



Physicians in an Era of Changing Immigration Policy

The Case of Nephrology

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Contents

Executive Summary	1
1 Introduction	4
A. Research Questions and Methodological Approach	4
B. Rationale for This Study	5
2 Demographic and Workforce Trends Affecting the Supply of and Demand for Nephrologists	6
A. Profile of the Current Nephrology Workforce	6
B. IMGs' Representation and Role in the Nephrology Workforce	7
C. Demand Drivers for Nephrology Services	12
D. Nephrologist Pipeline Challenges and Opportunities	14
3 Recent Policies Affecting the Education-to-Training-to-Practice Pipeline for IMG Nephrologists	15
A. Immigration Policies Affecting the Supply and Training of Immigrant Physicians	15
B. Health-Care Funding Policies That Reduce the Supply of and Demand for Immigrant Health-Care Professionals	22
C. Public Benefit Policies That Reduce Access to Services	23
4 Conclusion and Implications	25
Appendices	28
Appendix A. Nephrology: The Medical Specialty of Kidney Care	28
Appendix B. Spotlight on Indian Physicians: Global Migration Patterns and Opportunities	29
About the Authors	31
Acknowledgments	32

Executive Summary

One in seven U.S. adults live with kidney disease, and nephrology—the specialty responsible for their care—faces a perfect storm: soaring demand from an aging population, projected physician shortages, and sweeping policy changes that threaten to reduce the supply of international medical graduates (IMGs) who have long sustained the field. IMGs are physicians who earned their medical degrees outside the United States, and they comprised 54 percent of practicing nephrologists in 2024, the largest share of any medical specialty. This substantial reliance on IMGs has helped nephrology partially meet growing workforce demands, as 37 million U.S. adults had chronic kidney disease as of 2023 and more than 866,000 had kidney failure as of 2025.

This look at dynamics in one highly specialized field offers a case study for how immigration and other policy changes are affecting the broader high-skill health-care workforce and access to health services in U.S. communities.

This report presents an analysis of workforce and demographic data from numerous sources to discuss the nephrologist workforce and the forces shaping nephrologists' entry into the U.S. health-care system. This look at dynamics in one highly specialized field offers a case study for how immigration and other policy changes are affecting the broader high-skill health-care workforce and access to health services in U.S. communities.

Executive orders, regulatory changes, and proposed or enacted legislative actions under the second administration of President Donald Trump in 2025 and the first nine months of 2026 are poised to alter three policy domains critical to nephrology:

- ▶ **Immigration policy changes that govern how IMGs enter, train, and remain in the United States.** Changes include a final rule replacing the practice of admitting J-1 visa holders for a flexible duration of stay with a fixed period capped at four years (preliminarily blocked by a federal court in September 2026); a revised H-1B visa lottery that favors petitions offering higher wages; proposals for a new fee of \$100,000 or more on certain new H-1B petitions; mandatory in-person visa renewals; and new screening procedures for visa applicants. These changes are already increasing processing times and are likely to reduce predictability for medical training programs and individual physicians.
- ▶ **Health-care and education financing changes that determine institutional capacity to train and employ physicians, including IMGs, and could limit patient access to care.** Changes include reduced federal matching rates for Emergency Medicaid under the budget reconciliation law commonly known as the *One Big Beautiful Bill Act*, and new federal student loan caps of \$50,000 annually and \$200,000 total that will affect access to medical education and subspecialty fellowship training.

- ▶ **Public benefit eligibility changes that shape patient access to care.** Changes include new Medicaid work requirements and recertification procedures; additional restrictions on immigrants' access to Medicaid, the Children's Health Insurance Program, and Medicare; and new expansive rules regarding which immigrants can be deemed "public charges." In addition, modified confidentiality protections and expanded immigration enforcement by U.S. Immigration and Customs Enforcement and other federal agencies could discourage immigrant patients from seeking health care.

Some of these policy changes are under legal review or have not been fully implemented, making any assessment of their full impact premature. However, taken together, these policy trajectories indicate potential workforce supply constraints that may exacerbate existing shortages, particularly in rural and underserved areas where IMGs are concentrated. These constraints will affect many Americans who need kidney care—not only the most vulnerable patients who depend on Medicaid, or immigrants who have lost access to benefits, but also privately insured patients, who are likely to face longer wait times, reduced access to specialists, and deteriorating quality of care.

Other key findings of this research include:

- ▶ **A significant nephrologist shortage is projected by 2038, with no near-term domestic solution.** The supply of nephrologists is projected to meet only 85 percent of demand by 2038. Because training a nephrologist requires a minimum of 13 years of education after high school, even substantial increases in medical school enrollment today would not produce new nephrologists well into the 2030s.
- ▶ **The population of older Americans, nephrology's primary patient base, has grown and will continue to grow.** Between 2010 and 2024, the population of adults ages 65 and older increased by 51 percent to more than 61.2 million, while the population under 65 grew by only 4 percent. Rates of kidney disease are substantially higher among older adults, and the prevalence of diabetes, a leading risk factor, continues to rise across all population groups.
- ▶ **An aging physician workforce is contributing to projected nephrologist shortages.** As of 2024, 32 percent of all U.S. physicians were age 60 or older. Among nephrologists, 31 percent were age 60 or older in 2023, up from 28 percent in 2014. Retirement-driven attrition will increase workforce shortages as demand from an aging patient population continues to rise.
- ▶ **Nephrology relies on IMGs more than any other medical specialty.** IMGs comprised 54 percent of practicing nephrologists and 61 percent of nephrology fellows in 2024. This reliance has grown substantially over the past two decades: IMGs accounted for less than 40 percent of practicing nephrologists in 2004, but their share has continued to grow as interest in nephrology has declined among U.S. medical graduates.
- ▶ **U.S. medical graduates are increasingly choosing other subspecialties, making IMGs an essential resource for kidney care.** In the most recent fellowship match, only 89 U.S. allopathic and 74 U.S. osteopathic candidates applied for nephrology fellowship positions. The proportion of fellowship positions left unfilled through the match rose from 5.9 percent in 2010 to 33.5 percent in 2026, reflecting declining interest among U.S. medical graduates.

- ▶ **IMG nephrologists play a key role in providing care to underserved communities.** As of 2023, 72 percent of U.S. counties lacked a nephrologist, with shortages concentrated in nonmetropolitan and rural areas. Among nephrologists practicing in nonmetropolitan and rural settings, 67 percent of IMGs provided care in federally designated Medically Underserved Areas, compared with 55 percent of U.S. medical graduates.
- ▶ **Nearly half of incoming nephrologists are noncitizens whose training and practice opportunities are shaped by immigration policy changes.** In 2025, 43 percent of nephrology fellows were noncitizens, including 26 percent on J-1 visas, 10 percent on H-1B visas, and 7 percent who were legal permanent residents (i.e., green-card holders). Policy changes affecting visa duration, visa renewal, or adjustment of status could therefore significantly affect the international nephrology pipeline.
- ▶ **India is the single largest source of IMG nephrologists, and future physician migration from that country may now be at risk.** Indian-born physicians accounted for approximately 14 percent of U.S. nephrologists and 5 percent of all physicians nationwide in 2023. Recent visa data suggest that obtaining a U.S. visa has become more difficult for Indian applicants: J-1 visa issuances for all Indian nationals (not only IMGs) fell 36 percent in April–June 2025 compared with the same period in 2024, and as of January 2026, H-1B visa interview appointments in India were already being scheduled for 2027.
- ▶ **The United States has been losing its global competitive edge in attracting international health-care talent.** The share of foreign-trained physicians practicing in the United States versus other developed countries fell from 48 percent to 36 percent between 2010 and 2023, according to data from the Organization for Economic Cooperation and Development. Countries such as Canada, Ireland, and the United Kingdom, which offer more predictable immigration pathways and a comparable quality of life, are attractive alternatives for skilled health-care workers.

The findings of this study, while focused on one specialized medical workforce, have implications relevant to stakeholders both in and beyond the nephrology field. These include professional medical societies such as the American Society of Nephrology and other specialty organizations that track workforce trends and are considering policy engagement; policymakers seeking evidence on how immigration, health-care financing, and benefit eligibility policies affect the health-care workforce; hospital administrators and graduate medical education program directors navigating an uncertain policy environment; and immigration policy analysts, researchers, advocates, and funders interested in how immigration and benefits restrictions affect access to care in underserved communities.

1 Introduction

High-skilled immigrant health professionals are a critical component of the U.S. health-care workforce. In 2024, international medical graduates (IMGs)¹ accounted for more than one-quarter of the 1 million physicians in the United States.² Their role is especially important in nephrology,³ a specialty projected to face significant physician shortages by 2038⁴ and one in which IMGs made up 54 percent of physicians in 2024.⁵

IMGs disproportionately serve rural areas, safety-net institutions, and communities with higher levels of poor and undereducated residents.⁶ Yet a cluster of policy changes and proposals—which fall into three broad categories—threaten to disrupt the supply of these professionals and patients’ access to their services:

- ▶ **immigration policies** governing physician entry, access to medical residency and fellowships, and permanent residence (green-card) pathways;
- ▶ **health-care financing policies** affecting institutions that sponsor, train, and employ physicians, including medical education funding and safety-net institution reimbursement; and
- ▶ **public benefit eligibility policies** affecting patient access to care, particularly in communities where many IMGs practice.

A. Research Questions and Methodological Approach

This study examines demographic and workforce trends in nephrology and analyzes policy changes that affect IMG physicians. The research addresses four questions:

- 1 What are the key demographic and workforce trends that have been shaping nephrology and the broader medical field?

1 International medical graduates (IMGs) are physicians who graduated from medical schools outside the United States. What defines them is where they were educated, not where they were born or hold citizenship, so the category includes both foreign-born and U.S.-born physicians. Most IMGs are foreign born, and for them, entry into U.S. graduate medical education and the ability to practice depend on immigration policy as well as U.S. medical licensing requirements. Physicians who graduated from U.S. medical schools are referred to as U.S. medical graduates. In the data discussed in this report, IMGs are physicians (foreign and U.S. born) who have met the requirements to practice in the United States, which in most cases includes currently doing or having completed a U.S. residency. One caveat is that before July 2025, physicians educated in Canada were counted as U.S. medical graduates. Because the most recently available data are from 2024, the IMG counts and shares in this report exclude Canadian-educated physicians, as they are counted in the dataset as U.S. medical graduates. See Aaron Young et al., “FSMB Census of Licensed Physicians in the United States, 2024,” *Journal of Medical Regulation* 111, no. 2 (2025): 7–17.

2 Authors’ analysis of Association of American Medical Colleges (AAMC), “U.S. Physician Workforce Data Dashboard: 2024,” accessed August 31, 2026. The dashboard is based on the American Medical Association (AMA) Physician Professional Data (PPD).

3 See Appendix A for a brief description of the specialized care nephrologists provide.

4 National Center for Health Workforce Analysis (NCHWA), “Physician Workforce: Projections, 2023–2038” (fact sheet, U.S. Health Resources and Services Administration, Rockville, MD, December 2025).

5 Authors’ analysis of AAMC, “U.S. Physician Workforce Data Dashboard.”

6 Neeraj Kaushal, Robert Kaestner, and Tsewang Rigzin, “Foreign-Trained Physicians in the United States: A Descriptive Profile,” *Medical Care Research and Review* 79, no. 5 (2022): 717–30.

- 2 What is the role of IMGs and how do they fit into discussions about the challenges facing workforce sustainability?
- 3 What recent policies affect IMGs' access to medical residency and training, their ability to practice medicine, and their ability to remain in the United States?
- 4 What policy priorities and research directions should leading medical societies such as the American Society of Nephrology (ASN) and research organizations consider to strengthen the U.S. physician workforce?

The analysis draws on multiple data sources. Nephrology and broad health-care workforce data are from the research and data systems of ASN, the Association of American Medical Colleges, and the Federation of State Medical Boards. Additional demographic analysis draws from the U.S. Census Bureau's 2024 American Community Survey. The policy analysis includes review of federal legislation, executive orders, agency regulations and guidance, and legal challenges during 2025 and the first nine months of 2026. The research team also conducted interviews with ASN and U.S. medical school leadership to understand early implementation effects and institutional responses.

