March 2016, https://depts.washington.edu/fammed/rhrc/wp-content/uploads/sites/4/2016/03/RHRC_FR157_Patterson.pdf. States generally use employer records to track J-1 visa waiver placements. As such, individuals who remain in the communities where they are placed but at different employers may be not be followed.

residency positions. (As noted below, IMGs include noncitizen FMGs and U.S. citizens who graduated from foreign medical schools.) Unmatched applicants from prior graduation years may also apply for residency.

More than 90% of medical students who graduated in 2023 and attended U.S.-based medical schools (which confer doctor of medicine [MD] degrees) or osteopathic medical school (medical training that also includes training in osteopathic manipulation and leads to the receipt of a doctor of osteopathy [DO] degree) received residencies in 2023. Individuals who trained at international medical schools (i.e., IMGs) are also eligible to apply for GME positions. In 2023, the percentage of noncitizen IMGs who received residency positions was lower (59% of 8,469 graduates) than for U.S. citizen IMGs (68% of 4,963 graduates). Individuals who graduated from medical school in earlier years, whether U.S.- or foreign-trained, may also seek GME positions. However, in the past, approximately half have been successful at doing so. GME is required for a physician to be fully licensed, so not obtaining a position means that an individual cannot become a physician.

The reasons that people do not receive residency positions vary. Obtaining a position is competitive, and some programs and specialties considered more desirable than others receive more applicants than available spots allow. Applicants are matched into positions that maximize their preferences with the residency programs' preferences. Despite the surplus of applicants (domestic and foreign medical graduates) over positions, a small number of positions are not filled each year, generally because they are considered less desirable based on specialty or geographic location.

**Sources:** CRS Report R44376, *Federal Support for Graduate Medical Education: An Overview*; The Match: National Residency Matching Program, *Advance Data Tables*, 2022 Main Residency Match, March 17, 2023, p. 10, https://www.nrmp.org/wp-content/uploads/2023/03/2023-Advance-Data-Tables-FINAL.pdf; and Nicole M. Mott et al., "What's in a Number? Breaking Down the Residency Match Rate," *New England Journal of Medicine*, March 16, 2022. For a critical perspective, see Center for Immigration Studies, "Doctors Without Jobs; Qualified American Physicians Are Being Turned Down for Residency in Favor of Foreign-Educated Physicians," podcast, May 26, 2022.

**Note:** Non-U.S. IMGs include individuals who seek to enter the U.S. for training on J-1 and other visa types.

## TN Visa: USMCA Professionals

The North American Free Trade Agreement (NAFTA), which entered into force in 1994, established the TN nonimmigrant classification to allow citizens of Canada and Mexico to seek temporary entry into the United States to engage in business activities at a professional level.[49] The U.S.-Mexico-Canada Agreement (USMCA) replaced NAFTA in July 2020, and the TN visa provisions were carried over.[50] There are approximately 60 qualifying professions—typically requiring a bachelor's degree or higher for work at the entry level.[51] These include the following healthcare-related occupations: dentist, dietician, medical technologist, nutritionist, occupational therapist, pharmacist, physician (teaching or research only), physical therapist, psychologist, recreational therapist, and RN. Spouses and children can accompany principal TN nonimmigrants on TD visas. There is no annual numerical limit on the number of people accorded TN or TD status.[52]

To obtain TN status, an individual must provide evidence of Canadian or Mexican citizenship, a job offer from an employer, and professional credentials.[53] A Mexican citizen must obtain a TN

[49] INA §214(e), 8 U.S.C. §1184(e).

[50] For more information on NAFTA, see CRS Report R42965, *The North American Free Trade Agreement (NAFTA)*. For more information on USMCA, see CRS Report R44981, *The United States-Mexico-Canada Agreement (USMCA)*.

[51] The full list of qualifying professions and their education/credential requirements can be found in Section D, Annex 16-A, of the USMCA, available at https://ustr.gov/sites/default/files/files/agreements/FTA/USMCA/Text/16_Temporary_Entry.pdf.

[52] Some have argued for greater use of the TN visa for STEM and medical occupations. See, for example, Julia Gelatt, *Unblocking the U.S. Immigration System: Executive Actions to Facilitate the Migration of Needed Workers*, Migration Policy Institute, February 2023.

[53] 8 C.F.R. §214.6(d)(3).

visa from a U.S. embassy or consulate prior to arrival at a U.S. port of entry.[54] Citizens of Canada are not required to obtain TN visas prior to travel. Rather, they may apply directly for admission as TN nonimmigrants at U.S. ports of entry.[55]

TN nonimmigrants are admitted for an initial period of up to three years and may extend their status for additional periods in increments of up to three years. There is no specific limit on the total period of time an individual may be in TN status provided he or she continues to be engaged in TN business activities and otherwise continues to properly maintain TN nonimmigrant status.[56] Data on TN nonimmigrants working in health care occupations are not publicly available, and the data that do exist do not include all TN workers.[57] CRS obtained unpublished data from USCIS showing that from FY2017 through the first five months of FY2022, USCIS approved 4,640 employer petitions for TN workers in health care occupations. The share of approved employer petitions for TN workers in health care occupations increased from 3.7% of all approved TN petitions in FY2017 to 14.2% in FY2022.[58] Among all the occupations requested by TN employers, health technicians ranked third over this period and accounted for over 10% of approved TN petitions in the first five months of FY2022.[59]

## O Visa: Persons with Extraordinary Ability

Persons with extraordinary ability who come to the United States temporarily to continue working in their fields can be admitted on O-1 visas. This visa category is subdivided into O-1A visas for individuals with extraordinary ability in the sciences, education, business, or athletics and O-1B visas for individuals with extraordinary ability in the arts or with extraordinary achievement in the motion picture and television industry. Regulations define *extraordinary ability in the field of science, education, business, or athletics* as a level of expertise indicating that the person is "one of the small percentage who have arisen to the very top of the field of endeavor."[60]

A U.S. employer or agent must file a petition on behalf of a prospective O-1 worker. The petition must generally include a letter from a peer group in the prospective O worker's field stating its opinion of the prospective O worker's ability, a process known as *consultation*. O nonimmigrants are admitted for up to three years and may extend their status in increments of up to one year.[61] Spouses and children can accompany principal nonimmigrants on O-3 visas. There is no annual numerical limit on the number of O visas that may be issued.

Physicians and other health care professionals who demonstrate extraordinary ability by documenting their past achievements and contributions to the field of medicine (e.g., research,

[54] 8 C.F.R. §214.6(d)(1).

[55] 8 C.F.R. §214.6(d)(2). Alternatively, a prospective TN employer may choose to file a petition with USCIS on behalf of a Canadian citizen who is outside the United States. If the petition is approved, the prospective worker may apply for admission at a port of entry by providing proof of Canadian citizenship and the approved petition from USCIS.

[56] 8 C.F.R. §214.6(h).

[57] USCIS does not regularly publish data on employer petitions for TN nonimmigrants. Moreover, data on employer petitions cover only a fraction of TN workers because such petitions are required only for individuals already in the United States who are requesting extensions or change of status.

[58] The FY2022 data cover only the first five months of the fiscal year (i.e., through March 9, 2022).

[59] CRS analysis of unpublished data provided by USCIS in April 2022.

[60] 8 C.F.R. §214.2(o)(3)(ii).

[61] USCIS may authorize an extension of stay in increments of up to one year for an O-1 or O-2 beneficiary to continue or complete the same event or activity for which he or she was admitted. There is no limit to the number of extensions of stay a petitioner can file for the same beneficiary. 8 C.F.R. §214.2(o)(12)(ii).

scientific publications) may be able to work in the United States in O-1 nonimmigrant status. From FY2017 through the first five months of FY2021, 2,300 of the approved employer petitions for O-1A nonimmigrants were for workers in health care occupations, representing approximately 8% of all O-1A approved petitions.[62]

## H-2B Visa: Nonagricultural Workers[63]

The H-2B visa provides for the temporary admission of foreign workers to the United States to perform temporary nonagricultural service or labor if employers cannot find unemployed U.S. workers to do the work. H-2B workers are not limited to a particular set of occupations. The H-2B visa is subject to a statutory annual cap of 66,000.[64]

For work to qualify as temporary for purposes of the H-2B visa, the employer must establish that his or her need for the worker will end in the "near, definable future." Additionally, the employer's need for the duties to be performed by the worker must be a one-time occurrence, a seasonal need, a peak-load need, or an intermittent need. The employer's need must generally be for a period of one year or less but, in the case of a one-time occurrence, could last up to three years.[65] An employer can apply to extend an H-2B worker's stay in increments of up to one year, but an H-2B worker's total period of stay may not exceed three consecutive years.

