

Brain Waste among U.S. Immigrants with Health Degrees

A Multi-State Profile

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Executive Summary

The COVID-19 pandemic that hit the United States with tremendous force beginning in March 2020 shone a spotlight on the health-care field, highlighting the contributions of U.S.-born and immigrant workers alike in hospitals, community clinics, medical offices, and nursing homes. More than 2.6 million immigrants were employed in the health-care field before the outbreak began, 1.5 million of them in higher skilled positions such as doctors, registered nurses, and pharmacists.

Yet even as they serve important roles in health care, another 263,000 immigrants and refugees in the United States who have at least a four-year college degree in medical and health sciences and services are largely sidelined, either working in low-skilled jobs or out of work as a result of credential-recognition difficulties, limited English proficiency, and other barriers.

The Migration Policy Institute (MPI) for years has mapped skill underutilization, which its researchers refer to as “brain waste,” at the U.S. level. This fact sheet presents a first-ever profile by state of the 263,000 highly skilled immigrants with undergraduate degrees in health care who are experiencing this skill underutilization. By analyzing data from the U.S. Census Bureau and the U.S. Department of Labor,

this profile explores where these immigrant professionals live, the languages they speak, their English proficiency, college degree majors, and legal status.

The authors find that immigrant health professionals relegated to low-skilled jobs or out of work are not just concentrated in the handful of traditional immigrant-gateway states, but instead are widely distributed across the United States. Almost two-thirds speak either only English or speak English very well (and so are deemed English proficient). There is substantial overlap between the languages spoken by these underutilized immigrant college graduates and those spoken by the states’ limited English proficient populations. More than 80 percent them are legally present in the country; they are either naturalized U.S. citizens, legal permanent residents, humanitarian migrants, or holders of temporary nonimmigrant visas.

Immigrant health professionals relegated to low-skilled jobs or out of work are not just concentrated in the handful of traditional immigrant-gateway states.

Despite the severe job losses in the health sector in March and April, it remains the case that immigrants with health-related degrees who are on the side-

lines because of licensing and other barriers could represent a needed reserve of professionals to help offset the immense strains imposed on the health-care system by the coronavirus. Their linguistic and cultural skills represent a valuable asset during a public-health crisis, as they can more easily and effectively communicate about the sensitive topics of disease and a person's movements and associations. These skills are all the more important as it may be particularly challenging to establish the needed level of trust given the chilling effects of complex public-charge rules and perceived increases in immigration enforcement under the Trump administration. In the immediate term, one role these health professionals could fill would be to supplement the rapidly growing force of contact tracers who can be critical to limiting the disease's further spread.

1 Introduction

As COVID-19 cases soar to staggering new heights, with 1 million new infections detected within a 28-day span in June and July,¹ governments across the United States have been under great pressure to develop strategies to expand testing to the general population, help hospitals provide necessary care, and monitor the infection's spread. In March and April 2020, a number of governors and mayors called for retired health-care professionals to return to the field; others encouraged the early graduation of medical students and nurses to boost the ranks of a health-care workforce being overtaxed in hotspots. The governors of Colorado, Idaho, Massachusetts, Michigan, Nevada, New Jersey, New York, and Pennsylvania used their executive authority to temporarily suspend or adjust licensing requirements for certain health professions. These executive policies aimed to expand states' access to health-care professionals by, among other things, making it easier for internationally trained health-care professionals to apply for professional licenses or to practice (including via telemedicine) with licenses from other countries

that are in good standing. (See the Appendix for a brief overview of these policies.)

However, the push to expand the supply of medical professionals was followed by massive job dislocations caused by stay-at-home orders, leading to widespread layoffs and furloughs of health-care workers across the entire sector.² An estimated 1.4 million health-care workers lost their jobs in April alone amid a ban on elective medical procedures and a precipitous drop in the number of patients coming to private medical offices and community clinics.³ May and June saw a partial recovery, with job growth in the sector rising by 312,000 and 358,000, respectively.⁴

There are several reasons to expect an uptick in demand for health-care workers.