B. *Rationale for This Study*

Trends in nephrology are not only important in and of themselves for Americans' health, but they also provide an important case study for examining the impacts of immigration policy on the broader, high-skill immigrant health-care workforce and on access to health services. The specialty is particularly sensitive to immigration policy changes because it has the highest concentration of IMGs of any medical field. Nephrology's patient population also has several notable characteristics: It tends to be older, given

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the higher prevalence of kidney disease among older adults; racial/ethnic minorities, immigrants, and Medicaid enrollees are overrepresented; and significant rural-urban disparities affect access to services. These factors create multiple pathways through which policy changes can affect kidney-care delivery and quality.

The study's findings are relevant to medical fields beyond nephrology. IMGs make up more than one-quarter of physicians in other medical specialties, many of which also face physician shortages. The effects of immigration, health-care financing, and public benefit eligibility policies will be felt in a variety of specialties, including internal medicine and geriatrics, that face similar workforce challenges and reliance on IMGs.

2 Demographic and Workforce Trends Affecting the Supply of and Demand for Nephrologists

Understanding trends in the supply of nephrologists and the demand for kidney care is essential to assess how policy changes may affect access to services. This section examines the profile of the nephrology physician workforce, the role of IMGs within it, and the demographic factors driving increased demand for nephrology services.

A. *Profile of the Current Nephrology Workforce*

Growth over Time and Projections

The U.S. physician workforce has grown substantially over the past decade and a half, increasing by 27 percent since 2010,⁷ outpacing total U.S. population growth. About 1 million licensed U.S. physicians cared for a national population of more than 340 million people in 2024, a ratio of 318 licensed physicians per 100,000 people, up from 277 in 2010.⁸ Nephrology experienced particularly robust expansion during this period, increasing by 67 percent between 2008 and 2024 from about 7,600 nephrologists to approximately 12,600, outpacing many other medical specialties.⁹

Despite this growth, existing and projected shortages are severe. The United States is expected to face a shortage of more than 141,000 physicians across all specialties by 2038.¹⁰ Nephrology is projected to face troubling shortfalls, with a percent adequacy of 85 percent by 2038. This means that for every seven nephrologists needed, only six are projected to be available and the other one position will go unfilled.¹¹

This shortfall places nephrology among other specialties with similarly large projected workforce deficits, including cardiology (85 percent), geriatrics (84 percent adequacy), and general internal medicine (83 percent).¹² These projections indicate that despite growth in fellowship positions in recent years, the nephrology field will struggle to meet growing demand for services. The projected shortage is especially concerning because of nephrology's critical role in managing kidney disease and kidney failure.

7 Young et al., "FSMB Census."

8 Young et al., "FSMB Census."

9 Authors' analysis of AAMC, "U.S. Physician Workforce Data Dashboard." Data for 2008 provided to the authors by Kurtis Pivert, Director of Data Science for the American Society of Nephrology (ASN) Alliance for Kidney Health.

10 NCHWA, "Physician Workforce: Projections, 2023–2038."

11 NCHWA, "[Workforce Projections](#)," accessed on September 1, 2026. According to NCHWA projections, the total percent adequacy—the projected number of doctors active in the workforce divided by the number of doctors required to provide a level of service—is 85 percent for nephrologists, compared with 88 percent for all physicians. See NCHWA, "Physician Workforce: Projections, 2023–2038." For details on definitions and the microsimulation model that projects the current and future supply of and demand for health-care workers by occupation, geographic area, and year, see NCHWA, "[Health Workforce Projections Dashboard](#)," accessed on September 1, 2026.

12 NCHWA, "Workforce Projections."

A Graying Workforce

Workforce aging adds to the supply challenge. Like the U.S. population overall, the physician workforce is aging. As of 2024, 32 percent of U.S. physicians were ages 60 and older. Between 2010 and 2024, the number of licensed physicians ages 60 and older increased by 57 percent, compared with a 25-percent increase in the number of physicians younger than 50.¹³

The trend is similar among nephrologists: The share of physicians ages 60 and older was 31 percent in 2023, up from 28 percent in 2014, increasing the likelihood that retirements in the coming years will create significant replacement challenges.¹⁴

Geographic Distribution Challenges

Shortages of health-care professionals are especially pronounced in rural communities. While 20 percent of the U.S. population lived in rural areas as of 2020, only 11 percent of physicians practiced in those areas.¹⁵ Similarly, nephrologists are unevenly distributed across the United States, ranging from 5.53 nephrologists per 100,000 residents in the District of Columbia as of 2023 to a low of 1.02 nephrologists per 100,000 in Wyoming.¹⁶ Rural and other nonmetropolitan areas face far greater shortages than metropolitan areas: As of 2023, 72 percent of U.S. counties lacked a nephrologist,¹⁷ and 77 percent of those counties were in nonmetropolitan areas.¹⁸ These geographic disparities challenge equitable access to nephrology care across regions and highlight the potential for severe shortages in specific communities.¹⁹

B. IMGs' Representation and Role in the Nephrology Workforce

IMG representation is substantially higher in nephrology than in the overall U.S. physician workforce. In 2024, IMGs accounted for more than half (54 percent) of practicing nephrologists, compared with nearly 26 percent of all U.S. physicians.²⁰ The IMG share of nephrologists has grown substantially over the past two decades, as IMGs represented less than 40 percent of practicing nephrologists in 2004. As of 2024, IMGs accounted for 61 percent of nephrology fellows, the next generation of nephrologists.²¹

However, nephrology is not the only medical specialty that relies heavily on IMGs. IMGs represented one-quarter or more of all active physicians in 24 other specialties in 2024 (see Table 1). Specialties that similarly employ large shares of IMGs and are increasingly important to serving an aging U.S. population

13 Young et al., "FSMB Census."

14 Data provided to the authors by Kurtis Pivert of ASN based on his analysis of the 2023 AMA PPD.

15 U.S. Census Bureau, "2020 Census Urban Areas Facts," accessed September 2, 2026; Stacy Weiner, Patrick Boyle, and Bridget Balch, "Rural Medical Students and the Match," AAMC News, March 19, 2025.

16 Data provided to the authors by Kurtis Pivert of ASN based on his analysis of the 2023 AMA PPD.

17 Data provided to the authors by Kurtis Pivert of ASN based on his analysis of the 2023 AMA PPD. Other specialties are also in short supply. For example, nearly half of U.S. counties lacks a cardiologist. See Mark Johnson, "Counties Most in Need of Cardiologists Are the Most Likely to Have None," *The Washington Post*, July 29, 2024.

18 Data provided to the authors by Kurtis Pivert of ASN based on his analysis of the 2023 AMA PPD.

19 Edward Salsberg, Leah Masselink, and Xiaoli Wu, *The US Nephrology Workforce: Developments and Trends* (Washington, DC: ASN, 2014).

20 Authors' analysis of AAMC, "U.S. Physician Workforce Data Dashboard."

21 Accreditation Council for Graduate Medical Education (ACGME), *Data Resource Book Academic Year 2023–2024* (Chicago: ACGME, 2024).

include geriatrics (52 percent) and endocrinology, diabetes, and metabolism (46 percent). IMGs are also concentrated in specialties that are projected to face physician shortages: internal medicine (41 percent), pathology (36 percent), cardiovascular disease (32 percent), and family medicine (26 percent).²²

TABLE 1

Specialties in Which International Medical Graduates Make up More Than 25 Percent of Practitioners, 2024

Specialty	Active Physicians	Share Who Are IMGs
Nephrology	12,600	53.5%
Geriatric medicine	6,700	52.4%
Interventional cardiology	6,000	48.2%
Endocrinology, diabetes, and metabolism	9,200	45.6%
Clinical neurophysiology	2,800	42.6%
Critical care medicine	17,500	41.3%
Internal medicine	129,000	40.8%
Hematology and oncology	186,000	38.6%
Infectious diseases	11,000	37.3%
Rheumatology	7,100	37.3%
Clinical cardiac electrophysiology	3,200	36.7%
Neonatal-perinatal medicine	6,700	36.6%
Pathology	21,800	36.0%
Pulmonary disease	4,500	33.2%
Neurology	14,900	32.5%
Cardiovascular disease	23,000	32.4%
Child and adolescent psychiatry	11,100	31.2%
Gastroenterology	17,200	30.5%
Psychiatry	40,800	29.6%
Pediatric cardiology	3,500	27.1%
Pediatric critical care medicine	3,400	27.0%
Family medicine/general practice	126,200	25.9%
Pediatric hematology/oncology	3,700	25.8%
Obstetrics and gynecology	44,000	25.6%
Hospice and palliative medicine	3,500	25.2%
All active physicians	1,032,400	25.6%

Source: Authors' analysis of the Association of American Medical Colleges, "U.S. Physician Workforce Data Dashboard: 2024," accessed August 31, 2026.

IMGs' geographic mobility and visa requirements influence their practice locations to some extent. For many IMGs who arrive on temporary J-1 or H-1B visas to pursue U.S. medical residency, these visas open opportunities for U.S. employment and eventual transition to permanent residence. One such opportunity

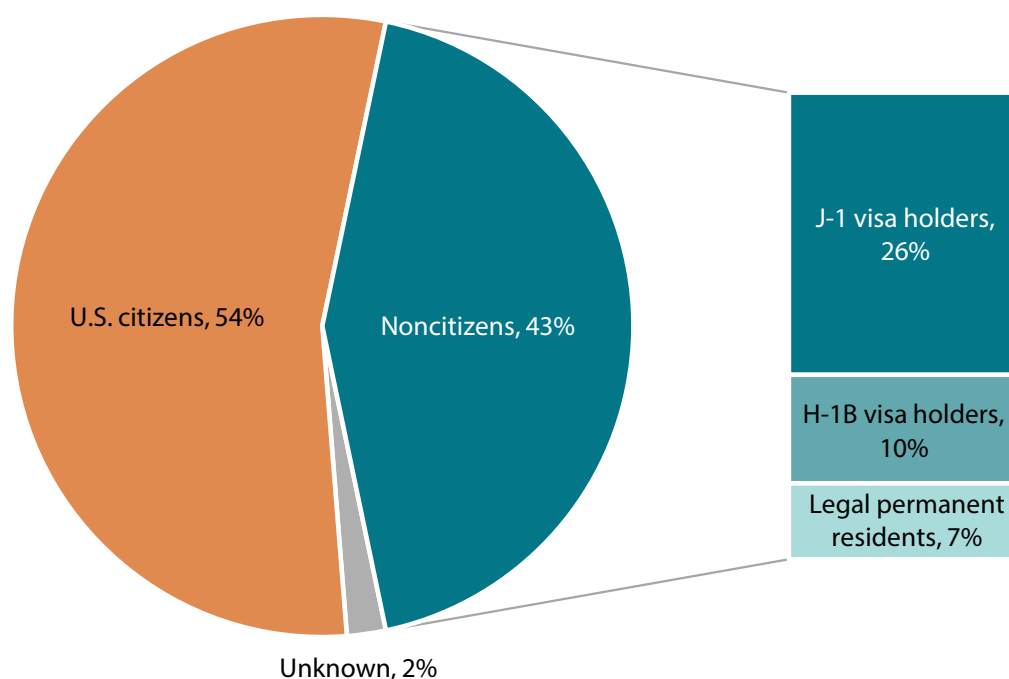
²² To see which specialties are projected to experience shortages, see NCHW, "Physician Workforce: Projections, 2023–2038."

is a three-year commitment to practice in federally designated Medically Underserved Areas or Health Professional Shortage Areas.²³ In 2021, about 64 percent of IMGs provided care in such areas, and almost 46 percent of these physicians practiced in rural areas.²⁴ Among nephrologists practicing in nonmetropolitan or rural settings in 2023, 67 percent of IMGs practiced in Medically Underserved Areas, compared with 55 percent of U.S. medical graduates.²⁵

IMG nephrologists hold differing immigration statuses (see Figure 1), with implications for workforce stability at a time of rapid changes in immigration policy. According to a 2025 ASN survey of nephrology fellows:²⁶

- ▶ 26 percent held J-1 visas, the nonimmigrant “exchange visitor” visa IMGs use the most for U.S. medical residency and fellowship training.
- ▶ 10 percent held H-1B visas, a nonimmigrant “specialty occupation” visa IMGs use to provide direct patient care and, in some cases, to complete residency or fellowship training.
- ▶ 7 percent were legal permanent residents, foreign nationals authorized to live and work in the United States indefinitely, commonly known as green-card holders.