The process of bringing H-2B workers into the United States involves multiple agencies. As a first step, employers must apply to DOL for labor certification for their desired numbers of H-2B worker positions. Through the H-2B labor certification process, as through the labor certification application process for permanent EB immigrants discussed above, DOL makes a determination whether U.S. workers capable of performing the work are available and whether the employment of foreign workers will adversely affect the wages and working conditions of similarly employed U.S. workers. As part of the H-2B labor certification process, prospective H-2B employers must conduct recruitment for U.S. workers and offer at least prescribed minimum levels of wages and benefits. If employers receive DOL labor certification, they can then submit petitions to DHS for up to the certified number of H-2B positions.

Over the years, the H-2B visa has been used to bring in workers to perform a variety of jobs. DOL publishes quarterly data on the top 10 H-2B certified positions by occupation. Historically, health care occupations have not been on these lists. For FY2017, DHS published a one-time table on "Approved H-2B Cap-Subject Beneficiaries by Job Code." It indicated that the "health service" job code accounted for up to 390 (or 0.4%) of approved H-2B workers out of a total of more than 90,000.[66]

[62] CRS analysis of unpublished data provided by USCIS in April 2022.

[63] This section was authored by Andorra Bruno, CRS Specialist in Immigration Policy.

[64] For more information on the H-2B visa, see CRS Report R44849, *H-2A and H-2B Temporary Worker Visas: Policy and Related Issues*, and CRS Report R44306, *The H-2B Visa and the Statutory Cap*.

[65] More information about these requirements is available in DHS regulations at 8 C.F.R. §214.2(h)(6)(ii)(B).

[66] DHS, USCIS, "Approved H-2B Cap-Subject Beneficiaries by Job Code, Fiscal Year 2017," https://www.uscis.gov/sites/default/files/document/data/approved-h-2b-cap-subject-beneficiaries-by-job-code-fy-2017.pdf.

**Table 3. Major Nonimmigrant Visa Options for Health Care Workers**

| Category | Eligibility Criteria | Period Admitted | Annual Numerical Limit |
|---|---|---|---|
| **H-1B Visa** (Specialty Occupation Workers) | Theoretical and practical application of highly specialized knowledge and attainment of a bachelor's or higher degree in the specific specialty. | 3 years; can be renewed once for 3 years. | 65,000 new visas, plus 20,000 H-1B workers with U.S. master's or higher degrees. Unlimited visas for employees of nonprofit or government research organizations and universities. |
| **H-1B1 Visa** (Specialty Occupation Workers) | Similar to H-1B but limited to citizens of Chile and Singapore. | 1 year; can be renewed twice for 1-year increments. Further extensions require new LCA filed with DOL. | 1,400 citizens of Chile and 5,400 citizens of Singapore. |
| **E-3 Visa** (Specialty Occupation Workers) | Similar to H-1B but limited to citizens of Australia. | Up to 2 years. Further extensions require new LCA filed with DOL. | 10,500. |
| **J-1 Visa** (Exchange Visitors) | Must be sponsored by an exchange program so designated by DOS. | Period needed to complete exchange program, education, or training. J-1 physicians must return home for two years before applying for certain other U.S. visas unless granted waivers. | Conrad 30 Waiver Program allows each state to sponsor up to 30 foreign medical graduates who must work full-time for 3 years in medically underserved communities. No limit for IGAs. |
| **TN Visa** (USMCA Professionals) | For Mexican and Canadian citizens with U.S. job offers in about 60 qualifying professions, typically requiring at least a bachelor's degree. | Up to 3 years initially; can be renewed indefinitely for increments of up to 3 years; no total period limit. | No limit. |
| **O Visa** (Persons with Extraordinary Ability) | Must possess expertise indicating "one of the small percentage who have arisen to the very top of the field of endeavor." | Up to 3 years initially; can be renewed indefinitely for increments of up to 1 year; no total period limit. | No limit. |
| **H-2B Visa** (Temporary Nonagricultural Workers) | For temporary nonagricultural service or labor if employers cannot find unemployed U.S. workers to do work. Not limited by occupation. | Generally for 1 year or less; up to 3 years for a one-time occurrence. | 66,000. |

**Source:** CRS compilation of information in statute (see the previous sections for more detail).

# Expired Immigration Provisions

During the 1980s and 1990s, Congress responded to concerns about nursing shortages by creating two nonimmigrant visas for nurses that have since expired: H-1A visas, issued from FY1990 to FY2000, and H-1C visas, issued from FY2001 to FY2012.

## H-1A Visa

Congress created the H-1A nonimmigrant worker classification in 1989 to allow foreign RNs to work temporarily in the United States at facilities where DOL had determined there was a shortage of health care professionals.[67] It required the nurses to

- be licensed where they had been originally trained or to have been trained in the United States or Canada; and
- have passed an appropriate examination or to have licenses and be otherwise eligible to practice immediately in the state of intended employment.

Employers were required to attest, among other things, that the nurses would be paid comparable wages to existing employees and their employment would not detrimentally impact the latter's wages and working conditions.[68] H-1A nurses were admitted initially for three years with one extension permitted such that the total period of admission did not exceed five years (six years under extraordinary circumstances). H-1A visas were not numerically limited.

The H-1A provisions expired after five years in September 1995.[69] Subsequent legislation allowed nurses who had entered the United States with H-1A visas to remain in the country and work as RNs until September 30, 1997.[70] The visa classification was eliminated and replaced by the Nursing Relief for Disadvantaged Areas Act of 1999 (P.L. 106-95). The last H-1A visas were issued in FY2000. From FY1990 to FY2000, DOS issued a total of 36,743 H-1A visas, an average of 3,340 per year (**Table 4**).

**Table 4. H-1A Visa Issuances, FY1990-FY2000**

| Fiscal Year | H-1A Visas |
|---|---|
| 1990 | 2 |
| 1991 | 7,443 |
| 1992 | 7,377 |
| 1993 | 6,388 |
| 1994 | 6,441 |
| 1995 | 7,261 |
| 1996 | 1,745 |
| 1997 | 61 |
| 1998 | 18 |
| 1999 | 5 |
| 2000 | 2 |
| **Total** | **36,743** |
| **Annual Average** | **3,340** |

[67] See the Immigration Nursing Relief Act of 1989 (P.L. 101-238). This law also allowed certain nonimmigrant nurses who had been working in the United States for at least three years to apply to adjust to LPR status without regard to numerical limits. Under this law, 7,830 nurses and 4,350 family members obtained LPR status.

[68] H.Rept. 106-135.

[69] H.Rept. 106-135.

[70] "A bill to extend the authorized period of stay within the United States for certain nurses" (P.L. 104-302).

**Source:** DOS, "Nonimmigrant Visa Issuances by Individual Class of Admission: FY1987-1991 Detail Table, FY1992-1996 Detail Table, and FY1997-2001 Detail Table."

## H-1C Visa

The H-1C nonimmigrant worker classification was created in 1999 to allow foreign RNs to work temporarily in the United States where DOL had determined there was a shortage of health care professionals.[71] Eligibility criteria for the H-1C visa were similar to that of the H-1A. Nurses were required to

- be licensed where they had been originally trained or to have been trained and licensed in the United States;
- have passed the Commission on Graduates of Foreign Nursing Schools (CGFNS) examination or to have a full and unrestricted license to practice as RNs in the states of intended employment; and
- be fully qualified and eligible in the place of intended employment to practice as RNs immediately upon U.S. admission and be authorized by such laws to be employed by the facilities.