It is unclear if the rest of these jobs will come back, when they will do so, how they might be transformed, and whether furloughed employees might be deployed to meet staffing needs created by COVID-19. However, there are several reasons to expect an uptick in demand for health-care workers. Following states' reopening of their economies, public-health officials reported wide new outbreaks as people began to return to work, schools, public spaces such as restaurants and shops, and public transportation.⁵ As a result, the number of daily new cases nationwide has risen to the highest levels since the outbreak began: as of mid-July 2020, the daily rate of infections exceeded 50,000.⁶ Many of those with the virus will need to receive treatment; some will need intensive care in hospitals, many of which are again overwhelmed. Additionally, hospital administrators remain concerned about another wave during the fall/winter season.⁷ Outside of coronavirus-related demand, many hospitals have resumed elective procedures and patients are being called back for tests and procedures. Beyond the immediate crisis,

demand for health services will expand with the aging of the U.S. population—demand that is rising just as many physicians and nurses are reaching retirement.⁸

Immigrant and refugee health-care professionals who are on the sidelines because of licensing and other barriers could become a resource during the pandemic in several critical capacities, even if they cannot immediately get jobs at their skill levels. They can join other health-care providers in hospitals and community clinics participating in the testing and treatment of COVID-19 patients. They could also bolster the rapidly expanding workforce engaged in contact tracing, bringing to bear their linguistic and cultural competencies. A long-used public-health strategy to contain the outbreak of communicable diseases, contact tracing helps quickly identify people who have been exposed to an infection and provide them with instructions and information on the next steps, encouraging them to get tested or to self-quarantine. South Korea, Germany, China, and Singapore have used widespread contact tracing as one of their strategies to keep the number of coronavirus cases down.⁹ One estimate prepared for the U.S. Health Resources and Services Administration in July 2020 found that more than 340,000 workers would be needed nationwide to fully staff the contact tracing workforce, given the high levels of COVID-19 cases being reported.¹⁰

In an April 2020 analysis, Migration Policy Institute (MPI) analysts drew on data from the U.S. Census Bureau's American Community Survey (ACS) and found that there are 263,000 immigrants¹¹ nationwide with undergraduate degrees in medical and health sciences and services¹² whose skills were underutilized¹³—that is, they were either working in low-skilled jobs or out of work.¹⁴ (These immigrants made up about one-quarter of the 1.1 million underutilized adults with health-related undergraduate degrees nationwide.) While many of these immigrants may also hold advanced degrees, the ACS only collects information on degree majors regarding respondents' undergraduate degrees.

This fact sheet draws on ACS data to provide state-level estimates of the number and key characteristics of underutilized immigrants with health-related degrees.¹⁵ One focus here is on these immigrants' language and cultural competencies—unique assets that could be employed in sharing information with, and providing care to, populations that may face English or cultural communication challenges. With immigrant and minority communities among the hardest-hit during this public-health crisis,¹⁶ linguistic and cultural competencies can be invaluable resources.

2 State-Level Numbers and Characteristics of Underutilized Immigrant Health-Care Professionals

The authors' research on the underemployment of college graduates, a phenomenon often referred to as "brain waste," shows that immigrants with health-related degrees in general are less likely to suffer from skill underutilization than their counterparts with degrees in education or business.¹⁷ Prior to the COVID-19 outbreak, more than 2.6 million immigrants were employed in the health-care field in 2018, with 1.5 million of them in higher skilled occupations such as doctors, registered nurses, and pharmacists.¹⁸ Nonetheless, some immigrants find it extremely difficult to restart their careers as doctors, nurses, and dentists due to institutions' failure to recognize their foreign degrees and experience, licensing barriers, their lack of professional networks, and other barriers.

Explore the Data

U.S. and state-level data from this analysis are available on the MPI website. Find the data here: bit.ly/ImmBrainWasteHealth

A. Geographic Distribution

Nationwide, about 1.1 million immigrants hold a health-related undergraduate degree, as shown in Table 1. The eight states with executive policies to expand the health-care workforce by including internationally trained professionals (those highlighted in light teal) are home to 23 percent (or 61,000) of the 263,000 immigrants with undergraduate degrees in

a health field who are either working in low-skilled jobs or out of work. Other states with large numbers of underutilized immigrant health-care workers include California, Florida, Texas, and Illinois.