FIGURE 1
Citizenship and Visa Status of Nephrology Fellows, 2025



Note: Shares may not add up to 100 percent due to rounding.

Source: Kurtis A. Pivert et al., *2025 ASN Nephrology Fellow Survey: First Look* (Washington, DC: American Society of Nephrology, 2025).

²³ Kaushal, Kaestner, and Rigzin, “Foreign-Trained Physicians in the United States.”

²⁴ AMA, “AMA Urges DHS to Exempt Physicians from New \$100,000 H-1B Visa Fee” (press release, September 25, 2025).

²⁵ Data provided to the authors by Kurtis Pivert of ASN based on his analysis of the 2023 AMA PPD. Medically Underserved Area status is measured at the census tract level. Nonmetropolitan or rural settings are defined as nonmetropolitan counties corresponding to codes 4–9 of the U.S. Department of Agriculture (USDA) 2023 Rural-Urban Continuum Codes. For Rural-Urban Continuum codes and definitions, see USDA, Economic Research Service, “*Rural-Urban Continuum Codes*,” updated January 2024.

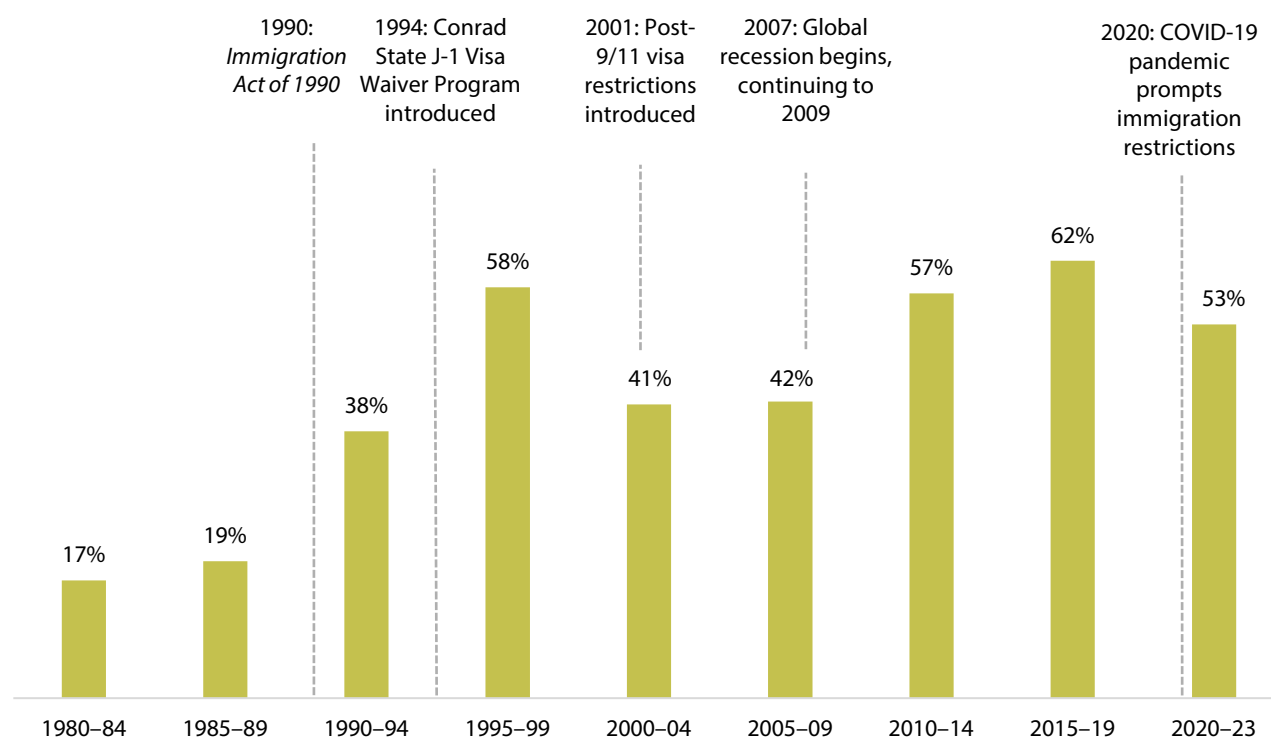
²⁶ Kurtis A. Pivert et al., *2025 ASN Nephrology Fellow Survey: First Look* (Washington, DC: ASN, 2025).

The ASN survey also revealed that IMGs pursue subspecializations that extend their training period at higher rates than U.S. medical graduates. As a result, nephrology fellows on J-1 and H-1B visas are especially vulnerable to changes in immigration and visa policies such as revised duration-of-status rules (discussed in Section 3.A.) that effectively shorten their training periods.

While it may be too early to determine the full impact of immigration and other policies introduced in 2025 and beyond, the effects of earlier immigration policies provide useful context.²⁷ The foreign-born share of nephrology fellows has fluctuated substantially since 1980 (see Figure 2).

FIGURE 2

Share of Nephrology Fellows Born Outside the United States, by Graduation Period, 1980–2023



Source: Data provided to the authors by Kurtis Pivert, Director of Data Science for the American Society of Nephrology, Alliance for Kidney Health.

Two important policy shifts took place in the first half of the 1990s that have contributed to an increase in the number of foreign-born physicians seeking graduate training in nephrology. Prior to 1990, IMGs could generally obtain temporary employment in the United States only if they were primarily teaching or researching at public or nonprofit institutions. The *Immigration Act of 1990* established the H-1B program, which opened a pathway for foreign physicians to provide direct patient care.²⁸ The law gives these

27 Eram Alam, *The Care of Foreigners: How Immigrant Physicians Changed US Healthcare* (Baltimore, MD: Johns Hopkins University Press, 2025).

28 Gabrielle Redford, “Hospitals and Health Systems Depend on H-1B Visa-Sponsored Physicians. So, What Happens Now?” AAMC, January 21, 2026. The direct patient care pathway was finalized through the *Miscellaneous Technical Immigration and Naturalization Amendments of 1991*.

physicians (and other “highly skilled” H-1B visa holders) dual intent status, enabling them to pursue U.S. permanent residence while working temporarily for up to six years of authorized employment.²⁹

The second notable change came in 1994 with the creation of the Conrad 20 J-1 Visa Waiver Program (later expanded in 2002 and referred to as Conrad 30).³⁰ By waiving a requirement to return home for at least two years for those on J-1 visas, the policy allows IMGs to remain in the United States if they agree to practice for at least three years in a federally designated Medically Underserved Area.³¹ States can apply for up to 30 waivers that allow IMGs to practice in rural and other areas with physician shortages. Some states also receive additional flex positions that can be used to fulfill additional needs, potentially raising the total to 40 waivers.³² States have flexibility in developing their own application and participation rules for J-1 visa physicians and the health-care facilities that sponsor them, although not all states use the 30 waivers available to them every year. States must also attest that sufficient effort has been made to recruit domestically trained physicians, although research has found that Conrad 30 program participants do not displace U.S.-trained physicians.³³ Enjoying broad bipartisan support, as well as support from the American Medical Association, the National Rural Health Association, and the American Hospital Association, the Conrad 30 program brought nearly 23,000 physicians to areas with shortages and to patients with significant medical needs between 2001 and 2024.³⁴

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Other prominent policy changes have coincided with significant declines in the number of IMGs. Visa restrictions imposed in the aftermath of the terrorist attacks on September 11, 2001,³⁵ likely led to a drop in the number of immigrants in nephrology fellowship programs. IMG flows have also been affected by

29 Sarah Donovan, William Kandel, and Jill Wilson, *U.S. Employment-Based Immigration Policy* (Washington, DC: Congressional Research Service, 2024).

30 Created in 1994 and named for its sponsor, Senator Kent Conrad of North Dakota, the Conrad 20 program allowed each state to seek up to 20 waivers annually. In 2002, Congress raised the cap to 30 per state, and the program has since been known as Conrad 30 or Conrad State 30. In 2004, Congress further expanded the program to allow states to recruit both primary care and specialty physicians and exempted employers of IMGs from annual numerical H-1B caps. See Karma Ester, *Foreign Medical Graduates: A Brief Overview of the J-1 Visa Waiver Program* (Washington, DC: Congressional Research Service, 2009); Provider Retention and Information System Management Collaborative of 3RNET, *Findings of the Conrad 30 J-1 Visa Waiver Physician Survey, 2022* (Jefferson City, MO: 3RNET, 2023).

31 Immediately after completing their U.S. medical training, IMGs on J-1 visas must commit to working full time for three years in a federally designated Health Professional Shortage Area, Medically Underserved Area, or for a Medically Underserved Population and provide safety-net services for medically underserved communities. See Kristie De Peña, “Conrad 30 J-1 Visa Waiver Program” (policy brief, Niskanen Center, Washington, DC, July 2017).

32 Kelley Arredondo et al., “Current Programs and Incentives to Overcome Rural Physician Shortages in the United States: A Narrative Review,” *Journal of General Internal Medicine* 38, Suppl. 3 (June 2023): 916–22.

33 Breno Braga, Gaurav Khanna, and Sarah Turner, “Migration Policy and the Supply of Foreign Physicians: Evidence from the Conrad 30 Waiver Program” (working paper 32005, National Bureau of Economic Research, Cambridge, MA, December 2023).

34 Matthew La Corte and Gil Guerra, “The Bipartisan Immigration Policy That Helps Rural Americans Get Access to Local Physicians” (commentary, Niskanen Center, Washington, DC, 2023); 3RNET, “Conrad 30 State Totals from FY 2001 through FY 2024,” accessed April 20, 2026.

35 For an overview of these post-September 11 policy changes, see Migration Policy Institute (MPI), *Chronology of Events since September 11, 2001, Related to Immigration and National Security* (Washington, DC: MPI, 2003).

economic and health trends and policies, including the onset of the Great Recession in 2007–09 and, starting in 2020, COVID-19 pandemic-induced declines in visa issuance and global mobility restrictions.³⁶

IMGs' Countries of Birth

Nephrology has one of the highest shares of Asian physicians among all medical specialties: 38 percent, compared with 19 percent of all U.S. physicians in 2023.³⁷ Leading countries of origin include India (14 percent of nephrologists), Pakistan (5 percent), and the Philippines and Syria (1.4 percent each; see Table 2).

India is the largest source country for IMG physicians overall and nephrologists specifically. In 2024, nearly 63,000 Indian-born physicians and surgeons provided care across the United States, representing 21 percent of all employed immigrant physicians.³⁸ A complex set of personal choices, the power of diaspora networks, and policies adopted by both India and receiving countries have driven the migration of Indian physicians to the United States and other developed countries. (See Appendix B for a brief history of Indian physicians' global migration.)

TABLE 2

Top Countries of Birth of Nephrologists Providing Care to Adults in the United States, 2023

Birth Country	Share of Total
Total	100.0%
United States	42.5%
India	14.1%
Pakistan	4.8%
Philippines	1.4%
Syria	1.4%
China	1.1%
Nigeria	1.1%
Lebanon	1.1%
Iran	0.8%
Egypt	0.7%
Jordan	0.6%
Bangladesh	0.6%
Nepal	0.6%
Romania	0.5%
Canada	0.5%

Source: Data provided to the authors by Kurtis Pivert, Director of Data Science for the ASN Alliance for Kidney Health based on his analysis of the 2023 American Medical Association's Physician Professional Data.