H-1C nurse employers were required to (1) be located in HPSAs, (2) meet specified minimum thresholds for the size of their Medicare (35%) and Medicaid (28%) patient populations, (3) have at least 190 acute care beds, and (4) be DOL certified, among other requirements.[72] Employers also had to provide DOL with attestations similar to those required for H-1A nurses. DOL initially identified 14 U.S. hospitals that met the eligibility criteria for hiring H-1C nurses. That number subsequently expanded.[73]

The H-1C visa had an annual limit of 500.[74] Spouses and children could enter the United States on H-4 visas (which are not numerically limited) and were not granted work authorization. States with populations of less than 9 million in 1990 could have no more than 25 H-1C nurses, and those with populations of more than 9 million could have no more than 50. The H-1C visa classification was extended for three years in 2006, and it expired on December 20, 2009. The last H-1C visas were issued in FY2012.[75] From FY2001 to FY2012, DOS issued a total of 1,042 H-1C visas, an average of 87 per year (**Table 5**). Most were issued to nationals from the Philippines.[76]

[71] Nursing Relief for Disadvantaged Areas Act of 1999 (P.L. 106-95). The H-1C classification can be found in INA §101(a)(15)(H)(i)(c), 8 U.S.C. §1101(a)(15)(H)(i)(c). The requirement for employers of H-1C nurses can be found in INA §212(m), 8 U.S.C. §1182(m). Related regulations are found at 20 C.F.R. §§655.1100-1260. For background information on the H-1C visa, see DHS, USCIS "H-1C Registered Nurse Working in a Health Professional Shortage Area as Determined by the Department of Labor," June 17, 2013 (archived).

[72] DHS, USCIS, "H-1C Registered Nurse Working in a Health Professional Shortage Area as Determined by the Department of Labor."

[73] Greg Siskind, "H-1C Visas for Registered Nurses," *ILW.com*, December 17, 2007. This article does not indicate how many hospitals ultimately met the H-1C hiring eligibility criteria.

[74] The Rural and Urban Health Act of 2001 (S. 1259), which was introduced during the 107th Congress but was not acted upon, would have expanded the number of H-1C visas from 500 to 195,000.

[75] As of the date of this report, CRS was unable to determine why H-1A and H-1C visas described below were issued after these visa programs had expired. An inquiry to DOS on this issue remains outstanding.

[76] DOS, *Nonimmigrant Visa Statistics*, "Nonimmigrant Visa Issuances by Visa Class and by Nationality," FY2001-FY2012, https://travel.state.gov/content/travel/en/legal/visa-law0/visa-statistics/nonimmigrant-visa-statistics.html.

**Table 5. H-1C Visa Issuances, FY2000-FY2012**

| Fiscal Year | H-1C Visas |
|---|---|
| 2000 | 0 |
| 2001 | 34 |
| 2002 | 212 |
| 2003 | 191 |
| 2004 | 110 |
| 2005 | 63 |
| 2006 | 8 |
| 2007 | 26 |
| 2008 | 174 |
| 2009 | 128 |
| 2010 | 86 |
| 2011 | 7 |
| 2012 | 3 |
| **Total** | **1,042** |
| **Annual Average** | **87** |

**Source:** DOS, "Nonimmigrant Visa Issuances by Visa Class and by Nationality, FY1997-2021 Detail Table."

### Addressing the Shortages of Nurses

The shortage of nurses in the U.S. health care system has been widely acknowledged for decades. Federal policy to address nursing shortages has changed over time. Experts identified that the largest cause of the U.S. nursing shortages was insufficient numbers of nurse faculty, which led to nursing schools being unable to accept qualified students. As such, some federal efforts have focused on increasing the number of nursing faculty. For example, Title VIII of the Public Health Service Act authorizes a number of programs to train nurses and nurse faculty and programs that provide scholarships and loan repayment to incentivize U.S. citizens and domestically trained nurses to practice in rural and underserved areas. U.S. reliance on foreign nurses has decreased in the past decade. The 2007-2009 recession saw fewer nursing retirements than had been predicted among the domestic nursing population, leading to reduced need for internationally educated nurses. Researchers also found that the delay in nursing retirements contributed to growth in the nursing workforce. In more recent years, nursing shortages emerged again during the COVID-19 pandemic.

**Sources**: U.S. Department of Labor, Bureau of Labor Statistics, "Job Openings by Industry, Seasonally Adjusted," November 2022; HHS, Health Resources and Services Administration, *Justification of Estimates for Congressional Committees: FY2023*, pp. 164-189; National Advisory Council on Nurse Education and Practice, *The Impact of Nurse Faculty Shortage on Nurse Education and Practice*, August 2010; National Academies of Sciences, Engineering, and Medicine et al., *The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity*, National Academies Press, 2021, p. 65; and David I. Auerbach, Peter I. Buerhaus, and Douglas O. Staiger, "Registered Nurses Are Delaying Retirement, a Shift That Has Contributed to Recent Growth in the Nursing Workforce," *Health Affairs*, vol. 33, no. 8 (2014), pp. 1474-1480.

# Health Care Training and Licensing Requirements

Apart from immigration requirements, foreign health care workers must also complete training and licensing requirements, which vary by specific profession. Examples of licensing for nurses and physicians are discussed below. Nursing licensure is highlighted because the process is similar for other non-physician health professions, and nurses represent a large percentage of

foreign-trained health care workers. U.S. licensure procedures for physicians are discussed because they require additional clinical training to be eligible for licensure, which makes their licensing processes distinct from other types of health professionals.

States are responsible for licensing health care providers, which generally includes verifying an applicant's education, whether the applicant has passed the relevant required examinations, and whether the applicant has sufficient relevant clinical training. Though states generally follow similar procedures for licensure, they may also have state-specific licensure requirements. Educational requirements must generally be met as a condition of taking the licensure exam for the relevant profession. Foreign-trained providers must attend training programs accredited by accepted international organizations.[77] Physicians require structured clinical training to be eligible for licensure. The training must be performed within U.S. medical residency programs after graduation from medical school and is also required for individuals who graduate from international medical schools. Such graduates would enter the United States to undertake this training, during which they would not be licensed to practice independently.

## Nursing Licensure for International Nursing Graduates[78]

As noted previously, states are responsible for licensing health care providers, generally through state licensing boards. They verify that applicants meet licensure requirements and set requirements needed to maintain a valid license (e.g., continuing education requirements). States are also responsible for gathering and investigating complaints against health care providers.

This section discusses two types of internationally educated nurses. RNs, also called first-level nurses or professional nurses, who provide and coordinate care after graduating from programs that are a minimum of two years and may be up to four years. RNs are qualified to supervise second-level nurses, also called licensed practical nurses (LPNs) or vocational nurses (VNs). The latter are nurses who provide basic nursing care under the direction of first-level nurses, and the length of their required training varies. Some states may impose additional criteria for licensure (e.g., a Social Security Number).

The National Council of State Boards of Nursing has developed uniform licensure requirements "to assure that all nurses, whether educated domestically or abroad, are safe and qualified to practice."[79] The general requirements applicable to internationally educated nurses are the following:

- Graduate from a nursing program that is equivalent to a program accepted by the relevant state or territorial member board. Boards use credential review agencies to verify graduation and whether the program is approved by an accrediting body. An applicant is required to provide information about the program he or she attended, its prerequisites for entry, its accreditation status, and the entity that accredited the program, among other information.

[77] For physician assistants (PAs), no foreign programs are currently accredited by the Accreditation Review Commission on Education for Physician Assistant (ARC-PA). Graduates from accredited PA programs in the United States are required to take the national licensing exam. See ARC-PA, "Frequently Asked Questions," http://www.arc-pa.org/frequently-asked-questions/non-us-health-care-professionals. Some programs may provide advanced educational standing for individuals who have previously trained as PAs in non-U.S. programs.

[78] Information in this section was drawn from the National Council of State Boards of Nursing (NCSBN), "Licensure," https://www.ncsbn.org/licensure.htm, and "U.S. Licensure for Internationally Educated Nurses," https://www.ncsbn.org/171.htm.

[79] NCSBN, *Resource Manual on the Licensure of Internationally Educated Nurses*, 2015, p. 1, https://www.ncsbn.org/20_IEN_manual_WEB.pdf.