While underutilized immigrants represent 25 percent of U.S. immigrants with health-related degrees, the share is higher in a number of states: almost 43 percent in Utah, 37 percent in Hawaii, and about one-third in Kentucky, North Carolina, and Colorado.

TABLE 1
Immigrant Adults (ages 25 to 64) with Health-Related Undergraduate Degrees, by State and Underutilization, 2017*

	Total Immigrants with Health-Related Undergraduate Degrees	Underutilized Immigrants	Underutilized Share of Total
United States	1,069,000	263,000	24.6%
California	223,000	60,000	27.0%
Florida	105,000	29,000	27.8%
Texas	101,000	23,000	22.8%
New York	110,000	22,000	19.7%
New Jersey	61,000	14,000	23.6%
Illinois	52,000	11,000	21.4%
Georgia	25,000	8,000	31.9%
Washington	25,000	8,000	29.8%
Maryland	35,000	7,000	21.1%
North Carolina	18,000	6,000	33.9%
Michigan	24,000	6,000	23.6%
Virginia	27,000	6,000	22.9%
Pennsylvania	28,000	6,000	20.8%
Ohio	20,000	5,000	24.2%
Massachusetts	33,000	5,000	16.6%
Colorado	11,000	4,000	33.4%
Nevada	12,000	4,000	31.1%
Arizona	18,000	4,000	21.7%
Indiana	10,000	3,000	30.6%
Tennessee*	9,000	3,000	28.0%
Minnesota	13,000	3,000	23.0%
Connecticut*	13,000	3,000	19.9%

TABLE 1 (cont.)

Immigrant Adults (ages 25 to 64) with Health-Related Undergraduate Degrees, by State and Underutilization, 2017*

	Total Immigrants with Health-Related Undergraduate Degrees	Underutilized Immigrants	Underutilized Share of Total
Utah*	4,000	2,000	42.5%
Hawaii*	7,000	2,000	37.4%
Kentucky*	5,000	2,000	34.1%
Oregon*	8,000	2,000	27.6%
Missouri*	8,000	2,000	20.8%
South Carolina*	4,000	1,000	24.7%

* Based on 2013–17 American Community Survey (ACS) data from the U.S. Census Bureau that have been pooled to provide a greater degree of accuracy for states with smaller ACS sample sizes. States shaded in light teal include 1) six states that have issued executive policies that revise licensing requirements to allow eligible internationally trained doctors, nurses, and some other practitioners to obtain professional licenses during the COVID-19 pandemic; and 2) Pennsylvania, which permits health professionals licensed and in good standing in another country to provide services to patients via telemedicine during the coronavirus emergency. Although Idaho is among the eight states with policies that allow certain internationally trained health professionals to practice, it is not included in this table due to the small sample size of underutilized immigrants with health-related degrees.

Notes: Health-related degrees refer to undergraduate degrees in medical and health sciences and services. The term “underutilized adults” is defined here as persons between ages 25 and 64 who hold undergraduate degrees or higher and who are employed in jobs that require no more than a high school diploma, are unemployed, or are not engaged in the civilian labor force.

Source: Migration Policy Institute (MPI) tabulation of data from the U.S. Census Bureau 2017 and pooled 2013–17 ACS data.