C. Demand Drivers for Nephrology Services

Understanding demand trends is equally important for gauging future needs for nephrology services and the IMGs who can provide them. Several demographic and health trends are increasing the need for nephrology services. According to the latest publicly available data, one in seven U.S. adults (37 million people) had chronic kidney disease as of 2023,³⁹ and in 2022 alone, about 131,000 Americans were newly diagnosed with kidney failure.⁴⁰ As of late 2025, more than 866,000 Americans were living with kidney failure.⁴¹

³⁶ Meghan Benton et al., *COVID-19 and the State of Global Mobility in 2021* (Washington, DC: MPI, 2022).

³⁷ Data provided to the authors by Kurtis Pivert of ASN based on his analysis of the 2023 AMA PPD.

³⁸ Authors' analysis of data from the U.S. Census Bureau's 2024 American Community Survey.

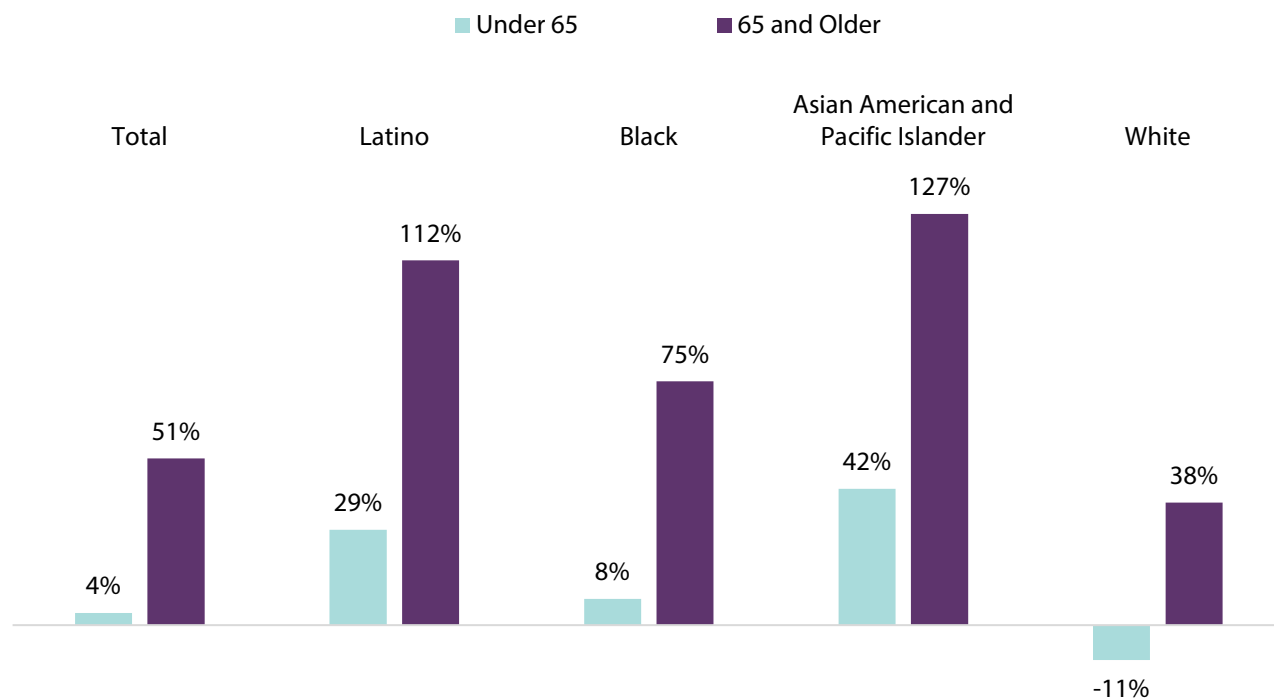
³⁹ Centers for Disease Control and Prevention, "Chronic Kidney Disease in the United States" (fact sheet, U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Atlanta, 2026).

⁴⁰ American Kidney Fund, "Quick Kidney Disease Facts and Stats," accessed September 12, 2025.

⁴¹ U.S. Department of Health and Human Services, National Institutes of Health (NIH), "ESRD (End-Stage Renal Disease) Quarterly Update, Point Prevalent Count of Reported ESRD (End-Stage Kidney Disease), 2023 Q1—2025 Q4," accessed August 31, 2026.

Population aging is a primary driver of increased demand for nephrology services because rates of kidney disease are substantially higher among older adults. As life expectancy rises, the number and share of adults ages 65 and older grows. This population increased by 51 percent between 2010 and 2024, from 40.5 million to more than 61.2 million (see Figure 3). In contrast, the population under age 65 grew by only 4 percent during the same period. Across all racial and ethnic groups, the older population grew faster than the younger one between 2010 and 2024.

FIGURE 3

Percent Population Change between 2010 and 2024, by Age Group and Race/Ethnicity

Source: Authors' analysis of data from the U.S. Census Bureau's 2010 and 2024 American Community Surveys.

Racial and ethnic shifts in the makeup of the U.S. population also affect demand patterns as the prevalence of kidney disease varies significantly by race and ethnicity.⁴² Compared with White Americans, Black Americans are four times more likely to develop kidney failure, and Latino Americans are more than twice as likely.⁴³ Both the Black and Latino populations in the United States are growing faster than the White population.

The prevalence of diabetes, a major risk factor for kidney diseases, also continues to increase.⁴⁴ Approximately one in three adults with diabetes may have kidney disease. Studies show that the prevalence

42 Eleanor Lederer and Jonathan Lebowitz, "Current State of the Workforce in Nephrology," *Advances in Chronic Kidney Disease* 7, no. 4 (2020): 281–90.

43 U.S. Renal Data System (USRDS), "Incidence, Prevalence, Patient Characteristics, and Treatment Modalities," in *USRDS Annual Data Report: Epidemiology of Kidney Disease in the United States* (Bethesda, MD: NIH, National Institute of Diabetes and Digestive and Kidney Diseases, 2024).

44 Centers for Disease Control and Prevention, "Risk Factors for CKD," accessed March 1, 2026.

of diabetes is generally higher among people who are Black, Latino, or Asian compared to those who are White.

Among immigrants and refugees, the risk of diabetes rises the longer they reside in the United States, an increase driven by the greater consumption of nutrient-poor, calorie-rich foods but also limited access to health care.⁴⁵ These combined trends strongly suggest that demand for nephrology services overall and by certain populations will continue to grow substantially in coming decades.

Even before recent policy changes, significant income disparities influenced access to nephrology care. Approximately one in eight Americans on dialysis, along with many post-transplant patients, could not afford the cost of care, highlighting the intersection of clinical need and socioeconomic barriers to treatment.⁴⁶

D. Nephrologist Pipeline Challenges and Opportunities

The nephrology workforce in the United States faces daunting challenges: growing demand for kidney care services, significant physician shortages projected through 2038, and an aging physician population. The field is also experiencing ongoing training challenges.

Declining Interest and Applications from U.S. Medical Graduates

Nephrology fellowship capacity has expanded, but interest in nephrology careers among U.S. medical graduates has declined. Data show that the number of nephrology fellowship positions has grown steadily, increasing 36 percent from 626 fellows in 2000 to 851 fellows in 2024. During this same period, the average number of fellows per program increased from 4.9 to 5.6.⁴⁷

Despite growth in fellowship positions, fellowship applications from residents who are U.S. medical graduates have declined.

However, despite growth in fellowship positions, fellowship applications from residents who are U.S. medical graduates have declined.⁴⁸ In the most recent fellowship match (through the National Resident Matching Program Specialties Matching Service for the academic year 2025–26), only 89

U.S. allopathic candidates and 74 U.S. osteopathic candidates sought matches for nephrology. This has continued a downward trend that began earlier: The total number of applicants to nephrology decreased steadily from 1.5 applicants for each available fellowship position in 2009 to only 0.6 applicants for each position in 2015.⁴⁹

45 Rebecca Jones-Antwi, Suzanne Judd, and Solveig Cunningham, “Food Choices during Resettlement among Immigrants in the US,” *BMC Public Health* 25, no. 2184 (2025); Seth Berkowitz et al., “Risk of Developing Diabetes among Refugees and Immigrants: A Longitudinal Analysis,” *Journal of Community Health* 41, no. 6 (2016): 1274–81; Jennifer Dias, Sandra Echeverria, Victoria Mayer, and Teresa Janevic, “Diabetes Risk and Control in Multi-Ethnic US Immigrant Populations,” *Current Diabetes Reports* 20, art. no. 73 (2020).

46 American Kidney Fund, *Hope within Reach: 2024 Annual Report* (Rockville, MD: American Kidney Fund, 2025).

47 Data provided to the authors by Kurtis Pivert of ASN.

48 Lederer and Lebowitz, “Current State of the Workforce in Nephrology.”

49 Data provided to the authors by Kurtis Pivert of ASN from the National Resident Matching Program, *Results and Data: Specialties Matching Service [2009–2026 Appointment Years]* (Washington, DC: National Resident Matching Program, 2026).

The proportion of nephrology fellowship positions that the fellowship match did not fill increased from 5.9 percent in 2010 to 33.5 percent in 2026,⁵⁰ highlighting the significant challenges in attracting U.S. medical graduates to the specialty. The number of unfilled positions, combined with projected workforce shortages, indicates that the large share of IMG placements in nephrology should not be characterized as crowding out U.S. medical graduates from the specialty.

Race/Ethnicity and Gender Imbalances

Research has linked better health-care outcomes and greater adherence to treatment protocols to physicians and patients having a shared racial/ethnic background.⁵¹ However, the demographic composition of the nephrology workforce does not reflect that of the population with kidney disease. Asians are highly represented in nephrology, but Black and Latino individuals are underrepresented relative to their share of the population with kidney disease and their higher risk of developing kidney disease.⁵²

Efforts have been made to diversify the nephrology field, including several programs aimed at attracting medical students and residents from underrepresented backgrounds.⁵³ However, data from academic year 2024–25 show that only 6 percent of all nephrology fellows (both adult and pediatric) identify as Black and 8–9 percent identify as Latino.⁵⁴ Women are also underrepresented, accounting for 41 percent of fellows in 2024–25, up slightly from 37 percent in 2015–16.

3 Recent Policies Affecting the Education-to-Training-to-Practice Pipeline for IMG Nephrologists

Policy changes in 2025 and 2026, substantial in both scope and pace, are reshaping how IMGs enter the medical field, whether institutions can afford to train and employ them, and whether their patients can access the care they provide. This section examines three policy domains: immigration, health-care financing and education, and benefit eligibility. The policies described here are current as of the end of September 2026, though several remain subject to litigation or await implementation and could change.

A. Immigration Policies Affecting the Supply and Training of Immigrant Physicians

Several pathways are available to IMGs entering medical practice in the United States. These pathways depend on several factors, including whether IMGs complete their medical residency in the United States or abroad, which visa they use to enter the United States, whether they intend to pursue a fellowship

50 Data provided to the authors by Kurtis Pivert of ASN from the National Resident Matching Program, *Results and Data*.

51 John Snyder, Rachel Upton, and Thomas Hassett, “Black Representation in the Primary Care Physician Workforce and Its Association with Population Life Expectancy and Mortality Rates in the US,” *JAMA Network Open* 6, no. 4 (2023): e236687.

52 Deidra C. Crews, “The Future of the US Nephrology Workforce Following the End of Affirmative Action,” *Clinical Journal of the American Society of Nephrology* 19, no. 7 (2024): 917–19.

53 Crews, “The Future of the US Nephrology Workforce.”

54 Data provided to the authors by Kurtis Pivert of ASN from the ACGME, *Data Resource Book: Academic Year 2024–2025* (Chicago: ACGME, 2025).

and subspecialty training, and the state where they intend to practice. In each case, IMGs must meet all requirements, including a U.S. medical residency or equivalent, to obtain a U.S. medical license.⁵⁵ Common immigration pathways include the following:

- ▶ IMGs who have not completed a medical residency in their home or another country and enter the United States on a J-1 visa to complete a U.S. internal medical residency, followed by a fellowship in a field such as nephrology and optional subspecialty training.
- ▶ IMGs who complete a medical residency in their home or another country and enter the United States on an H-1B or J-1 visa to complete a fellowship in a field such as nephrology.
- ▶ IMGs with medical licenses and practice experience abroad who enter the United States on family reunification or humanitarian visas or through the Diversity Visa Program and seek to satisfy U.S. medical residency, fellowship, and other requirements to become U.S. licensed doctors.