- Complete the specific National Council Licensure Examination (NCLEX) exam. For example, an RN would be required to complete the NCLEX-RN exam, whereas LPNs would complete the NCLEX-PN exam. The examination is available at various sites within the United States and at a number of international locations, including Australia, Canada, England, Germany, Hong Kong, India, Japan, Mexico, the Philippines, and Taiwan.[80] State boards are responsible for verifying successful exam completion.
- Disclose nursing licensure status in the country of origin (if applicable) and successfully pass an English language examination that includes demonstrating proficiency in speech, reading, writing, and listening. Applicants from countries where English is the native language and/or trained in countries where the nursing programs were taught in English and used English textbooks are not subject to this requirement. State boards must verify that these requirements are met for internationally educated nurses.
- Self-disclose all misdemeanors, felonies, and plea agreements (even if adjudications were withheld) and submit to state and federal background checks. State boards assess applicant reports on a case-by-case basis to determine if they are eligible for licensure. State boards require a psychological evaluation for any individual convicted of a sexual offense involving a minor or a sexual act against the will of another person. A board must approve a qualified expert to conduct this evaluation and must deny a license to an individual if the evaluation identifies "sexual behaviors of a predatory nature."[81]
- Self-disclose any substance use disorder within the past five years. State boards must evaluate those who disclose such information to verify applicants' capability to practice nursing.
- Disclose any licensure actions taken or initiated against a prior license. State boards must assess these actions and consider whether they impact applicants' ability to practice nursing safely.

When evaluating whether international programs are comparable to a U.S. accredited program, state boards generally use credentialing agencies. However, a board may conduct its own investigation.

Foreign nurses[82] seeking to work in the United States must also be certified by the CGFNS.[83] This agency has been approved by DHS to validate the credentials of nurses (among other health care professions) for occupational visas.[84] Some state nursing boards require CGFNS certification for licensure.[85] For immigration purposes, CGFNS screens an individual's education to determine

[80] NCSBN, *Resource Manual*, p. 1. The NCSBN *Resource Manual* includes Puerto Rico in its international list on page 12. Although the NCLEX exam is offered in multiple international locations, travel to take the exam may still be a barrier for some foreign-trained nurses who seek to work in the United States.

[81] NCSBN, *Resource Manual*, p. 7.

[82] Note that U.S. nationals may also be internationally educated. As such, this paragraph focuses on individuals who are internationally educated nurses but are not U.S. nationals.

[83] CGFNS International, "Apply for VisaScreen: VisaScreen Credentials Assessment," https://www.cgfns.org/faq/visascreen/applying-for-visascreen-visascreen-credentials-assessment/.

[84] The organization also verifies the credentials of audiologists, clinical laboratory scientists, clinical laboratory technicians, occupational therapists, physician assistants, physical therapists, and speech language pathologists. In addition, they verify registered psychiatric nurses. These nurses would be licensed in a similar manner to RNs but must additionally demonstrate specialized training in assessing and treating psychiatric disorders.

[85] NCSBN, *Resource Manual*, p. 18.

whether it is comparable to that of a U.S. graduate and verifies the individual's prior licenses, English proficiency, and, for RNs, examinations (NCLEX-RN or CGFNS Qualifying Exam). Individuals who complete this process (called a *visa screen*) are eligible for a certification that satisfies U.S. federal screening requirements for foreign health care workers.

## Physician Licensure for International Medical Graduates

To be eligible to practice medicine as a physician in the United States, an individual must graduate medical school (either an allopathic or an osteopathic medical school) and must complete medical residency training (also called graduate medical education, or GME) in an accredited training program.[86] To be eligible to apply for a residency program, an individual must have completed or be in the final year of medical school and must have passed Step 1 and Step 2 of the United States Medical Licensing Exam (USMLE).[87] An individual who graduated from a medical school outside the United States (or Canada for allopathic medical schools) must be certified by the Education Commission for Foreign Medical Graduates (ECFMG) in order to enter a U.S. medical residency program. To be eligible for ECFMG certification, an individual must

- be enrolled in or have graduated from an international medical school that meets ECFMG requirements; medical schools that meet ECFMG requirements are those that are included in the World Directory of Medical Schools;[88]
- have taken and passed the first two steps of the USMLE; and
- meet a communication skills requirement, including English proficiency.

ECFMG also serves as the only sponsoring organization for J-1 international medical graduates (see the "J-1 Visa: Exchange Visitor" section above).

Licensure for physicians is similar to licensure for other types of health professionals. Each state, through its state medical board, must verify that applicants meet licensure requirements, sets requirements needed to maintain a valid license (e.g., continuing education requirements), and has responsibility to gather and investigate complaints against physicians. Some states may set additional requirements for international medical graduates. The basic licensure requirements are that an individual has graduated from an accredited medical school (allopathic or osteopathic),

[86] Medical residency training and its accreditation are discussed in CRS Report R44376, *Federal Support for Graduate Medical Education: An Overview*. Allopathic physicians receive MD degrees, and osteopathic physicians receive doctor of osteopathic medicine degrees. International medical graduates are generally MDs, as foreign osteopathic programs are not recognized for certification.

[87] The examination is a collaboration between the Federation of State Medical Boards and the National Board of Medical Examiners. See USMLE, https://www.usmle.org/. In 2021, the USMLE discontinued a second Step 2 exam, "Step 2 Clinical Skills." This exam was previously required to enter a residency and served to verify communication skills for international medical graduates. The exam was discontinued in 2020 because it required traveling to a site and diagnosing model patients, which was deemed infeasible due to the COVID-19 pandemic.

[88] World Directory of Medical Schools, "Search the World Directory," https://www.wdoms.org/.

completed at least one year of training in an accredited residency,[89] and passed Step 3 of the USMLE.[90] Passing the prior steps is required to obtain a residency position.

Though requirements for physician licensure are similar from state to state, there is some variation. For example, some states may limit the number of times an individual can take the USMLE. Some states also require a background check for a physician to be licensed. States may have additional procedures for an individual who has been previously licensed in another state and is seeking a license in a different state (e.g., the individual must report prior licensure actions or complaints).

# Legislation Related to Facilitating Foreign Health Care Worker Immigration

During the past decade, Members of Congress have regularly proposed legislation to facilitate temporary and/or permanent immigration of foreign health care workers. What follows is a brief description of several legislative proposals, organized by the type of approach taken, that would have done so.[91] The selection of bills highlighted here profiles the types of approaches taken in legislative proposals forwarded during the period examined, although it does not comprise exhaustive coverage of all such proposals. The proposals were introduced over the span of the 113th (2013-2014) through the 117th (2021-2022) Congresses.[92] With the exception of S. 744/H.R. 15 from the 113th Congress (which passed the Senate by a vote of 68-32) and S. 3157 from the 117th Congress (which was passed into law [P.L. 117-210]), none of the bills described below saw any committee or floor action.[93]

## Revising Numerical Immigration Limits

A direct approach to increasing employment of foreign health care workers involves adjusting statutory numerical limits on immigration. Some bills would have increased the number of immigrant visas for health care professionals, either by shifting visa numbers from other immigrant categories or by increasing the overall numerical limit on immigrant visas. An example of the former is the Equal Access to Green cards for Legal Employment Act of 2022 (H.R. 3648, 117th Congress), which would have allocated up to 4,400 EB3 principal immigrant visas for nurses and physical therapists each year for seven years while maintaining the same total number

[89] Medical residencies are a minimum of three years. Although states may permit licensure with fewer years of residency training, completing a residency is generally required to practice independently and enroll as a provider in public and private insurance programs. Some states have developed assistant and associate physician licensure pathways, which permit medical school graduates who have not completed residencies to practice, generally in shortage areas. See Association of Medical Doctor Assistant Physicians, "What Is an Assistant Physician/Association Physician?," https://assistantphysicianassociation.com/.

[90] Federation of State Medical Boards, "State Specific Requirements for Initial Medical Licensure," https://www.fsmb.org/step-3/state-licensure/. Note that some states may have separate boards for osteopathic licenses.

[91] This section does not discuss legislation that would restrict immigration of foreign health care professionals or impose new requirements or restrictions on such immigration.

[92] The pool of bills from which the examples were selected was obtained through a legislation search on Congress.gov and Lexis by Sarah Caldwell, CRS Senior Research Librarian.

