American Hospital Association™
Advancing Health in America

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September 24, 2026

Joseph B. Edlow
Director, U.S. Citizenship and Immigration Services
U.S. Department of Homeland Security
5900 Capital Gateway Drive
Camp Springs, MD 20746

Re: Fee for Certain H-1B Petitions (USCIS-2026-0298), Aug. 25, 2026

Dear Director Edlow:

On behalf of our nearly 5,000 member hospitals, health systems and other healthcare organizations, our clinician partners — including more than 270,000 affiliated physicians, 2 million nurses and other caregivers — and the 43,000 healthcare leaders who belong to our professional membership groups, the American Hospital Association (AHA) appreciates the opportunity to comment on the Department of Homeland Security's (DHS) proposed fee for H-1B petitions.

DHS' proposed regulation would establish a new $103,265 fee for H-1B visa petitions that are subject to statutory caps. The AHA is concerned that the proposed filing fee would hinder hospitals and health systems' ability to use the H-1B visa program to fill critical shortages of highly skilled healthcare workers, thus leading to less access to care. The fee's impact could be especially significant for hospitals and health systems serving rural and other underserved communities where staffing shortages are the most acute. **The AHA recommends that DHS make healthcare professionals exempt from any additional fees to ensure continued access to timely, high-quality care for all communities.**

Workforce Shortages
Communities across America depend on a highly qualified and engaged workforce to ensure access to quality care 24 hours per day, seven days per week. However, the U.S. continues to face long-term, structural shortages of physicians, nurses, clinical laboratory experts and other highly skilled and educated healthcare professionals. For example:

- Data from the Health Resources and Services Administration (HRSA) shows that the nation is projected to have a shortage of 141,160 full-time equivalent

physicians by 2038, with rural or non-metro areas experiencing greater shortages than other parts of the country.[1]

- For nurses, the National Center for Health Workforce Analysis projects by 2038 a shortage of more than 108,000 registered nurses nationwide, with an 11% shortage in non-metro areas.[2]
- There are also critical shortages of medical laboratory personnel, with the most recent comprehensive survey from the American Society of Clinical Pathology showing average vacancy rates of between 7.7% and 28.5% across laboratory areas.[3]

Hospitals and health systems are also seeing more clinicians leave the healthcare field due to burnout and retirement, thereby exacerbating already critical shortages. Hospitals have responded to these challenges with robust efforts to bolster recruitment and retention and have invested in providing higher wages despite the substantial financial headwinds they continue to face.

H-1B Visas

H-1B-sponsored health professionals are essential in filling gaps in areas where care is urgently needed and do not replace U.S. workers. Rather, they supplement the domestic workforce and maintain access to care in the communities where recruitment challenges are most acute. Hospitals, states and the federal government have invested heavily in recruiting and training physicians and other healthcare workers, including through scholarships, loan repayment programs, rural residency programs and other workforce development initiatives.[4,5] Despite these investments, workforce shortages persist, and the domestic healthcare workforce remains insufficient to meet current needs, particularly in rural and underserved communities. Even with additional resources, these shortages cannot be resolved quickly. Educating, training and licensing new providers takes years, including 7 to 15 years for physicians, and 7 to 10 years for certified registered nurse anesthetists.[6,7] .

While the U.S. must invest more in training the next generation of healthcare workers, recruiting qualified foreign-trained healthcare professionals with H-1B visas is an effective short-term approach to increasing supply of health care professionals and thus

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[1] https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/State-of-US-Health-Care-Workforce-2025.pdf
[2] https://data.hrsa.gov/topics/health-workforce/nchwa/workforce-projections
[3] https://academic.oup.com/ajcp/article/164/5/759/8267738?guestAccessKey=b71106ba-dacd-4d92-8942-8b6f621d868c&login=false#540715239
[4] https://www.hrsa.gov/sites/default/files/hrsa/rural-health/rhd-2023-expanding-rural-workforce-development.pdf
[5] https://www.ncsl.org/health/strengthening-the-rural-health-workforce
[6] https://www.aamc.org/media/36776/download
[7] https://www.aana.com/about-us/about-crnas/become-a-crna/

ensuring access to care in communities across the country. These professionals make up less than 5% of H-1B visa holders currently in the U.S., and in fiscal year 2024, H-1B-sponsored physicians made up just 1% of all practicing physicians. Even with these 11,080 professionals, the U.S. still experienced a shortage of 64,000 physicians by the end of the year.[8]

H-1B health care professionals play an especially critical role in addressing acute workforce shortages and expanding access to care in rural and underserved areas. More than 101 million people live in regions designated by HRSA as Health Professional Shortage Areas (HPSAs), and 153 million live in areas without enough mental health providers.[9] Fourteen percent of all Americans live in rural areas, but only 10% of U.S. physicians practice in rural communities.[10]