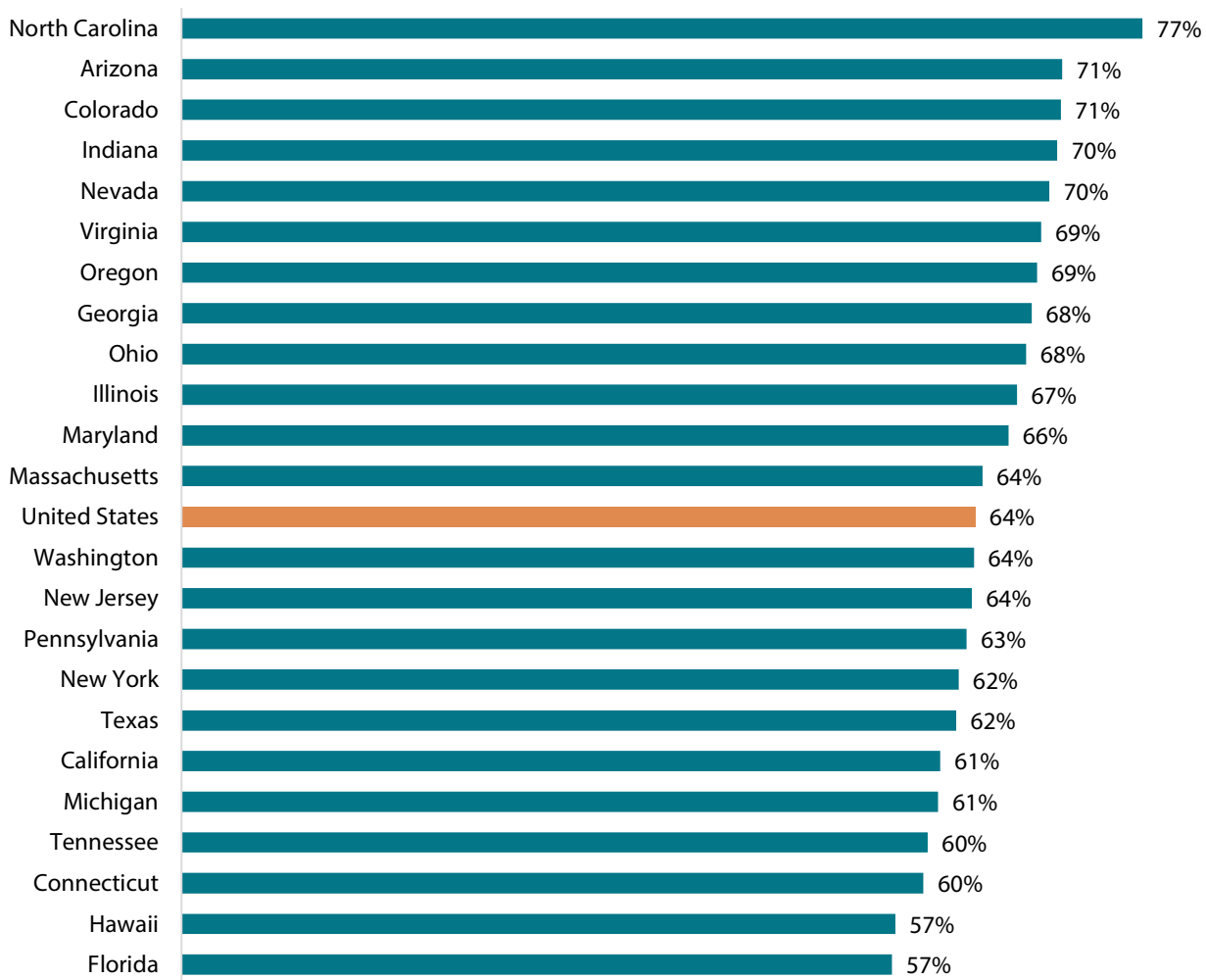
B. English Proficiency

A high level of English proficiency represents one distinct characteristic of underutilized immigrant health-care professionals. While the share of all im-

migrants who report speaking English “only” or “very well” is 53 percent, 64 percent of underutilized immigrant health-care workers nationwide are English proficient,¹⁹ as shown in Figure 1.

FIGURE 1

English Proficient Share of Underutilized Immigrants with Health-Related Degrees, Selected States, 2013–17



Note: The term “English proficient” refers to persons who reported speaking only English at home or speaking English “very well” if they also speak another language at home.

Source: MPI tabulation of U.S. Census Bureau pooled 2013–17 ACS data.