[93] S. 744/H.R. 15 in the 113th Congress would have comprehensively reformed many elements of current immigration law. S. 3157 in the 117th Congress required DOL to provide Congress with a study on employment opportunities for foreign-born workers.

of employment-based immigrant visas issued annually.[94] An example of the latter approach is the Emergency Nursing Supply Relief Act of 2017 (H.R. 3351, 115th Congress), which would have provided for up to 8,000 employment-based immigrant visas per fiscal year for qualifying nurses, physical therapists, and other health care workers (excluding physicians) and their accompanying family members. Such foreign nationals would have been exempt from numerical limits and the 7% per-country ceiling.

Similarly, the Backlog Elimination, Legal Immigration, and Employment Visa Enhancement Act (S. 970, 117th Congress) would have exempted from numerical caps immigrants coming to work in the United States as physical therapists or professional nurses. The FIRST COVID-19 Care Delivery Act of 2020 (H.R. 6905, 116th Congress) would have eased numerical immigration limits on foreign health care professionals already present in the United States on nonimmigrant visas in several ways. It would have provided LPR status to a qualifying foreign national who served in the United States as a physician or nurse during any emergency period and would have had to leave the United States because he or she was not otherwise eligible for LPR status.[95] The individual would have held either an H visa or a J visa, received temporary protected status, or been covered under the Deferred Action for Childhood Arrivals initiative.[96] The bill would have also waived certain applicable foreign residency requirements and certain numerical limitations, among other similar provisions.

More targeted approaches include the Conrad State 30 and Physician Access Reauthorization Act (H.R. 3541/S. 1810, 117th Congress), which would have increased the annual number of physician waivers a state could receive from 30 to 35 and allowed further adjustments based on demand (see the "J-1 Visa: Exchange Visitor" section above). Some physicians would have been exempt from direct annual numerical immigration limits if they met certain requirements. Similar provisions appeared in the Health Equity and Accountability Act of 2020 (H.R. 6637/S. 4819, 116th Congress) and the Doctors Helping Heroes Act of 2015 (H.R. 1272, 114th Congress).

Revising numerical immigration limits throughout the INA has typically occurred in comprehensive immigration reform legislation. The Border Security, Economic Opportunity, and Immigration Modernization Act (S. 744/H.R. 15, 113th Congress),[97] for example, would have exempted from numerical limits foreign national physicians who completed foreign residence

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[94] A *principal immigrant* is an immigrant who meets the immigrant eligibility criteria. A *derivative immigrant* is any accompanying family member such as a spouse or minor unmarried child. DHS data indicate that principal employment-based immigrants are accompanied by an average of about one family member. By reserving 4,400 immigrant visas for principal immigrants only (not including derivatives), the bill would effectively reserve an estimated 8,800 immigrant visas for principal and accompanying derivative immigrants. By statute, derivative immigrants are given the same order and consideration as principal immigrants. For example, the 140,000 annual limit on all employment-based immigrants includes both principal and derivative immigrants.

[95] *Emergency period* is defined in 42 U.S.C. §1320b-5(g)(1) and also includes the period during which a declaration of a public health emergency made by a state is in effect.

[96] When extraordinary conditions such as civil unrest, violence, or natural disasters occur in foreign countries, foreign nationals from those places who are present in the United States may not be able to return home safely. The INA allows DHS, in consultation with DOS, to grant temporary protected status to such foreign nationals, provided that doing so is consistent with U.S. national interests. For more information, see CRS Report RS20844, *Temporary Protected Status and Deferred Enforced Departure*. Under the Deferred Action for Childhood Arrivals (DACA) initiative, certain individuals without a lawful immigration status who were brought to the United States as children and meet other criteria may be granted deferred action for two years, subject to renewal. DACA recipients can apply for employment authorization but are not afforded a pathway to a legal immigration status. DACA was initiated in 2012 by the Obama Administration through an executive branch memorandum. For more information, see CRS Report R45995, *Unauthorized Childhood Arrivals, DACA, and Related Legislation*.

[97] For more information on this comprehensive immigration legislation, see archived CRS Report R43097, *Comprehensive Immigration Reform in the 113th Congress: Major Provisions in Senate-Passed S. 744*.

requirements under INA Section 212(e).[98] The bill would have similarly exempted from numerical limits all EB1 immigrants, a category that would have been revised to include foreign physicians accepted to U.S. residency or fellowship programs.[99] Certain foreign physicians adjusting to LPR status as EB2 immigrants would have been exempt from numerical limits as well as labor certification requirements.[100]

Regarding nonimmigrants, S. 744 (113th Congress) would have made the Conrad 30 Waiver Program permanent and would have allowed the annual state allotment to vary between 30 and 35 waivers based on demand.[101] The bill included provisions to regulate working conditions and add flexibility to the J visa program for these physicians.[102] Other provisions would have helped physicians holding J-1 or H-1B visas to remain in the United States. These would have included allowing *dual intent*[103] for J-1 foreign medical graduates;[104] making foreign national physicians who received Conrad waivers or completed their two-year home residency requirements exempt from EB2 numerical limits (as noted above);[105] and exempting spouses and children of J-1 visa holders from the two-year home residency requirement.[106] The bill would have also automatically extended the H-1B status of physicians who were completing their medical training.[107]

Some bills would have increased the number of foreign physicians by *recapturing* unused immigrant visa numbers from prior years and allocating them exclusively for health care professionals. For example, the Healthcare Workforce Resilience Act (H.R. 2255/S. 1024, 117th Congress) would have recaptured up to 40,000 unused employment-based immigrant visas (25,000 for nurses, 15,000 for physicians).[108]

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[98] S. 744, §2307.

[99] S. 744, §2307.

[100] S. 744, §§2402 and 2307(b)(1).

[101] S. 744, §2401.

[102] S. 744, §2403.

[103] Section 214(b) of the INA (8 U.S.C. §1184(b)) generally presumes that all aliens seeking admission to the United States intend to settle permanently. As a result, most foreign nationals seeking to qualify for nonimmigrant visas must demonstrate that they are not coming to reside permanently. There are three nonimmigrant visas for which *dual intent* is allowed, meaning that the prospective nonimmigrant visa holder is permitted simultaneously to seek admission to the United States on a nonimmigrant visa and to seek LPR status. Dual intent nonimmigrant categories largely encompass high-skilled workers and, in effect, bridge the employment-based systems for nonimmigrants and immigrants. Most such nonimmigrant workers are already embedded in the U.S. labor market and often work for the same employers who sponsor them for LPR status.

[104] S. 744, §2403(c).

[105] S. 744, §2307(b)(1).

[106] S. 744, §2405(c). Under current law, the J-2 spouses and children of J-1 nonimmigrants who are subject to the two-year home residency requirement must also return to their home countries for at least two years prior to being eligible for LPR status or certain other nonimmigrant statuses. See INA §212(e), 8 U.S.C. §1182(e).

[107] S. 744, §2405(b). If the petition for extending H-1B status was eventually denied, the employment authorization would have expired 30 days after the denial. In addition, the bill would have revised requirements for H-1Cs (nonimmigrant nurses), including by reducing the number of visas available for such workers from 500 to 300 per year and by facilitating their visa portability. See S. 744, §4212. Visa portability is the ability of a nonimmigrant worker to change employers.

[108] Immigrant visa recapture involves legislation passed by Congress that allows unused, numerically limited family-sponsored or employment-based immigrant visas to be recaptured and used rather than lost permanently as required by statute. This approach has been used before. For example, the REAL ID Act within the Emergency Supplemental Appropriations Act for Defense, the Global War on Terror, and Tsunami Relief, 2005 (P.L. 109-13) recaptured 50,000 unused employment-based immigrant visas for Schedule A health care occupations. For more information, see CRS Congressional Distribution Memorandum, *Assessing Four Department of State Methods to Compute Recapturable Immigrant Visa Numbers*, September 8, 2021.