Immigration law and regulations are critical gatekeepers for IMGs and other health-care professionals seeking to train and work in the United States.⁵⁶ Several recent policy changes have made it more difficult for IMGs to progress from education to training to practice.

1 Changes in J-1 and H-1B visa rules⁵⁷

- a. **Restricting J-1 visa duration of status.** In July 2026, the Department of Homeland Security (DHS) finalized a policy that imposes significant restrictions on how long IMGs, scholars, researchers, and others on J-1 visas and international students on F-1 visas can remain in the United States.⁵⁸ The rule departs from the longstanding “duration-of-status” practice, under which these visa holders could maintain their status for as long as their program lasted. Instead, DHS has set a fixed admission period tied to the program’s end date but capped at four years. Individuals needing more time will have to file a formal application to extend their stay, which may take a long time

55 A 2026 pilot program from the American Board of Internal Medicine, the organization that certifies physicians in internal medicine and its subspecialties, allows a group of “exceptionally qualified” IMGs who completed an internal medicine residency abroad and an ACGME-accredited U.S. subspecialty fellowship to become eligible for board certification without repeating a U.S. residency. For more information, see American Board of Internal Medicine, “Pilot Pathway E: Competency-Based Medical Education Pilot for International Medical Graduates Who Have Completed a Medicine Residency Abroad and an US-Based ACGME-Accredited Fellowship in the US,” accessed July 15, 2026. Also, as of May 2026, 27 U.S. states and two territories had legislation creating alternative licensure pathways for internationally trained physicians. See World Education Services (WES), “27 States Expand Pathways for Internationally Trained Physicians in 2026,” accessed September 20, 2026.

56 Julia Gelatt, “Trump Restrictions on Legal Immigration Could Sharply Reduce U.S. Population Growth” (commentary, MPI, Washington, DC, 2026).

57 Foreign physicians training and working in the United States often rely on J-1 (exchange visitors) or H-1B (specialty occupation) visas. IMGs commonly use the J-1 visa for residency and fellowship training. The J-1 visa is subject to a two-year home-country return requirement unless waived, often by serving in a Medically Underserved Area. To work in hospitals, clinics, or private offices, IMGs generally need to apply for an H-1B visa either from abroad or within the United States.

58 U.S. Department of Homeland Security (DHS), “Establishing a Fixed Time Period of Admission and an Extension of Stay Procedure for Nonimmigrant Academic Students, Exchange Visitors, and Representatives of Foreign Information Media,” *Federal Register* 91, no. 136 (July 17, 2026): 44976; Jeanne Batalova, “A New DHS Rule Just Made Life Significantly More Complicated for International Students on F-1 Visas and J-1 Exchange Visitors” (LinkedIn post, July 2026).

given the large and growing backlog of applications at U.S. Citizenship and Immigration Services (USCIS)—12 million as of March 2026.⁵⁹

ASN data show that IMGs pursue nephrology subspecialty training at higher rates than U.S. medical graduates, and the training time required often exceeds the four-year limit. Although the new rule allows some status extensions, it eliminates predictable authorization periods, which complicates career planning and could disrupt continuity of patient care.⁶⁰ The new rule was set to take effect on September 15, 2026, but a federal judge in Massachusetts issued a nationwide preliminary injunction a day before, blocking its implementation while the litigation continues. The government is expected to appeal.⁶¹

- b. Changing H-1B priorities.** In December 2025, DHS published a final rule replacing the H-1B random lottery (applicable to employers subject to the annual visa cap) with a wage-based selection system.⁶² Under the Department of Labor's four-tier Occupational Employment and Wage Statistics system, the wage level offered to a foreign worker by a petitioner (employer) determines how many entries an application receives in the lottery and therefore the likelihood of obtaining a visa: Applicants at a level IV wage (the highest level) receive four lottery entries, whereas those with a level I wage receive one entry, reducing their selection odds.⁶³ This rule disadvantages professionals at the start of their career, such as IMGs moving from training into cap-subject employment. Such positions often correspond to lower wage levels than those of established professionals, even when the physician is entering a high-demand specialty or a community with a significant doctor shortage.⁶⁴
- c. New \$100,000 fees to obtain an H-1B visa.** In September 2025, the White House announced a \$100,000 employer-paid fee for new H-1B petitions.⁶⁵ The announcement provided few details, causing widespread confusion. Some medical institutions declined to rank H-1B candidates in their matching programs, and IMGs already in the United States on H-1B visas were advised not to travel. In October 2025, the government clarified that the fee would *not* apply to applicants already in the United States who are changing status from another temporary visa⁶⁶ such as a J-1

59 Julia Gelatt, "USCIS Published Its Latest Processing Data Yesterday" (LinkedIn post, August 2026); Cecilia Esterline, "Legal Immigration in Numbers: August 2026 Status Update," Niskanen Center, August 31, 2026.

60 This rule was initially introduced in late August 2025. American Hospital Association, "Coalition, Including AHA, Urges DHS to Exempt Foreign Medical Graduates from 'Duration of Status' Designation Changes," accessed October 2, 2025.

61 Presidents' Alliance on Higher Education and Immigration, "Duration of Status Litigation," accessed September 21, 2026; Court Listener, "Presidents' Alliance on Higher Education and Immigration v. United States Department of Homeland Security (1:26-cv-13799)," accessed September 7, 2026.

62 DHS, "Weighted Selection Process for Registrants and Petitioners Seeking to File Cap-Subject H-1B Petitions: A Rule by the Homeland Security Department on 12/29/2025," *Federal Register* 90, no. 245 (December 29, 2025): 60864. The rule went into effect on February 27, 2026, and was first applied in the fiscal year 2027 cap lottery conducted in March 2026.

63 DHS's own projections set out in the rule show that level I registrations have a 15.29 percent selection probability to file a cap-subject petition compared with more than 61 percent for level IV. See DHS, "Weighted Selection Process."

64 DHS responded to health-sector comments by noting that physicians are usually cap-exempt or have other pathways such as J-1 and the Conrad 30 program. However, the weighted system applies at the transition into cap-subject employment such as a private or rural practice.

65 On the scope of the proclamation, see Michelle Hackman, "U.S. Narrows Who Pays \$100,000 H-1B Visa Fee," *Wall Street Journal*, October 26, 2025.

66 Stuart Anderson, "U.S. Immigration Service Issues Guidance on Who Pays The \$100,000 H-1B Fee," *Forbes*, October 20, 2025.

or O-1 visa.⁶⁷ The American Medical Association, ASN, and more than 50 other medical societies petitioned for a physician exemption under the proclamation's case-by-case exception, but no blanket physician exemption was granted.⁶⁸ In June 2026, a federal court in Massachusetts vacated the policy, finding the fee to be an unlawful tax that only Congress could authorize, and the Court of Appeals for the First Circuit declined to stay that ruling in July.⁶⁹ In September 2026, the White House extended the proclamation through September 2027.⁷⁰ At the end of September 2026, a federal district court judge granted preliminary injunction and invalidated both the original \$100,000 fee and the September proclamation.⁷¹

Separately, in late August 2026, DHS proposed a new \$103,265 fee on all cap-subject H-1B petitions, whether the worker is abroad or already in the United States.⁷² This would not apply to petitions from cap-exempt employers, such as universities and their affiliated hospitals, nor to petitions for physicians with Conrad 30 waivers. However, as with the wage-based lottery, if the rule is finalized and the fee implemented, it would affect IMGs who move from training into cap-subject employment, including at many community and rural hospitals outside the academic system.

- d. Delays in J-1 visa interviews.** In late May 2025, J-1 visa issuances stalled, stranding some IMGs and jeopardizing timely residency start dates.⁷³ When visa interviews resumed, they included new social media vetting involving a comprehensive review of applicants' social media, media coverage, and other open-source information.⁷⁴ Applicants also must set their social media profiles to "public" so that U.S. consular officers can review their activity. Total J-1 visa issuances (not just to IMGs, because visa data are not broken out by occupation) during April–June 2025 fell by 16

67 The O-1 visa is an employer-sponsored, uncapped classification for individuals of extraordinary ability. IMGs with records of national or international distinction, a criterion that is hard to demonstrate, can use this as an alternative to the H-1B visa.

68 AMA, "AMA Urges DHS to Exempt Physicians"; Mark Leiser, Jill Rollet, and Monica Stonehill, "'Punch in the Gut': AMA Leads Effort for Physician Exemption from H-1B visa Fee Increase," *Healio*, September 26, 2025; Susanna Vogel, "Changes to H-1B Visa Program Threaten to Worsen Healthcare Labor Shortages," *Healthcare Dive*, September 25, 2025.

69 The same judge later stayed the decision to give the administration a chance to appeal. On July 24, 2026, a federal appeals court declined to reinstate the fee. See Paul Wiseman, "What to Know about Trump's \$100,000 H-1B Visa Fee, and the Legal Rebuke that Followed," *Public Broadcasting Service (PBS)*, June 11, 2026; Nate Raymond, "Appeals Court Rejects Trump Bid to Halt \$100,000 H-1B Visa Fee Ruling," *Reuters*, July 24, 2026.

70 The White House, "Restriction on Entry of Certain Nonimmigrant Workers" (presidential proclamation, September 18, 2026).

71 Stuart Anderson, "Judge Strikes Down Latest Version Of \$100,000 H-1B Immigration Fee," *Forbes*, Oct 01, 2026.

72 The public comment period closed September 24, 2026. Jeremy Neufeld, et al., "Explaining the Proposed \$103k H-1B Fee" (Q&A, Institute for Progress, Washington, DC, 2026).

73 Natalia Solenkova, "International Medical Graduates, Visa Disruptions, and the Future of the US Physician Workforce," *Journal of American Medical Association* 334, no. 17 (2025): 1513–14; Adithi Ramakrishnan and Devi Shastri, "Foreign Medical Residents Fill Critical Positions at U.S. Hospitals but Are Running into Visa Issues," *Associated Press*, July 4, 2025; National Public Radio (NPR), "U.S. Stops Scheduling Visa Interviews for Foreign Students," *NPR*, May 28, 2025.

74 Alex Curtis, "Suspension on F-1/J-1 Visa Interviews Lifted," *University of Utah*, June 20, 2025; *University of Washington*, "Screening and Vetting for Visa Applicants," June 26, 2025.

percent compared with the same period in 2024. Issuances for Indian nationals declined by 36 percent, the largest IMG group in U.S. residency programs.⁷⁵

- e. **In-person visa interviews.** In July 2025, the Department of State eliminated interview waivers for most nonimmigrant visa renewals, including J-1, H-1B, and B1/B2 visas. Applicants must now appear in person in the country of their residence,⁷⁶ adding delays and other burdens, especially for IMGs from high-volume countries such as India.⁷⁷ The change is already affecting applicants: In January 2026, H-1B visa interviews in India were already being scheduled for 2027, stranding some professionals in the country.⁷⁸
- f. **Loss of automatic work authorization for H-4 spouses of H-1B workers.** As of late October 2025, DHS eliminated the automatic 540-day extension of employment authorization documents (EADs) for eligible⁷⁹ H-4 visa holders (an estimated 100,000 people) while their renewal applications are pending.⁸⁰ With processing times now ranging from 6 to 15.5 months, affected spouses lose the right to work as soon as their current EADs expire, creating income gaps for many IMG families and adding to their uncertainty.
- g. **Proposed elimination of the 60-day grace period.** Since 2017, an H-1B worker whose employment ends has been able to remain in the United States for up to 60 days to find a new sponsor, change status, or depart. In September 2026, DHS published a proposed rule that would eliminate this grace period for H-1B holders and certain other temporary workers and their dependents.⁸¹ If the rule is finalized as written, an H-1B physician who loses a position, along with any dependent family members, would lose status the day after employment ends, leaving essentially no time to arrange new sponsorship. Remaining in the United States after falling out of status also carries the risk of accruing unlawful presence, which may trigger three- and ten-year bars on reentry.