C. Linguistic Competency

Extensive medical research documents the detrimental impact of language barriers on access and quality of health care. Limited English proficient (LEP) patients have lower access to primary and preventive care, report lower satisfaction with their care, and are more likely to disregard medical advice.²⁰ While professional interpreters can significantly improve the quality of care for LEP patients, the cost of such services is high, especially when serving diverse populations that speak a wide range of languages.²¹

Immigrant health-care professionals have linguistic and cultural competencies that can reduce some of the barriers LEP and ethnic minority patients face. The ability of health-care providers to communicate in the languages that patients understand becomes even more essential in explaining the risks and treatment options of a still largely mysterious illness—one that emerged just as complex new public-charge rules went into effect. These rules widely expand the public

benefits, income, health, and other criteria that will be taken into account in determining whether immigrants can obtain a green card. The highly technical and complex rules were finalized in February 2020, and many commentators have expressed concerns that they will have a broad chilling effect on the use of health and other public benefits by immigrants and their families due to fear and confusion.²²

The data indicate that across the United States there is a significant overlap between the top languages spoken by underutilized immigrant health-care professionals and those spoken by the LEP population. To illustrate, significant numbers of immigrant health professionals experiencing brain waste speak the languages of the largest LEP populations in California: Spanish, Chinese, Vietnamese, Tagalog, Korean, and Farsi (see Table 2). Similarly, in Massachusetts, LEP residents and immigrant health professionals experiencing skill underutilization speak Spanish, Portuguese, Chinese, Haitian Creole, and Arabic.

TABLE 2

Top Languages Spoken by Limited English Proficient Population and by Underutilized Immigrants with Health-Related Degrees: United States, California, Massachusetts, and New Jersey, 2013–17

State	State's LEP Population		Underutilized Immigrant Health-Care Professionals	
	Rank	Language	Rank	Language
United States	1	Spanish	1	Spanish
	2	Chinese	3	Chinese
	3	Vietnamese		
	4	Korean	5	Korean
	5	Tagalog	2	Tagalog
	6	Arabic	4	Arabic
	7	Russian		
California	1	Spanish	2	Spanish
	2	Chinese	3	Chinese
	3	Vietnamese	6	Vietnamese
	4	Tagalog	1	Tagalog
	5	Korean	4	Korean
	6	Armenian		
	7	Farsi	7	Farsi

TABLE 2 (cont.)

Top Languages Spoken by Limited English Proficient Population and by Underutilized Immigrants with Health-Related Degrees: United States, California, Massachusetts, and New Jersey, 2013–17

State	State's LEP Population		Underutilized Immigrant Health-Care Professionals	
	Rank	Language	Rank	Language
Massachusetts	1	Spanish	1	Spanish
	2	Portuguese	3	Portuguese
	3	Chinese	2	Chinese
	4	Haitian Creole	5	Haitian Creole
	5	Vietnamese		
	6	Russian		
	7	Arabic	4	Arabic
New Jersey	1	Spanish	1	Spanish
	2	Chinese	6	Chinese
	3	Korean	4	Korean
	4	Portuguese		
	5	Gujarati	3	Gujarati
	6	Polish		
	7	Arabic		

Note: The overlap in languages is indicated by the light teal shading.

Source: MPI tabulation of U.S. Census Bureau pooled 2013–17 ACS data.

The examples of common languages spoken by state LEP populations and immigrant health-care professionals experiencing skill underutilization include not only the most commonly spoken languages but also Amharic/Ethiopian (in Colorado, Nevada, and Virginia, for example), Arabic (Michigan, North Carolina, and Pennsylvania), French (Maryland), Gujarati (Georgia and New Jersey), Japanese (Hawaii), Kru/Mande/Fulani (Maryland), Polish (Illinois), Russian (Washington), and Urdu (Texas), as shown in the detailed state profiles [available here](#).

D. Top Three Fields of Study

Nursing is the most common degree held by underutilized immigrants nationwide and in most states. Forty-six percent of U.S. immigrants with health-related undergraduate degrees who experi-

ence brain waste had formal training as nurses. This was also true of roughly half of sidelined immigrants with health-related degrees in California, Florida, and Texas. The predominance of immigrants with nursing degrees among the underutilized was even higher in Hawaii (77 percent) and Nevada (67 percent). Other top undergraduate degrees earned by immigrant professionals experiencing brain waste were in pharmacy and pharmaceutical science, and in treatment therapy, a classification that includes physical and occupational therapists.