## Facilitating Employment of Foreign Health Care Workers

Some legislative proposals would have facilitated the employment of foreign health care workers in ways that did not involve directly adjusting numerical limits. For example, the Grant Residency for Additional Doctors Act of 2021 (H.R. 4477, 117th Congress) would have required DOS to expedite visa processing for foreign nationals entering the United States for GME or training. The Health Care Workforce Protection Act of 2020 (H.R. 6717, 116th Congress) would have extended the authorized stay period for certain foreign health care workers to at least 60 days after the end of the declared COVID-19 emergency period.

The Heroes Act (H.R. 8406/S. 4800, 116th Congress) would have required DHS and DOS to expedite processing of immigrant petitions, nonimmigrant applications, and visas for certain foreign physicians and other nonimmigrants to practice medicine, provide health care, engage in medical research, or participate in GME or training. Such activities would have had to involve the diagnosis, treatment, or prevention of COVID-19. As part of this expedited process, required interviews and licensing requirements would have been waived in certain cases if other requirements were met. Additional provisions included increasing the number of Conrad 30 Waiver Program physicians allotted to each state from 30 to 35, providing temporary employment portability for health care workers involved in COVID-19 response, and granting EB4 special immigrant status to COVID-19 health care workers and their families.

The Physician Visa Reform Act of 2018 (H.R. 6123, 115th Congress) would have allowed foreign physicians who were approved to practice medicine by state licensing authorities in HPSAs to engage in medical practice without having to pass medical board examinations required by the INA.[109] The bill would have also granted such physicians and family members conditional permanent resident status. It would have removed the conditional status following the physician's passing of the required medical board examinations and two years of medical practice.

Some proposals would have provided direct assistance to prospective health care practitioners. The Professional's Access to Health Workforce Integration Act of 2022 (H.R. 8019, 117th Congress) would have provided grants to assist unemployed and underemployed skilled immigrants who were internationally trained health professionals to enter the U.S. health workforce. The Immigrants in Nursing and Allied Health Act of 2022 (H.R. 8021, 117th Congress) would have allowed HHS to provide grants to state, tribal, and local governments and private organizations for costs to assist lawfully present noncitizens to enter nursing or allied health professions. The International Medical Graduates Assistance Act of 2022 (H.R. 8022, 117th Congress) would have established programs allowing international medical graduates to practice medicine under the supervision of licensed physicians while completing their medical licensing examinations.

## Harnessing Skills of Foreign-Trained Health Care Workers

This report has focused on immigration pathways for health care workers residing abroad. Over the years, there have also been initiatives that have emphasized harnessing unused and/or underused skills of foreign workers already residing in the United States. This phenomenon, sometimes referred to as *brain waste*, encompasses an estimated 250,000-plus immigrants in the

[109] This refers to the requirement to have passed parts I and II of the National Board of Medical Examiners Examination as described in 8 U.S.C. §1182(a)(5)(B). Implementation of this bill would have been contingent on state action to approve physicians who had not passed the USMLE.

United States across all professions, including health care occupations.[110] Some immigrants with degrees in nursing, for example, may not be licensed and consequently work as home health aides or in other support professions that do not fully utilize their foreign degrees.

As mentioned previously, states are responsible for licensing health care professionals, so federal policy levers to facilitate licensing of foreign-trained individuals may be limited. The federal government may be able to support training opportunities to prepare individuals for relevant examinations needed for licensure or certification, or it may be able to provide support for licensing examinations or fees. Such preparation may also include assistance to attain English proficiency, a requirement for national licensure exams for nursing and other fields.[111] Federal support for education and student loan repayment for health professionals exists but is generally limited to U.S. citizens. Such programs, which typically provide scholarships or loan repayment in exchange for service commitments in shortage areas, potentially serve as models for leveraging the pool of immigrant health care workers with prior health training.[112]

Congress has demonstrated interest in this issue in the past. For example, the Bridging the Gap for New Americans Act (P.L. 117-210, 117th Congress), which became law on October 17, 2022, requires DOL to study and make recommendations on the factors that affect employment opportunities for individuals with professional credentials obtained outside the United States. Section 313 in the Health Equity and Accountability Act of 2018 (H.R. 5942/S. 3660, 115th Congress) would have allowed HHS to make grants to organizations that provide services to address unemployment and underemployment among skilled foreign nationals. A range of activities would have been funded to assist internationally educated health professionals residing in the United States with permanent work authorization to obtain employment matching their professional skills and education.

## Place-Based Visas

The U.S. immigration system operates at the federal level, with decisions about immigration policy determined by Congress and executive branch agencies for the entire nation. Proposals have been made for *place-based* systems that would decentralize that process for a portion of foreign workers. Such arrangements would require participating foreign nationals to live and work in specified U.S. locations such as a state, metropolitan area, or county. With the federal government maintaining its vetting and enforcement roles, these systems would allow states or municipalities to establish how many foreign nationals to accept, the criteria for their selection, and the duration of their stays.[113]

Place-based approaches, as currently conceived, would allow state or local governments to petition for foreign workers based on their occupational and industry needs. The demand for health care workers is often linked with such proposals. Some would admit foreign workers permanently, while others would provide temporary admission convertible to permanent status if

[110] See, for example, Jeanne Batalova and Michael Fix, *Leveraging the Skills of Immigrant Health-Care Professionals in Illinois and Chicago*, Migration Policy Institute, April 2022; and Jeanne Batalova, Michael Fix, and Sarah Pierce, *Brain Waste among U.S. Immigrants with Health Degrees: A Multi-State Profile*, Migration Policy Institute, July 2020.

[111] Ibid.

[112] For more information, see CRS Report R44970, *The National Health Service Corps*.

[113] For two placed-based approaches, see David J. Bier, "Chapter 5: State-Sponsored Visas," and Jack Graham and Rebekah Smith, "Chapter 6: The Community Visa: A Local Solution to America's Immigration Deadlock," in Alex Nowrasteh and David J. Bier, eds., *12 New Immigration Ideas for the 21st Century* (Washington, DC: Cato Institute, 2020).

applicants met certain residence, investment, or employment criteria. Most proposed place-based systems would supplement the federal immigration system, not replace it.[114]

Place-based proposals have been introduced in recent Congresses.[115] The State Sponsored Visa Pilot Program Act of 2019 (H.R. 5174, 116th Congress)[116] would have created a new nonimmigrant visa category to admit foreign nationals to states "to perform services, provide capital investment, direct the operations of an enterprise, or otherwise contribute to the economic development agenda of the state in a manner determined by the State." Under this plan, states would have opted into the system by creating programs—approved by their state legislatures and DHS—regulating participants' residence and employment and allowing them to change employers within the state or (under an inter-state compact) within a group of states.[117]

# Executive Branch Action

While Congress is responsible for passing immigration laws, under current laws the executive branch is afforded considerable authority and latitude to shape immigration policy.[118] Recent Administrations have applied executive actions such as executive orders and the rule-making process to alter immigration policy.[119] Members of Congress can also encourage executive actions through their communication with the President and executive branch agencies.

Recent examples of executive branch agency actions that are related to foreign health care workers include the following:

[114] See, for example, Michele Waslin, *Immigration at the State Level: An Examination of Proposed State-Based Visa Programs in the U.S.*, Bipartisan Policy Center, May 2020; and Brandon Fuller and Sean Rust, *State-Based Visas: A Federalist Approach to Reforming U.S. Immigration Policy*, Cato Institute, April 23, 2014.

[115] Compared with most proposals for facilitating health care worker immigration to the United States, place-based visa proposals have generated more controversy. Some proponents of place-based approaches tout them as a means of re-invigorating places experiencing population loss and economic decline. See, for example, Great Lakes Metro Chamber Coalition, *Supporting Place-Based Immigration in the Great Lakes Region*, August 2019; Steve Tobocman, *Revitalizing Detroit: Is There a Role for Immigration?*, Migration Policy Institute, August 2014; and Rick Su, "Immigration as Urban Policy," *Fordham Urban Law Journal*, vol. 38 (2010), pp. 363-391. Opponents of place-based approaches argue that admitting more foreign workers could depress wages for U.S. workers and that places struggling with population loss and economic decline should focus on raising wages, improving benefits, and increasing training to keep or attract native-born workers. See, for example, David D. Haynes, "Are Foreign Workers the Answer to Wisconsin Losing People in Their Prime Working Years? Laboring for Labor," *Milwaukee Journal Sentinel*, May 26, 2019; and Dan Cadman, *State-Based Visas: Unwise, Unworkable, and Constitutionally Dubious*, Center for Immigration Studies, May 9, 2017.