Unlike the weighted lottery and the proposed fee of \$103,265, this rule would affect all H-1B workers (employed by cap-subject and cap-exempt employers alike), including physicians in teaching hospitals during and after training. The grace period remains in effect while the rule is

75 Authors' calculation based on U.S. Department of State, "Monthly Nonimmigrant Visa Issuance Statistics," accessed January 3, 2026. Visa statistics are not available by occupation, but J-1 visa trends provide a useful proxy for immigration policy impacts on internationally trained health-care professionals. The J-1 is the primary pathway for IMGs entering U.S. medical residency programs. Like their domestic peers, many IMGs begin residency on July 1, making uninterrupted visa processing essential to hospital staffing and continuity of care. Total J-1 visas issued in April–June 2025 fell from 143,800 to 120,800 compared with the same period in 2024, and from 4,200 to 2,700 for Indian nationals.

76 U.S. Department of State, "Adjudicating Immigrant Visa (IV) Applicants in Their Country of Residence," updated July 15, 2026.

77 U.S. Department of State, "Interview Waiver Update July 25, 2025," updated July 25, 2025.

78 *Times of India*, "H-1B Visa Stamping Delays Continue in India, Interview Dates Now Being Deferred to 2027," *Times of India*, January 22, 2026.

79 H-4 spouses are eligible for work authorization when the H-1B worker has an approved immigrant petition or has extended status beyond six years, so this group consists largely of families well along the path to permanent residence.

80 FWD.us, "Ending Automatic Work Authorization Extensions Will Cost Billions," updated April 9, 2026.

81 This also includes O-1, L-1, E, and TN workers. Reddy Neumann Brown PC, "DHS Proposes to Eliminate the 60-Day Grace Period for H-1B, L-1, O-1, E, and TN Workers," accessed September 21, 2026; DHS, "Proposed Rule: Eliminating the Discretionary 60-Day Grace Period," *Federal Register* 91, no. 175 (September 11, 2026). Comments are due by November 10, 2026.

pending, but the proposal alone may deter IMGs from accepting positions with smaller or less financially stable employers, such as rural hospitals.

- 2 Increased scrutiny of adjustment to permanent resident status.** In May 2026, USCIS issued a policy memorandum reframing adjustment of status (obtaining a green card from within the United States) as a disfavored form of relief to be granted on a case-by-case basis at an officer's discretion, rather than as a routine alternative to consular processing abroad.⁸² The memo acknowledged that dual-intent visa holders (e.g., H-1B visa holders)⁸³ may be eligible to adjust, which leaves physicians on this visa comparatively better positioned than others to obtain a green card without leaving the United States.⁸⁴ But for IMGs who are denied adjustment, consular processing in their home country could mean months abroad, compounded by visa interview backlogs and processing pauses. The result could be family separation, disrupted patient care, and added costs for hospitals and training programs.
- 3 Travel bans for nationals from 39 countries.** A proclamation that took effect on January 1, 2026, fully or partially suspended entry and visa issuance for nationals of 39 countries,⁸⁵ most of them in Africa, with others in Asia, the Middle East, and Latin America and the Caribbean.⁸⁶ For nationals of the 19 *fully* restricted countries, both immigrant and nonimmigrant visa issuance is suspended. For the 20 *partially* restricted countries, the suspension covers immigrant visas as well as J-1 and certain other nonimmigrant visas.⁸⁷ A related USCIS policy also froze extensions of status, work permits, and green-card applications for nationals of the 39 countries who were already in the United States, affecting thousands of physicians,⁸⁸ some of whom were placed on leave or stopped working.⁸⁹ USCIS exempted applications associated with physicians in May 2026, and in June 2026, a federal court vacated the USCIS policies that had frozen adjudications for nationals of the 39 countries altogether.⁹⁰ However, that ruling only applied to USCIS adjudications, not consular processing outside the United States, so physicians and incoming medical residents who remain abroad are still subject to the entry ban and visa suspension.

82 Jeanne Batalova, "Legal Immigration's New Obstacle Course" (post on LinkedIn, May 28, 2026).

83 Most people applying for a temporary U.S. visa must convince the consular officer that they plan to return to their home country once their studies, training, or job ends. If the officer believes an applicant intends to stay in the United States permanently, the visa can be refused. Congress carved out exceptions for a few temporary visa categories, including the H-1B visa for specialty occupations, the L-1 visa for employees transferred within a company, and fiancé and spouse K visas. Holders of these visas can apply for a green card without the application for a *temporary* visa counting against them, an idea referred to as dual intent. The O-1 visa for people with extraordinary ability is treated similarly under U.S. Citizenship and Immigration Services (USCIS) rules rather than by law, which makes that protection easier for an administration to narrow.

84 Following concern from employers, USCIS also clarified that the memo is not a blanket change and that officers will use their discretion to make individual decisions. Nonetheless, practitioners anticipate more requests for evidence and notices of intent to deny in cases that would previously have been approved. See Lauren Kaori Gurley and Ian Duncan, "Inside Trump's Suddenly Softened New Green Card Policy," *The Washington Post*, June 3, 2026; American Immigration Law Association (AILA), "USCIS's New Policy Weaponizes Discretion to Make It Harder to Get a Green Card" (policy brief, AILA, 2026).

85 Jill H. Wilson, "Expanded 'Travel Ban' to Take Effect January 1, 2026" (insight, Congressional Research Service, Washington, DC, December 19, 2025); Mariel Ferragamo, "A Guide to the Countries on Trump's Travel Ban List," Council on Foreign Relations, January 14, 2026.

86 Miriam Jordan, "Trump's Immigration Policy Sidelines Foreign Doctors amid Shortage," *The New York Times*, April 4, 2026.

87 The H-1B remains available to that second group, but consular officers are directed to shorten the validity of any such visa issued.

88 Myles Miller, "Trump Ends Visa Freeze That Exacerbated Foreign Doctor Shortage," Bloomberg, May 4, 2026.

89 Arielle Zions, "Delays in Visa Program Threaten Placement of Hundreds of Doctors in Underserved Areas," CBS News, May 1, 2026.

90 Aaron Reichlin-Melnick, "Federal Court Blocks Sweeping Pause on Legal Immigration for Nationals of 39 Countries," American Immigration Council, June 8, 2026.

- 4 **Cancellation of status for humanitarian migrants.** Beginning in early 2025 and continuing through 2026, DHS terminated or declined to renew temporary status and work authorization for an estimated 1.5 million individuals, such as beneficiaries of Temporary Protected Status (TPS) and other humanitarian programs.⁹¹ These status terminations removed many legally authorized workers from the U.S. labor pool, including in health care.⁹² Haitian TPS beneficiaries are a notable example, given many provided nursing and support services in hospitals and nursing homes.⁹³ In late June 2026, the Supreme Court allowed the Trump administration to proceed with terminating TPS for about 350,000 Haitians and 6,000 Syrians, whose work authorization expired a month later. The ruling is expected to hasten the end of pending challenges to TPS terminations for nationals of other countries.
- 5 **State action on H-1Bs.** New restrictions on H-1B workers have not been limited to the federal government. In January 2026, Texas Governor Greg Abbott directed state agencies and public universities to stop filing H-1B visa petitions without written permission from the Texas Workforce Commission, through May 2027.⁹⁴ Florida Governor Ron DeSantis proposed similar restrictions in October 2025, and in March 2026, the Florida Board of Governors, which oversees the state's university system, voted to suspend hiring of new H-1B visa holders until January 2027.⁹⁵ Both states' actions apply to public academic medical centers, which are among the largest institutional H-1B sponsors.⁹⁶ These institutions are also the cap-exempt employers that have been largely spared by the federal weighted lottery and proposed \$103,265 fee. Thus, the state H-1B hiring freezes close off the pathway the federal changes had left open for physicians training and working at public academic centers.

Members of the medical community and other stakeholders have pushed back against many of the policy changes described above—advocacy that has produced some results. In Spring 2026, after pressure from medical organizations, USCIS exempted applications associated with physicians from the processing hold tied to the 39-country travel ban. Courts have provided broader relief, vacating the \$100,000 H-1B fee and blocking the new duration-of-status rule, though each ruling is subject to appeal. Other efforts have fallen short: no blanket exemption from the H-1B fee was granted for physicians, and Florida declined to exempt physicians from its university hiring pause.

These measures, taken together, are likely to lengthen processing times, increase uncertainty, and signal a more restrictive environment for highly skilled professionals such as IMG nephrologists. The weighted lottery and H-1B fees largely spare cap-exempt employers such as public academic medical centers,

91 Immigrants with Temporary Protected Status (TPS) and those with humanitarian parole overlap significantly, and thus the exact total number of immigrants who have lost status cannot be determined. See Muzaffar Chishti, Kathleen Bush-Joseph, and Colleen Putzel-Kavanaugh, "[Unleashing Power in New Ways: Immigration in the First Year of Trump 2.0](#)," *Migration Information Source*, January 13, 2026.

92 Miriam Jordan and Madeleine Ngo, "Employers Fear Labor Shortage as Many Immigrants Lose Protected Status," *The New York Times*, July 26, 2026.

93 Vanessa Romo, "[The U.S. Healthcare System Is in Crisis. A Supreme Court Ruling Could Make Things Worse](#)," NPR, July 2, 2026; Andres Ayala and Jeanne Batalova, "[Haitian Immigrants in the United States](#)," *Migration Information Source*, September 3, 2026.

94 Joseph Rowe, "[Gov. Greg Abbot Orders Immediate H-1B Visa Freeze for Texas State Agencies, Universities](#)," Fox 7 Austin, January 27, 2026.

95 Leona Masangkay, "[Florida Board of Governors Approves Yearlong H-1B Visa Pause in State Universities](#)," *The Independent Florida Alligator*, March 2, 2026.

96 The University of Texas Southwestern Medical Center and MD Anderson Cancer Center have been among Texas's largest H-1B sponsors. See Shafaq Patel, "[Abbott Orders Texas Agencies, Public Universities to Freeze New H-1B Visas](#)," Axios Houston, January 27, 2026.

yet state freezes in Texas and Florida now close that pathway for institutions where many IMGs train and work. While it is too soon to fully evaluate the effects of these rapidly shifting policies, hospitals are likely to face difficulties in planning and staffing, physicians may encounter barriers to advancement and research participation, and the entry of new physicians could slow. The result could be deeper shortages in nephrology and other medical specialties, especially in rural areas where shortages are already acute.

B. Health-Care Funding Policies That Reduce the Supply of and Demand for Immigrant Health-Care Professionals

Even after IMGs enter the United States, the capacity of institutions to train and employ them depends on stable financing. Provisions in the budget reconciliation law commonly known as the *One Big Beautiful Bill Act* (OBBBA), signed into law in July 2025, together with other recent and anticipated budget proposals, will directly affect these institutions.

- 1 Reduced federal support for medical education.** The OBBBA caps federal student loans for students in professional education at \$50,000 per year and \$200,000 in total borrowing. Although the cap does not eliminate loans outright, it falls well short of covering the full cost of medical education in the United States—which, including post-graduate fellowships and subspecialty training, routinely exceeds these limits.⁹⁷ Students facing this gap have few options: turn to private loans with higher interest rates and fewer borrower protections, rely on personal or family wealth, or forgo medical school entirely.

While most IMGs are ineligible for federal student loans, narrowing access to medical training for otherwise qualified U.S. citizens and legal permanent residents risks deepening existing physician shortages, which IMGs often help address. The policy could also influence specialty choice: Students who finance their education through private debt may gravitate toward higher-paying specialties such as dermatology, orthopedics, or plastic surgery and away from already-undersupplied fields such as nephrology, primary care, and geriatrics where needs are great due to the demographic and workforce challenges discussed in prior sections.

