



MASSACHUSETTS MEDICAL SOCIETY

Every physician matters, each patient counts.

September 21, 2026

Samantha Deshommes, Chief
Regulatory Coordination Division, Office of Policy and Strategy
U.S. Citizenship and Immigration Services
Department of Homeland Security
Submitted electronically via www.regulations.gov

Re: Notice of Proposed Rulemaking, *Fee for Certain H-1B Petitions*, 91 Fed. Reg. 54817 (Aug. 25, 2026); DHS Docket No. USCIS-2026-0298; CIS No. 2861-26; RIN 1615-AD20

Dear Ms. Deshommes:

On behalf of the Massachusetts Medical Society (MMS), which represents more than 20,000 physicians, residents, and medical students, we appreciate this opportunity to provide comment on the above-referenced proposed rule that would impose a new, standalone \$103,265 fee on all H-1B cap-subject petitions, including those otherwise eligible for the advanced-degree exemption. MMS has a longstanding institutional interest in the adequacy of the physician workforce available to care for our patients, an interest this proposed rule directly and adversely affects.

For the reasons set forth below, MMS urges DHS to withdraw this proposed rule. Among other concerns, the rule (1) would materially worsen an already severe strain on the health care workforce; (2) exceeds DHS' statutory authority; and (3) would drive scarce, U.S.-trained physician talent to other countries at the exact moment the nation can least afford to lose these highly skilled individuals. In the alternative, if DHS proceeds to finalize any version of this fee, MMS urges DHS to categorically exempt physicians from its imposition.

I. Health Care Workforce

The United States is in the midst of a well-documented and worsening physician shortage. The Association of American Medical Colleges ("AAMC") projects that the nation will face a shortfall of up to 86,000 physicians by 2036, including a shortage of up to 40,000 primary care physicians and nearly 20,000 surgical specialists. Other analyses place the current shortage at roughly 64,000 physicians as of year-end 2024, growing to a projected shortfall of 141,000 physicians nationwide by 2038. In Massachusetts, the Health Policy Commission and the Massachusetts Health Quality Partners' primary care dashboard have separately documented declining primary care capacity and access, and MMS' own workforce studies have identified critical shortages across the Commonwealth.

International medical graduates ("IMGs") are indispensable to closing this gap. Roughly one in four practicing U.S. physicians is an IMG, and IMGs disproportionately practice in rural areas, medically underserved communities, and shortage specialties such as primary care, psychiatry, and geriatrics, which are precisely the areas and specialties where the AAMC projects the most severe shortfalls. Many of these physicians first enter the United States on J-1 exchange visitor status and, through the Conrad State 30 program or a similar waiver, remain to serve in a federally designated shortage area, later transitioning to

H-1B status through the cap-subject petition process that this rule would further burden. Others are recruited directly into H-1B status by community hospitals, rural health systems, and independent physician practices that are not affiliated with a university or nonprofit research institution and are therefore not cap-exempt under this proposed rule.

Those employers are the ones least able to absorb a \$103,265 per-physician fee. Academic medical centers with a qualifying institutional affiliation are more likely to be cap-exempt; however, the community hospitals, critical access hospitals, and independent or small-group physician practices that serve rural and underserved patients that are frequently the only source of obstetric, psychiatric, or primary care in their service area are not cap-exempt. A recent hospital-sector [survey](#) found that more than 70 percent of hospitals expect such a fee to directly affect patient care. Nearly 40 percent expect a significant impact, and 64 percent of hospitals that use or plan to use H-1B physicians report they will pause, defer, or limit recruitment as a result, with 57 percent of the affected positions being clinical roles. A [2025 study](#) found that the rural counties with the highest poverty and the most severe workforce shortages also have the highest concentration of H-1B-sponsored health professionals, meaning the burden of this fee will fall hardest on the communities that can least afford to lose even a single physician. [According to HRSA](#), 92 million Americans live in a federally designated primary care shortage area and 137 million live in an area without adequate mental health clinicians.

DHS' own Regulatory Flexibility Analysis confirms the severity of this burden: DHS estimates that 76 percent of small entities that filed cap-subject H-1B petitions in fiscal year 2025 would experience a cost increase exceeding one percent of revenue, which DHS itself defines as a significant economic impact. Rather than mitigating that acknowledged harm, DHS expressly declined to exempt or discount the fee for small entities, reasoning that doing so would “create a sizable perverse incentive for employers to avoid the fee.” 91 Fed. Reg. at 54837. In other words, DHS is knowingly directing the heaviest relative burden of this rule onto the smallest, most resource-constrained hospitals and practices. The predictable results of pricing these employers out of the H-1B cap-subject process are fewer physicians recruited, longer wait times, further strain and burnout among the physicians who remain, and reduced access to care in the communities that already face the greatest constraints.

II. The Proposed Fee Exceeds DHS' Statutory Authority

A. The proposed fee lacks the statutory nexus between charge and service that section 286(m) requires. Section 286(m) of the Immigration and Nationality Act, 8 U.S.C. § 1356(m), authorizes DHS to set fees only “for providing adjudication and naturalization services” at a level sufficient to recover “the full costs of providing all such services.” Yet, DHS' own cost tables allocate the proceeds of this fee overwhelmingly to activities that are not services provided to the H-1B petitioner who pays it. An H-1B cap-subject petitioner receives no adjudication or naturalization service from an immigration court, a criminal investigations directorate, a refugee resettlement program, or a labor-certification program serving agricultural employers. Section 286(m) does not authorize DHS to use a single class of fee-payers to cross-subsidize the government's entire immigration enforcement and adjudication apparatus, and section 286(n)'s reimbursement authority does not cure this defect.