[116] This bill was identical to S. 1040 from the 115th Congress.

[117] The bill would have required that states keep DHS informed of participants' employment and addresses and any failures to comply with the program. Participants would have initially been admitted for renewable terms of up to three years. Participating states would have been allocated at least 5,000 nonimmigrant visas per year, with the maximum allocation based on state population, national gross domestic product growth, and a state's program compliance. While participants could have applied for permanent status if they qualified under existing mechanisms, these bills would not have created a pathway to permanent status.

[118] For more information, see CRS Report R46142, *The Power of Congress and the Executive to Exclude Aliens: Constitutional Principles*.

[119] See, for example, Jessica Bolter, Emma Israel, and Sarah Pierce, *Four Years of Profound Change: Immigration Policy during the Trump Presidency*, Migration Policy Institute, February 2022; and Center for Migration Studies, "President Biden's Executive Actions on Immigration," May 24, 2021.

- Classifying all health care providers and workers in the health care industry as *essential workers* during the COVID-19 pandemic,[120]
- Expediting employment authorization for health care workers,[121] and
- Prioritizing "as emergencies on a case-by-case basis the immigrant visa cases of certain healthcare workers who will be employed at facilities that are engaged in responding to the COVID-19 pandemic."[122]

In some cases, facilitation can occur by exempting foreign health care workers from certain existing immigration policies. For example, in the April 27, 2020, executive order suspending entry of immigrants, an exception was permitted for any immigrant "physician, nurse, or other health care professional; to perform medical research or other research intended to combat the spread of COVID-19; or to perform work essential to combating, recovering from, or otherwise alleviating the effects of the COVID-19 outbreak."[123]

Another possible administrative change that could be made through the rule-making process, if consistent with an Administration's priorities, would be to add nursing to the list of academic fields defined by DHS as STEM fields for purposes of optional practical training (OPT). Foreign students on F-1 visas are eligible to participate in OPT—temporary employment that is directly related to their major areas of study. Generally, an F-1 student may work up to 12 months in OPT, which may be completed before or after graduation. Those who receive degrees in STEM fields may apply for a two-year extension of their OPT, known as STEM OPT. Those who are authorized for the STEM OPT extension are thus allowed to work for up to three years in the United States. In this way, OPT often serves as a bridge for students on F-1 visas to transition to longer-term status. DHS maintains a list of degree programs that qualify for the STEM OPT extension and periodically makes changes to the list, most recently in January 2022.[124] Adding nursing to the list would allow nursing students who are being trained in the United States and qualify for OPT to work an additional two years in the United States. Depending on their country of origin, such OPT participants could potentially acquire LPR status as EB3 immigrants.

# Other Policy Considerations

Policymakers seeking immigration-related solutions to address health care worker shortages may consider other related issues that merit a brief discussion despite being largely beyond the scope of this report.

[120] DHS, Cybersecurity and Infrastructure Security Agency, *Advisory Memorandum on Ensuring Essential Critical Infrastructure Workers' Ability to Work During the COVID-19 Response*, August 10, 2021.

[121] DHS, USCIS, "USCIS Guidance on Expedited EADs for Healthcare Workers," December 28, 2021; see also Silva Mathema, "Removing Barriers for Immigrant Medical Professionals Is Critical to Help Fight Coronavirus," Center for American Progress, April 2, 2020.

[122] DOS, Bureau of Consular Affairs, "Immigrant Visa Prioritization," August 30, 2021.

[123] Executive Office of the President, "Suspension of Entry of Immigrants Who Present a Risk to the United States Labor Market During the Economic Recovery Following the 2019 Novel Coronavirus Outbreak," 85 *Federal Register* 23441-23444, April 27, 2020. For more information, see CRS Insight IN11362, *COVID-19-Related Suspension of Immigrant Entry*.

[124] DHS, USCIS, "Update to the Department of Homeland Security STEM Designated Degree Program List," 87 *Federal Register* 3317, January 21, 2022.

## Home Health Care

The scope of this report has been limited to health care professionals, with a focus on nurses and physicians. However, a substantial amount of health care service delivery outside of clinical settings involves home health care and nursing homes.[125]

Home health care workers include certified nursing assistants, nursing aids, and personal care aids.[126] Unlike other medical professionals emphasized in this report, home health care workers do not require a similarly substantial time investment in training. While many may have extensive experience, they typically have varied and sometimes relatively little or no professional training or certification.[127] These jobs often require providing intensive personal care and can be physically demanding.

Home health care has become increasingly prominent because of the aging of the U.S. population, most notably the large cohort of baby boomers now entering or already in retirement age.[128] Concerns have been raised about boomers' ability to *age in place* (i.e., live at home rather than in institutional settings).[129] This issue is important for at least two reasons: (1) a majority of elderly persons prefer to live at home and can experience negative physical health and psychological outcomes from relocating to institutional settings,[130] and (2) institutional settings have important fiscal implications because U.S. taxpayers bear some of their costs through Medicare and Medicaid.[131]

Noncitizens who seek to work as home health care workers typically cannot qualify for H-1B visas or other nonimmigrant categories that require substantial training and/or educational attainment. The main permanent immigration option available to home health care workers is the 10,000 set-aside for "other skilled workers" within the EB3 permanent immigrant category (**Table 1**). Those who immigrate to the United States must be certified by "a USCIS-approved credentialing organization verifying that they have met the minimum requirements for education,

[125] U.S. Bureau of Labor Statistics, "Home Health and Personal Care Aides," *Occupational Outlook Handbook*, September 8, 2022.

[126] Elizabeth Bien and Ron Smith, *The Unique Occupational Environment of the Home Healthcare Worker*, NIOSH Science Blog, Centers for Disease Control and Prevention, September 29, 2020.

[127] See, for example, Mehgan Gallagher, "The Truth Behind Home Health Aide Certification Requirements," O'Neill Institute for National and Global Health Law (Georgetown University Law School), February 15, 2018; and AARP, "Family Caregiving, How to Hire a Caregiver," September 27, 2021.

[128] See, for example, Christopher Rowland, "Senior Care Is Crushingly Expensive. Boomers Aren't Ready," *Washington Post*, March 20, 2023.

[129] See, for example, Kristin Butcher, Kelsey Moran, and Tara Watson, "Immigration and the Care of America's Older Population—Analysis," *Eurasia Review*, March 1, 2022; and Joshua Rodriguez, "Immigrant Labor Holds the Key to Whether Americans Can Age at Home," Niskanen Center, February 15, 2022.

[130] See, for example, Joanne Binette and Kerri Vasold, "Home and Community Preferences: A National Survey of Adults Age 18-Plus," *AARP Research*, August 2018; and Judith D Kasper, Jennifer L Wolff, and Maureen Skehan, "Care Arrangements of Older Adults: What They Prefer, What They Have, and Implications for Quality of Life," *The Gerontologist*, vol. 59 (2019), pp. 845-855.

[131] See, for example, Kristin Butcher and Tara Watson, *Immigration and Tomorrow's Elderly*, Working Paper, Peter G. Peterson Foundation, March 15, 2019; and Donald Redfoot, Lynn Fienberg, and Ari N. Houser, "The Aging of the Baby Boom and the Growing Care Gap: A Look at Future Declines in the Availability of Family Caregivers," AARP Public Policy Institute, August 2013. Some research suggests that an increase in the less-educated, foreign-born labor force share in a given locale substantially reduces institutionalization among the elderly. See, for example, Domininkas Mockus, "The Effect of Immigration on the Living Arrangements of Elderly Natives," SSRN 3982734, December 16, 2021; and Kristin F. Butcher, Kelsey Moran, and Tara Watson, *Immigrant Labor and the Institutionalization of the U.S.-Born Elderly*, National Bureau of Economic Research, Working Paper no. 29520, November 2021.

training, licensure, experience, and English proficiency in their field."[132] Some home health care workers may be LPNs or VNs and therefore would be covered by USCIS credentialing organizations, but occupations such as nursing assistant and personal care aide would not be covered and therefore could not be so certified.