- 2 Reduced federal funding for noncitizen emergency care.** The OBBBA lowers the federal matching rate for Emergency Medicaid for certain unauthorized immigrants,⁹⁸ threatening hospitals' fiscal sustainability. The policy is likely to have a more profound impact on safety net institutions that serve rural, low-income, or high-immigrant communities and on those institutions' capacity to sponsor and employ IMGs.⁹⁹

97 For example, an Urban Institute analysis shows that 41 percent of full-time students in medicine or osteopathic medicine borrowed above the new annual limit of \$50,000 in 2019–20. See Jason Cohn, “How New Federal Student Loan Limits Could Affect Borrowers,” Urban Institute, July 24, 2025.

98 Certain noncitizens (unauthorized immigrants and some lawfully present immigrants) are ineligible for federal Medicaid. However, Emergency Medicaid reimburses hospitals for emergency care provided to these immigrants if they would have qualified for Medicaid except for their immigration status. The budget reconciliation law commonly known as the *One Big Beautiful Bill Act* (OBBBA) limits reimbursement to the state's Medicaid match rate instead of the more generous federal match rate allowed under the *Affordable Care Act*. KFF, “Health Provisions in the 2025 Federal Budget Reconciliation Law: Medicaid,” August 4, 2025; Jillian Kirby Bronner, “An Analysis of the One Big Beautiful Bill Act (OBBBA's) Impact on Healthcare for New York,” Rockefeller Institute of Government, July 10, 2025.

99 Brian Arola and Ana Radelat, “‘Seismic’ Medicaid Changes Will Be Rough on Rural Hospitals,” MinnPost, July 8, 2025.

These financing changes could narrow the pipeline by reducing residency and fellowship positions while worsening workplace conditions through shrinking budgets and hiring freezes, thereby reducing opportunities for immigrant health professionals. Together, these changes raise concerns about the ability of fields such as nephrology to attract highly qualified applicants and train physicians and physician-scientists, including those from abroad.

C. *Public Benefit Policies That Reduce Access to Services*

Beyond affecting physician supply, recent policy changes have also restricted access to health services and insurance, which affects demand for services, institutional revenue, and ultimately patient health. Immigrant communities will be especially affected by the following changes:

- 1 **New Medicaid requirements.** The OBBBA imposes new work requirements and frequent recertification checks on all participants, increasing “churn” in coverage. For dialysis patients who rely on Medicaid to cover Medicare premiums, interruptions in coverage could prove destabilizing. These interruptions are likely to disproportionately affect individuals with limited English proficiency, who face documented barriers navigating Medicaid renewal systems.¹⁰⁰
- 2 **Expanded exclusions from means-tested benefits.** The OBBBA narrows immigrant eligibility for Medicaid, the Children’s Health Insurance Program, *Affordable Care Act* (ACA) subsidies, and Medicare, newly excluding a number of groups such as refugees, asylees, people paroled in the United States for at least one year, and survivors of human trafficking, among others. Only legal permanent residents, Cuban and Haitian entrants, migrants admitted under the Compacts of Free Association, and U.S. citizens remain eligible.¹⁰¹
- 3 **Exclusion from Federally Qualified Health Centers (FQHC) services.** In July 2025, the Department of Health and Human Services published a *Federal Register* notice narrowing FQHC services supported under the federal Health Center Program by excluding unauthorized immigrants and many people with temporary statuses such as TPS and Deferred Action for Childhood Arrivals (DACA).¹⁰² In September 2025, a federal district court preliminarily enjoined the notice for the 21 plaintiff states and the District of Columbia.¹⁰³ If fully implemented, the exclusion of affected immigrant groups from FQHC care would weaken a longstanding safety net and could reduce patient visits to centers in rural and underserved areas where immigrant physicians often practice.

100 Jules Lutaba, “Racial Disparities Persist during the Unwinding of the Medicaid Continuous Coverage Requirement,” National Health Law Program, August 7, 2024; Akeiisa Coleman and Sara Federman, “Work Requirements for Medicaid Enrollees,” The Commonwealth Fund, September 30, 2025.

101 OBBBA removed refugees, asylees, TPS holders, and parolees from the list of eligible groups. Heidi Altman, Tanya Broder, and Ben D’Avanzo, “The Anti-Immigrant Policies in Trump’s Final ‘Big Beautiful Bill,’ Explained,” National Immigration Law Center, August 20, 2025. The three Compacts of Free Association countries are the Federated States of Micronesia, the Marshall Islands, and Palau.

102 U.S. Department of Health and Human Services, “HHS Bans Illegal Aliens from Accessing Its Taxpayer-Funded Programs” (press release, July 10, 2025, updated November 24, 2025).

103 The notice is nominally in effect in the remaining states. However, the *Personal Responsibility and Work Opportunity Reconciliation Act of 1996* exempts nonprofit organizations (and most Federally Qualified Health Centers are nonprofits) from verifying immigration status, and no verification requirement has been issued.

- 4 Expanded public-charge determinations.** Starting in mid-September 2026, the federal government began applying a much broader test when deciding whether someone applying for a green card is likely to become a “public charge” (that is, dependent on public support).¹⁰⁴ Under the revised policy, officers may weigh the use of almost any federal, state, or local means-tested benefit,¹⁰⁵ alongside an applicant’s age, health, income, family circumstances, and education. Notably, the use of public benefits by eligible family members may also be counted against the green-card applicant. Because health and likely future reliance on government-funded care such as Medicaid are explicit considerations,¹⁰⁶ green-card applicants with kidney failure or other medical conditions requiring sustained treatment are among those most exposed.

Prior research shows that announcements of policies such as the public-charge rule create “chilling effects,” leading immigrants and their families, including U.S.-citizen children, to disenroll from public benefit programs for which they are eligible.¹⁰⁷ For nephrology, the consequences are twofold: Patients who forgo Medicaid to protect a pending or future immigration case may postpone care, and the resulting coverage losses may reduce revenue at safety-net institutions, which employ a disproportionate share of IMGs.

- 5 State-level rollbacks.** As of June 2025, 14 states had policies extending state-funded health coverage to at least some immigrants regardless of immigration status. Economic uncertainty and cuts in federal funding have led some states to reverse these policies. For example, California, Illinois, Minnesota, and Washington, DC, have begun reducing state-funded coverage not only for unauthorized immigrants but also for some lawfully present immigrants who do not qualify for federal Medicaid benefits.¹⁰⁸
- 6 Chilling effects from privacy and immigration enforcement changes.** In January 2025, DHS rescinded a policy that had limited immigration enforcement at hospitals, schools, and other sensitive locations.¹⁰⁹ And in July 2025, media reported that the federal government had shared Medicaid enrollees’ personal information, including home addresses, with immigration enforcement agencies.¹¹⁰ Together these changes are likely to discourage some immigrants and their family members from seeking care, even when they are eligible for it. For patients with kidney disease who require dialysis on a regular basis, this could have serious consequences.

104 Protecting Immigrant Families, “[Public Charge Regulation Toolkit](#),” updated September 18, 2026. Twenty-two states and the District of Columbia, along with a coalition of cities, filed suit in September 2026 to block the rule. As of late September, no court had done so, and the rule took effect as scheduled.

105 Until September 18, 2026, only cash welfare and long-term institutional care counted against an applicant.

106 Julia Gelatt, “[Trump Administration Public-Charge Rule Would Amplify Harms to Immigrant Families](#)” (commentary, MPI, Washington, DC, January 2026).

107 Jeanne Batalova, Michael Fix, and Mark Greenberg, *Chilling Effects: The Expected Public Charge Rule and Its Impact on Legal Immigrant Families’ Public Benefits Use* (Washington, DC: MPI, 2018); Samantha Artiga et al., “[Potential ‘Chilling Effects’ of Public Charge and Other Immigration Policies on Medicaid and CHIP Enrollment](#),” KFF, December 2, 2025.

108 Akash Pillai, Drishti Pillai, and Samantha Artiga, “[Recent State Actions Impacting Immigrants’ Access to State-Funded Health Coverage and Other Public Programs](#),” KFF, June 16, 2025.

109 Camilo Montoya-Galvez, “[Trump Officials Revoke Biden Policy that Barred ICE Arrests Near ‘Sensitive Locations’ Like Schools and Churches](#),” CBS News, January 21, 2025.

110 Kimberly Kindy and Amanda Seitz, “[Trump Administration Hands over Medicaid Recipients’ Personal Data, Including Addresses, to ICE](#),” Associated Press, July 17, 2025.

Demand-side restrictions compound supply-side constraints by shrinking the insured patient base and reducing revenue, making it more difficult for institutions to retain IMG and non-IMG physicians alike, further destabilizing care delivery.

4 Conclusion and Implications

Policy changes introduced by the Trump administration that affect the pipeline of medical subspecialists, including nephrologists, have proceeded at a rapid pace in 2025 and 2026. These restrictions affect not only immigrant physicians (many of whom work on J-1, H-1B, and O-1 visas) but also other health professionals who previously had temporary legal protection (such as Temporary Protected Status). Changes have been advanced through a wide array of policy instruments, including executive orders, administrative regulations, agency guidance, and legislation, each with different levels of durability and legal authority. Some changes have not yet been fully implemented, while others are being contested in the courts. As a result, it remains to be seen what their full impacts will be on IMGs and other health-care professionals' ability to enter and practice in the United States, patients' access to nephrology care, and the financial stability of institutions in which IMGs study, do research, and practice.

The effects will extend beyond IMGs themselves, rippling through the entire health-care system to affect a broad swath of American patients.

What is clear is that new rules affecting specialties such as nephrology that rely heavily on IMGs to fill fellowship and staff positions that would otherwise go unfilled are likely to have significant and wide-ranging consequences. The effects will extend beyond IMGs themselves, rippling through the

entire health-care system to affect a broad swath of American patients, particularly those living with chronic diseases such as kidney disease, as well as hospitals, clinics, and their staff.

Training Takes Time: Why “Domestic Only” Will Not Work

Many of the regulatory changes have been justified as mechanisms to protect U.S. workers by reducing competition and raising wages. Yet those goals are fundamentally misaligned with the realities of specialties such as nephrology that have substantial, well-documented shortages that IMGs help offset.¹¹¹ In fields experiencing genuine labor shortages, not labor market competition, restricting the workforce does not raise wages or improve opportunities for domestic workers; it leaves positions unfilled and patients without care. Delays in access to nephrology care can have life-threatening consequences for patients with kidney failure.

It takes more than a decade to educate and train a physician in the United States after high school. For instance, becoming a nephrologist takes 13 years after high school, and becoming a pediatric nephrologist takes 14 years, with many adding a year or more for advanced training. Even a large expansion of medical school enrollment today would not produce new nephrologists until well into the 2030s, and residency positions, not just medical school seats, remain a bottleneck. IMGs, by contrast, arrive having already completed medical school and often residency. Expanding domestic medical education and making

¹¹¹ Braga, Khanna, and Turner, “Migration Policy and the Supply of Foreign Physicians.”

nephrology more attractive to U.S. medical graduates are necessary steps, but on any timeline that matters to today's patients, these strategies would complement the retention of IMGs rather than substitute for it.

Who Will Likely Feel the New Policies' Effects?

The immigration and other policy changes examined in this report will have far-reaching consequences for patients, communities, and hospitals throughout the health-care system.