A 2025 study in the Journal of the American Medical Association found that rural counties, counties with the highest poverty levels and counties most affected by workforce shortages also had the highest number of H-1B-sponsored professionals, including physicians, nurse practitioners, physician assistants, nurse anesthetists and other healthcare workers.[11] AHA members also report that H-1B-sponsored professionals are especially critical for "persistently hard-to-fill" roles, including subspecialties such as cardiology, oncology, psychiatry, rural medicine and critical care, as well as non-direct-care roles such as laboratory scientists and researchers.[12] In some rural communities, the ability to recruit even one H-1B professional can be the difference between keeping a clinical position filled and service lines, like oncology or obstetrical services, open for their communities.

The AHA is concerned that the proposed fee would disproportionately harm the rural and safety-net providers that depend most on H-1B-sponsored professionals but are least able to absorb additional recruitment costs. More than 40% of rural hospitals are operating at a financial loss, with hundreds more at high financial risk, threatening access to care in communities that often have few or no alternative providers.[13] Many of these providers lack the university or research-institution affiliation needed for cap-exempt status, leaving them subject to the proposed fee – a cost they can ill afford.

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[8] https://jamanetwork.com/journals/jama/fullarticle/2840740
[9] https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard
[10] https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf
[11] https://jamanetwork.com/journals/jama/fullarticle/2840740
[12] https://www.aha.org/2026-04-01-fact-sheet-impact-h-1b-filing-fee-health-care-workforce
[13] https://www.chartis.com/insights/2026-rural-health-state-state?_gl=1*mrrt61*_up*MQ..*_ga*MTcwNTIwODE1OC4xNzg5NjU1ODg5*_ga_R8WTPS62NW*czE3ODk2NTU4ODgkbzEkZzEkdDE3ODk2NTYwOTQkajYwJGwwJGgw

This standalone fee would be in addition to the current filing and statutory fees and other applicable fees and payments, including any separate payment required under a presidential proclamation. The AHA appreciates that the proposed policy would apply only to cap-subject H-1B petitions, lessening its potential impacts on healthcare professionals who qualify for cap exemptions. However, the proposed fee would still apply to those healthcare workers who are subject to the lottery process, as they are not hired by cap-exempt employers.

Furthermore, the proposed fee could negatively impact the recruitment of foreign-trained physicians who have recently completed graduate medical education (GME) in the U.S. To practice in the U.S., most foreign-trained physicians must complete one to three years of GME, even if they have foreign training and already completed medical residency in their home country (although some states have waived these requirements). To pursue U.S.-based GME, physicians generally must first apply for and receive a J-1 visa. After completing their GME program, the individual is required to leave the U.S. and fulfill a two-year home-country physical presence requirement. In instances where they do not qualify for an H-1B cap exemption, these H-1B visa holders, who are already trained in U.S. residency programs and familiar with U.S. clinical standards, would be among those who would be subject to the petition fee should they want to return to the U.S. after their residency for work.

Lastly, if DHS is intent on adopting this policy, we urge it to mitigate its potential impact on foreign-trained physicians who have received a waiver of the home-country physical presence obligation provided through the Conrad 30 Waiver Program. The program is available in all 50 states, the District of Columbia, Puerto Rico and Guam, and supports up to 30 international medical graduates each year per state or territory for a J-1 waiver. Each state has developed its own application rules and guidelines for these waivers, but all J-1 graduate students are required to, among other conditions, fulfill a three-year commitment to practice medicine in an H-1B nonimmigrant status at a healthcare facility located in an area or serving a population designated by the U.S. Department of Health and Human Services as an HPSA, Medically Underserved Area, or Medically Underserved Population. The proposed rule would apply the new fee to cap-subject H-1B petitions requesting a change of status inside the U.S. as well as those processed through a consular post abroad. As a result, some Conrad 30 physicians changing from J-1 to H-1B status while remaining in the U.S. would be subject to the new fee. The AHA urges DHS to implement an exemption for Conrad 30 physicians.

Given the staffing and financial challenges hospitals and health systems already face, the proposed H-1B fee likely would prevent many providers from continuing to recruit essential healthcare staff and could force a reduction in the services they are able to provide. The AHA asks DHS to exempt cap-subject H-1B petitions for healthcare professionals from its proposed $103,265 fee.

We thank DHS for the opportunity to comment on this proposed rule. We stand ready to work with the agency to ensure its policies support access to quality care in communities across America. Please contact me if you have any further questions, or feel free to have a member of your team contact Adrienne Thomas, AHA senior associate director for standards and care delivery policy, at athomas@aha.org.

Sincerely,

/s/

Stacey Hughes
Executive Vice President
Government Relations and Public Policy