Some contend that foreign workers are essential to help fill the shortage of home health care workers.[133] They cite a broader pattern of staffing shortages leading to more stressful working conditions in health care settings. Some cite worker burnout as a primary cause for workers quitting their jobs.[134]

Using immigration policy as a means to address shortages of home health care workers raises broader issues about the U.S. labor market for relatively less-skilled workers.[135] Unlike labor market forces surrounding medical professionals such as nurses and doctors, the shortage of home health care workers does not reflect a lack of skilled personnel who require time-intensive training and certification. Because home health care work has relatively low barriers to entry, it provides employment opportunity for relatively less-educated U.S. workers. Some observers dispute the existence of labor shortages more generally, particularly where lower-skilled workers are concerned, and argue that when there are not enough lower-skilled workers available to fill jobs, this may indicate that the jobs offer insufficient wages and/or unattractive working conditions as opposed to a labor shortage.[136] In light of this perspective, some may view the desirability of using immigration policy to fill lower-skilled home health care positions differently than using immigration policy to fill high-skill medical positions.

## Nursing Home Workers

Many of the same workforce issues for the home health care sector exist for nursing homes. Nursing and residential care facilities lost roughly 400,000 employees, or about 12% of their workforce, between early 2020 and 2022 before rebounding more recently.[137] Nursing homes often face recruitment competition for nurses and other skilled professionals from hospitals that provide more diverse career experience and often higher pay.[138] Nursing homes may be able to use some of the immigration options discussed in this report to recruit nurses but may also face similar challenges as home health care employers when it comes to staffing.

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[132] DHS, USCIS, "Health Care Worker Certification," June 9, 2022.

[133] See, for example, Abha Bhattarai, "Worker Shortages Are Fueling America's Biggest Labor Crises," *Washington Post*, September 16, 2022; Jason Laljee and Juiana Kaplan, "Workers Are Getting Bolder. The Number of Strikes Tripled from Last Year as Americans See Their Wages Shrink and Bosses Profit," *Business Insider*, September 17, 2022; and Ben Finley and Tom Krisher, "Labor Shortage Leaves Union Workers Feeling More Emboldened," Associated Press, September 6, 2021.

[134] Lisa S. Rotenstein et al., "The Association of Work Overload with Burnout and Intent to Leave the Job Across the Healthcare Workforce During COVID-19," *Journal of General Internal Medicine*, 2023, https://doi.org/10.1007/s11606-023-08153-z; and Petros Galanis et al., "Nurses' Burnout and Associated Risk Factors During the COVID-19 Pandemic: A Systematic Review and Meta-Analysis," *Journal of Advanced Nursing*, vol. 77 (2021), pp. 3286-3302.

[135] For a more in-depth discussion of labor market imbalances, see CRS Report R47059, *Skills Gaps: A Review of Underlying Concepts and Evidence*.

[136] See, for example, Heidi Shierholz, "U.S. Labor Shortage? Unlikely. Here's Why," Economic Policy Institute, May 4, 2021; Justin Schweitzer and Rose Khattar, "It's a Good Jobs Shortage: The Real Reason So Many Workers Are Quitting," Center for American Progress, December 7, 2021; and Robert Reich, "There Is No US Labor Shortage. That's a Myth," *The Guardian*, January 15, 2023.

[137] U.S. Bureau of Labor Statistics, "Nursing and Residential Care Facilities," (NAICS Code 623), *Employment, Hours, and Earnings from the Current Employment Statistics Survey (National)*, data extracted January 27, 2023.

[138] Jordyn Reiland, "Why Immigration Falls Short as a Nursing Home Workforce Solution—and How to Fix It," *Skilled Nursing News*, August 23, 2022.

## Health Care Brain Drain and Worker Shortages Abroad

Migration of health care workers to the United States may create health care access considerations for migrant source countries. This phenomenon is sometimes referred to as *brain drain* in the context of physician shortages. However, the recruitment of foreign workers may contribute to shortages of all types of health care workers from sending countries.[139]

This may be a particular challenge for developing countries and countries with large emigrant health worker populations. For example, India—the largest source of physicians working abroad—has implemented policies to reduce emigration because of its own shortage of health workers.[140] Some observers argue that countering brain drain is the responsibility of both the sending countries, through increasing domestic training and employment opportunities to encourage providers to stay, and the recipient countries, through producing an adequate workforce to meet their population's needs.[141] The salience of this issue is highlighted by the fact that recipient countries are generally high-income countries, while countries whose health workers emigrate are more likely to be low- and middle-income countries. Given U.S. investments in international development and global health,[142] proposals to facilitate the admission of foreign health care workers to the United States may benefit from consideration of both the need for workers in the U.S. labor market and the impact on the countries from which such workers emigrate.

# Concluding Observations

Facilitating the admission of foreign health care workers represents one policy response among several available to Congress to address U.S. health care labor market needs. Other responses include policies that expand wages and benefits for health care workers and/or provide additional training and economic incentives to encourage more U.S. workers to pursue careers in health care.[143]

Discussion of admissions for foreign health care workers raises broader questions about the existing U.S. system for training health care professionals.[144] Some observers, for example, contend that the number of physician residency programs is insufficient to meet a growing

[139] See, for example, James Buchan, Howard Catton, and Franklin A. Shaffer, *Sustain and Retain in 2022 and Beyond: The Global Nursing Workforce and the Covid-19 Pandemic*, International Centre on Nurse Migration, January 2022; Stephanie Nolen, "Rich Countries Lure Health Workers from Low-Income Nations to Fight Shortages," *New York Times*, January 24, 2022; and Kingsley Ighobor, "Diagnosing Africa's Medical Brain Drain," *Africa Renewal*, December 2016-March 2017.

[140] Margaret Walton-Roberts and S. Irudaya Rajan, *Global Demand for Medical Professionals Drives Indians Abroad Despite Acute Domestic Health-Care Worker Shortages*, Migration Policy Institute, January 23, 2020, https://www.migrationpolicy.org/article/global-demand-medical-professionals-drives-indians-abroad.

[141] G. Richards Olds, "How to Reverse the Medical Brain Drain," World Economic Forum, October 16, 2016, https://www.weforum.org/agenda/2016/10/how-to-reverse-the-medical-brain-drain/; and Giorgio Cornetto et al., "Health Workforce Brain Drain: From Denouncing the Challenge to Solving the Problem," *PLOS*, vol. 10, no. 9 (September 17, 2013).

[142] For more information, see CRS In Focus IF11758, *U.S. Global Health Funding: FY2020-FY2023 Appropriations*.

[143] Several programs in the Bureau of Health Workforce at the Health Resources and Services Administration provide training opportunities for health workforce students in areas such as opioid treatment. See HHS, Health Resources and Services Administration, "Behavioral Health Workforce Education and Training Program, Academic Years 2014-2019."

[144] See, for example, The White House, *Economic Report of the President*, March 2023, p. 202.

demand and that many foreign nationals are granted these residencies at the expense of U.S. citizen trainees who are then unable to practice medicine.[145]

Training health care professionals in the United States is a relatively expensive and time-consuming undertaking. While debates about foreign workers typically consider impacts on native workers, an aspect worth consideration is the investment made, often with taxpayer funds, in the health care education and training of foreign nationals who subsequently often have little choice but to leave the United States. For example, the federal government provides the primary sources of support for medical residency training, expending approximately $150,000 per year per resident. Apart from the care provided while residents reside in the United States, that investment is transferred elsewhere when such residents return home or move to other countries.[146]

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[145] U.S. Congress, House Committee on the Judiciary, Subcommittee on Immigration and Citizenship, *Is There a Doctor in the House? The Role of Immigrant Physicians in the U.S. Healthcare System*, testimony of David J. Skorton, president and CEO of the Association of American Medical Colleges; Raghuveer Kura, interventional nephrologist at Poplar Bluff Regional Medical Center; Kristen A. Harris, principal at Harris Immigration Law; and Kevin Lynn, co-founder of Doctors Without Jobs, 117th Cong., 2nd sess., February 15, 2022.

[146] For general information on training, see CRS Report R44376, *Federal Support for Graduate Medical Education: An Overview*.

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