- ▶ **Patients.** The most vulnerable patients (those who depend on Medicaid or safety net institutions) are likely to feel the impact most acutely, but privately insured Americans will not be spared. As physician shortages deepen across the country, even patients with robust insurance coverage can expect longer wait times, reduced access to specialists, and deteriorating quality of care. Longer wait times delay diagnoses and treatment, and for patients with acute conditions, months-long waits can mean the difference between manageable illness and life-threatening complications. Wait times for physician appointments already average 31 days in major metropolitan areas—up 19 percent since 2022—and exceed 40 days in some specialties.¹¹² Additional reductions in the physician workforce will only aggravate these delays.
- ▶ **Underserved communities.** Communities that have been classified as shortage areas for decades, despite the contributions IMGs disproportionately make to care in such areas, will face greater shortfalls in skilled staffing. As of 2023, 72 percent of U.S. counties did not have a nephrologist, and nearly half of U.S. counties lacked a cardiologist. Immigration restrictions could deepen these disparities and force some community hospitals and Department of Veterans Affairs medical facilities to reduce services. Others will close departments or shut down entirely, creating health-care deserts.
- ▶ **Hospitals and clinics.** Cutbacks in Medicaid, ACA subsidies, and other changes will place increasing pressure on safety net hospitals, community hospitals, and rural facilities that depend on immigrant physicians. DHS has not exempted health-care facilities seeking to recruit a health-care professional on an H-1B visa from the hefty fees. If sponsoring a physician were to cost about \$100,000, many facilities might be forced to operate with significantly fewer staff and distribute the workload across fewer physicians.
- ▶ **Health-care workforce.** The physicians who remain in the health-care system will face increased workloads, longer hours, and greater stress, worsening already high burnout rates and driving more physicians to leave clinical practice.
- ▶ **Public health.** Reduced access to primary care and preventive services will lead to more emergency department visits, more hospitalizations for preventable conditions, and worse population health outcomes overall. Both the health and financial consequences will be borne by patients, who will see health-care costs rise if manageable, less costly outpatient care is replaced by expensive emergency interventions.

112 KFF, “Wait Times Up for Doc Appointments across Many Specialties, Survey Finds,” KFF Health News, May 29, 2025.

America Is Already Losing Ground Globally

The policies discussed in this report take place alongside another troubling trend: The United States is already losing its global competitiveness in attracting physicians and other health-care professionals. Of all foreign-trained physicians practicing in Organization for Economic Cooperation and Development (OECD) countries, the share practicing in the United States fell from 48 percent in 2010 to 36 percent in 2023.¹¹³ Countries such as Australia, Canada, and the United Kingdom as well as EU Member States (e.g., Ireland and Germany), which offer more predictable immigration policies, streamlined pathways to domestic permits to practice, and a comparable quality of life, are attractive alternatives for skilled health-care workers.¹¹⁴

A less welcoming climate for immigrants, combined with the unpredictability of work and residency in the United States, is likely to accelerate this trend. IMGs considering where to practice will naturally gravitate toward countries that welcome them, offer stable pathways to permanent residency, and provide better living and work opportunities for their families.¹¹⁵ As health systems become increasingly global—for example, through the growth of medical tourism and greater reliance on internationally trained health-care professionals in many advanced economies¹¹⁶—the longstanding expectation that the United States has an upper hand in attracting health-care talent might no longer be a reality.

IMGs considering where to practice will naturally gravitate toward countries that welcome them, offer stable pathways to permanent residency, and provide better living and work opportunities for their families.

Immigration Policy as Health Policy

The United States has among the worst performing health systems among comparable countries, despite spending more per capita on health care.¹¹⁷ Expanded immigration restrictions threaten to worsen this standing. This situation illustrates a critical challenge in policymaking: Changes in one policy domain can trigger cascading consequences in seemingly unrelated areas.

The Trump administration's immigration policy focuses on limiting people from entering and remaining in the United States, but it is also reshaping health-care delivery in ways that policymakers may not have fully anticipated or intended. For patients in rural communities who cannot see a nephrologist, and for privately insured patients who face longer wait times for life-sustaining dialysis, immigration policy is health-care policy.

113 Ave Lauren et al., "International Migration of Health Professionals to OECD Countries," in *International Migration Outlook 2025* (Paris: Organization for Economic Cooperation and Development, 2025). In that report, "foreign-trained" professionals are those who obtained their first medical degree outside the country where they currently reside. This term in the international literature is similar to the U.S. term "international medical graduate."

114 Jeanne Batalova, Michael Fix, and Kate Hooper, *Making New Yorkers Healthier: Leveraging Underemployed Immigrants' Skills* (Washington, DC: MPI, forthcoming).

115 Demetrios G. Papademetriou, Will Somerville, and Hiroyuki Tanaka, "Talent in the 21st Century Economy," in *Talent, Competitiveness, and Migration* (Washington, DC and Gütersloh, Germany: MPI and Bertelsmann Stiftung, 2009).

116 Lauren et al., "International Migration of Health Professionals to OECD Countries."

117 Emma Wager and Cynthia Cox, "International Comparison of Health Systems," in *Health Policy 101*, ed. Drew Altman (San Francisco: KFF, 2025).

Appendices

Appendix A. Nephrology: The Medical Specialty of Kidney Care

Nephrologists are physicians who specialize in diagnosing and treating kidney disease. The scale of kidney disease in the United States is significant, affecting one in seven U.S. adults or 37 million Americans.¹¹⁸

Nephrologists treat a wide range of conditions in their daily practice, including chronic kidney disease, which can progress to complete kidney failure; acute kidney injury, which can occur suddenly because of infection, medication, or other medical emergencies; kidney stones; and high blood pressure caused by or affecting the kidneys, among other issues. Nephrologists also oversee dialysis, a treatment that artificially filters the blood when the kidneys can no longer do so. Nephrologists work closely with dialysis centers, monitoring patients who can spend several hours a day, multiple days each week connected to dialysis machines. Nephrologists also evaluate and prepare patients for kidney transplantation.

Becoming a nephrologist in the United States involves a long training pathway, typically at least 13 years after high school: four years of undergraduate education, four years of medical school, three years of internal medicine residency, and two or three years of nephrology fellowship.¹¹⁹

During their three-year internal medicine residency, physicians work under supervision in hospitals while gradually assuming more responsibility for patient care. Most enter residency through the National Resident Matching Program, and all must pass a three-step licensing sequence, either the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination. Step 1 is taken after the preclinical phase of medical school, Step 2 during the final year before residency applications, and Step 3 during residency itself. Physicians who choose to complete the two-to-three-year fellowship to specialize in nephrology receive intensive training in kidney disease, dialysis, transplantation, and the interpretation of kidney biopsies.

The path for international medical graduates (IMGs) requires additional steps. They must have their medical credentials verified and certified by the Educational Commission for Foreign Medical Graduates, pass the first two steps of the USMLE, and meet clinical and communication skills requirements. IMGs must then secure a U.S. medical residency position, which is more competitive for them than for U.S. graduates, and those who are not U.S. citizens or permanent residents must find a program willing to sponsor them for a J-1 or H-1B visa. Many IMGs also complete additional training or conduct research in the United States to strengthen their residency applications.

After completing all required training, nephrologists must obtain medical licensure in the state where they intend to practice and typically pursue board certification in both internal medicine and nephrology by passing examinations administered by the American Board of Internal Medicine. Board certification

¹¹⁸ Centers for Disease Control and Prevention, "Chronic Kidney Disease in the United States."

¹¹⁹ Callie Torres, "How to Become a Nephrologist? - A Step by Step Guide," University of Medicine and Health Sciences, January 15, 2024.

demonstrates that a physician has met recognized standards in the specialty and must be renewed periodically through continuing medical education and examination.

Appendix B. Spotlight on Indian Physicians: Global Migration Patterns and Opportunities

Most advanced countries face growing health-care workforce challenges as their populations age and demand for medical services increases. As they have in the past, countries such as Canada, the United Kingdom, and the United States admit internationally trained health professionals to help address critical skills gaps and geographic mismatches. Since 2010, the number of foreign-trained physicians¹²⁰ working in Organization for Economic Cooperation and Development (OECD) countries has increased by 62 percent, while the number of foreign-trained nurses has grown by 71 percent,¹²¹ underscoring the role of international medical professionals in sustaining health-care systems across developed economies.

India is the world's largest source of emigrant physicians. Between 2000–01 and 2020–21, the number of Indian-born physicians in OECD countries rose by 76 percent, reaching nearly 100,000.¹²² These Indian-born physicians accounted for 12 percent of all immigrant physicians across OECD countries in 2020–21. In the United States in 2023, Indian-born physicians accounted for about 5 percent of all U.S. physicians and 14 percent of nephrologists.¹²³

Why Physicians Historically Left India

The decision to emigrate stems from a complex interplay of professional, economic, and systemic factors, including the belief that Western training is superior to domestic training, the expectation of substantially higher income, opportunities to obtain advanced subspecialty training, and opportunities to practice high-tech medicine that are largely unavailable in India.¹²⁴ Indian IMGs have also emigrated because of frustration with bureaucratic barriers and perceived governmental mismanagement of health-care and education systems.¹²⁵

Historical factors have also facilitated emigration. Since the colonial era, Indian medical schools have structured their curricula to meet Western standards rather than address India's predominantly rural primary care needs, creating an incentive to emigrate to Canada, the United Kingdom, and the United

120 The term "foreign-trained" professionals is used in the international literature in a way similar to "international medical graduate" in the U.S. context, to describe those who obtained their first medical degree outside the country where they currently reside.

121 Lauren et al., "International Migration of Health Professionals to OECD Countries."

122 Lauren et al., "International Migration of Health Professionals to OECD Countries."

123 Authors' analysis of data from the 2023 American Community Survey; data provided to the authors by Kurtis Pivert of ASN based on his analysis of the 2023 AMA PPD.

124 Fitzhugh Mullan, "Doctors for the World: Indian Physician Emigration," *Health Affairs* 25, no. 2 (2006): 380–93.

125 Mullan, "Doctors for the World;" Margaret Walton-Roberts and S. Irudaya Rajan, "Global Demand for Medical Professionals Drives Indians Abroad Despite Acute Domestic Health-Care Worker Shortages," *Migration Information Source*, December 3, 2020; Barbara Stilwell et al., "Developing Evidence-Based Ethical Policies on the Migration of Health Workers: Conceptual and Practical Challenges," *Human Resources for Health* 1, no. 8 (2003).

States.¹²⁶ English-language medical instruction has also facilitated physician migration to English-speaking countries.¹²⁷

The U.S. Advantage: Why the United States Became the Premier Destination

Initially, the United Kingdom was the primary destination for physicians from India (and those from Bangladesh, Pakistan, and Sri Lanka) because of colonial ties and expanding opportunities to work in the National Health Service.¹²⁸ These physicians filled positions left vacant when UK-trained physicians immigrated to Australia, Canada, and the United States seeking better pay and working conditions. Indian physicians also tended to work in locations and specialties that were less popular among UK-trained physicians, such as inner-city general practice, geriatrics, and psychiatry.

Changes in U.S. policy in the second half of the 20th century, combined with financial incentives, shifted migration toward the United States. The *Immigration and Nationality Act of 1965* removed national origins quotas and opened pathways for non-European immigrants. The act also expedited the entry of health-care and other professionals. IMGs, in particular, were allowed to enter the United States to provide care in shortage areas.¹²⁹ The *Immigration Act of 1990* and the Conrad State Program also created new opportunities to practice in the United States and obtain permanent residency, facilitating the migration of Indian and other physicians. U.S. physician salaries significantly exceed those in many other countries, rewarding the substantial investment in private medical education in India (often \$75,000–\$100,000) with emigration to the highest-paying market.¹³⁰

For subspecialists such as nephrologists, the United States offers opportunities to obtain advanced training in areas such as transplant nephrology, interventional nephrology, and onco-nephrology, creating a strong link between international migration and career advancement. Indian nephrologists also benefit from established professional and educational networks and the presence of the broader Indian diaspora in the United States, the second largest Asian diaspora in the country, with more than 5.8 million people as of 2024.¹³¹ These communities provide mentorship, job placement assistance, and cultural support, making the transition to practicing in the United States easier for newcomers and their families. However, as opportunities and facilities in India continue to improve, the number of qualified physicians seeking training and employment in the United States may decline, especially given the barriers created by recent policy changes.

126 Peter Trewby, “Migrating Doctors,” *Clinical Medicine* 17, no. 1 (2017): 4–5.

127 Walton-Roberts and Rajan, “Global Demand for Medical Professionals.”

128 Julian M. Simpson, “Diagnosing a Flight from Care: Medical Migration and ‘Dirty Work’ in the NHS,” *History and Policy*, accessed September 2, 2026.

129 Alam, *The Care of Foreigners*.

130 Mullan, “Doctors for the World.”

131 MPI Migration Data Hub, “Top Diaspora Groups in the United States, 2024,” accessed January 29, 2026.

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