B. This proposed rule would circumvent pending litigation. Proclamation 10973's \$100,000 H-1B payment is the subject of ongoing litigation in *California v. Mullin*, a lawsuit in which Massachusetts is a plaintiff and in which the district court vacated DHS' guidance implementing that payment, with the appellate court declining to pause the lower court's blocking of the guidance. Rather than awaiting the final

outcome of that litigation, DHS is now proposing to lock in a substantially similar real-world fee that the courts are currently being asked to review, only this time through a vehicle that would be considerably harder to unwind than the previous proclamation at issue in the pending litigation. DHS all but confirms its intent to do so, noting that if the proclamation's payment requirement is enjoined, "DHS would collect the payment consistent with the terms of the Proclamation," while this rule is "based on different authority." 91 Fed. Reg. at 54831. Finalizing a substantively identical fee through backup regulatory authority while the lawfulness of the original fee is *sub judice* raises serious questions about whether this rulemaking is a good-faith exercise of section 286(m) authority or an attempt to insulate a desired policy outcome from adverse judicial review.

C. This proposed rule is a major question that requires clear congressional authorization. DHS itself estimates that this rule would impose approximately \$8.8 billion in new annual costs and \$74.9 billion over ten years and separately designates the rule "economically significant" under Executive Order 12866 because its annual effects exceed \$100 million. A rule of this magnitude is precisely the kind of extraordinary case in which reviewing courts require the agency to identify clear congressional authorization for the action taken.

D. The rule undermines the advanced-degree exemption Congress enacted. Congress exempted the first 20,000 H-1B petitions filed annually on behalf of workers holding a U.S. master's degree or higher from the annual numerical cap specifically to make it easier for U.S. employers to secure highly educated talent. Physicians hold, at minimum, a doctoral-equivalent degree (M.D. or D.O.). Yet DHS' proposed rule expressly applies the \$103,265 fee to petitions eligible for the advanced-degree exemption, in addition to all other applicable fees. Imposing the single largest fee in USCIS history on precisely the highly-educated class of petitioners that Congress sought to exempt directly violates this evident purpose and is not a result DHS has reasonably explained.

III. The Proposed Fee Would Deprive the United States of Critical Medical Talent

The United States invests substantially in training the physicians this rule would price out of the workforce, including through Medicare-funded graduate medical education positions that underwrite International Medical Graduate (IMG) residency training. A \$103,265 barrier to employing these same physicians, layered atop years of visa processing, existing filing fees, prevailing-wage compliance costs, and immigration counsel fees, will predictably push a meaningful share of them toward other countries that actively recruit U.S.-trained physicians and impose no comparable entry fee. The result would be a one-way transfer of physician talent financed by the American health care system to health systems that bore none of that cost. This situation would result in self-inflicted brain drain of physicians from the U.S. occurring at a moment that the AAMC projects the nation's physician shortage will continue to widen.

IV. DHS Should Categorically Exempt Physicians From the Proposed Fee

MMS' principal request is that DHS withdraw this proposed rule in its entirety. If DHS nonetheless proceeds to a final rule, MMS urges DHS to adopt a categorical exemption from the fee for H-1B petitions filed on behalf of physicians. Such an exemption would be squarely consistent with the approach DHS has already adopted in this very rule: DHS proposes to exempt cap-exempt petitioners affiliated with nonprofit and governmental research organizations and institutions of higher education because those employers serve a public mission that DHS has determined should not bear this cost. Physicians providing direct patient care, often in communities that HRSA has designated as medically underserved, serve that same public mission.

This request is not novel; it reflects an emerging bipartisan consensus. Legislation introduced in the current Congress would exempt health care workers from the comparable \$100,000 H-1B fee imposed by Proclamation 10973, and that effort has been publicly endorsed by the MMS and many national health care societies, including the American Hospital Association, the American Medical Association, and the AAMC. It is likewise consistent with DHS' own past practice of using fee exemptions and waivers to avoid burdening visa applicants whose services serve the public interest. If any population should be shielded from a fee premised on “ability to pay,” it is the community hospitals, rural health systems, and independent physician practices that are net providers of essential, and at time uncompensated, care.

V. Conclusion

For the foregoing reasons, MMS respectfully urges DHS to withdraw this proposed rule. Should DHS nonetheless proceed to finalize it, MMS urges DHS to categorically exempt H-1B petitions filed on behalf of physicians from the fee, consistent with the exemption DHS has already extended to other public-interest petitioners in this same rulemaking. MMS appreciates the opportunity to comment and welcomes the opportunity to discuss these concerns further with DHS. If you have any questions, or if you would like to discuss this matter further, please contact MMS Federal Relations Director, Casey Rojas, JD, MBE at CRojas@MMS.org or by phone at (781) 434-7082.

Sincerely,

Rebecca Brendel, MD, JD
President, Massachusetts Medical Society