E. U.S. Citizenship and Legal Status

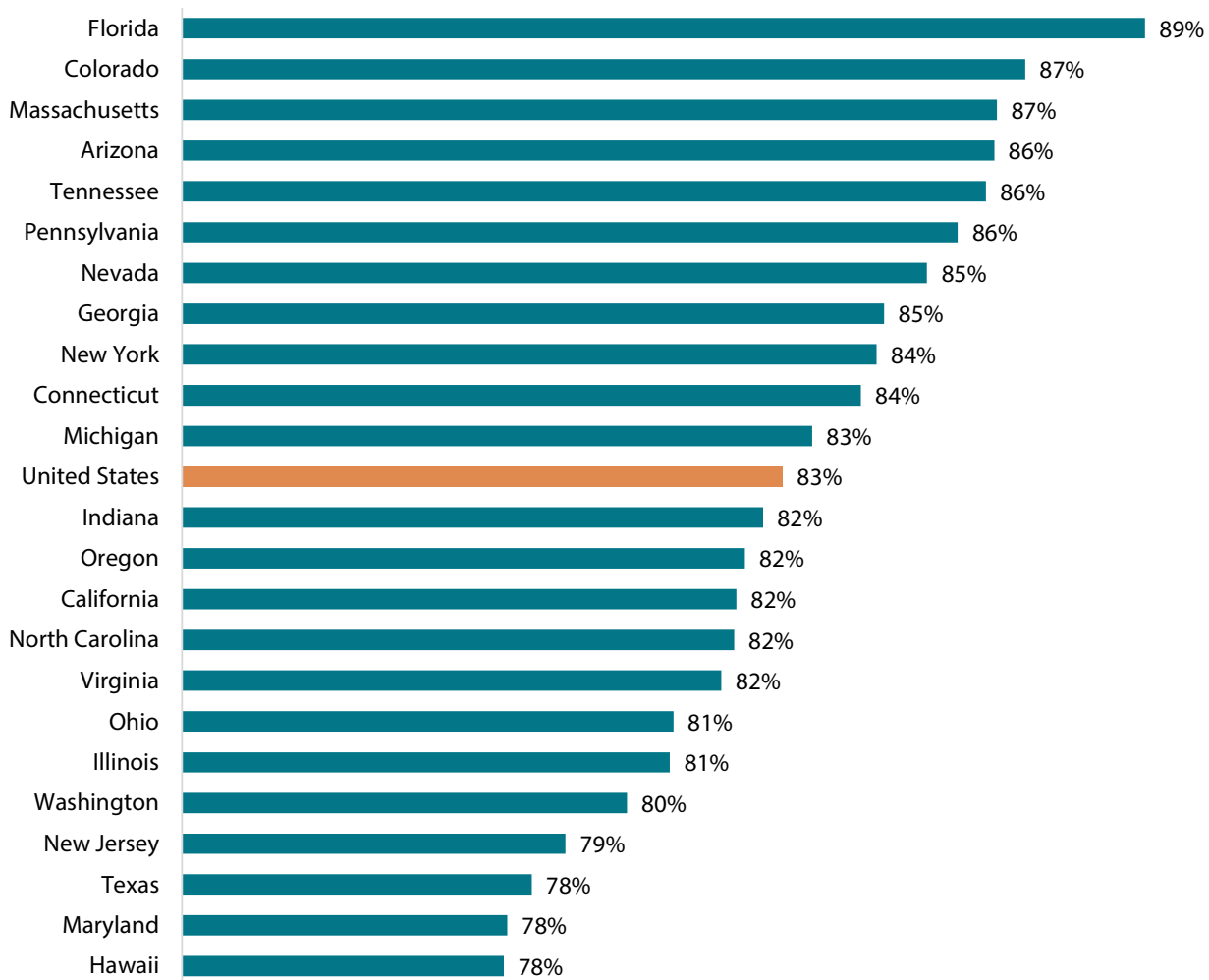
Most, if not all, health professions that require a four-year college degree are regulated and therefore require a professional license. This means they are closed

to immigrants without legal status except in a handful of cases.²³ The authors' earlier research showed that immigrant college graduates (regardless of their field of study) were more likely to be underemployed if they were unauthorized, net of other factors.²⁴ However, lack of legal status does not fully explain underemployment. Among all underutilized immigrants with

health-related undergraduate degrees, almost half were naturalized U.S. citizens, one-quarter were green-card holders (i.e., legal permanent residents), and 17 percent were unauthorized. In only four states—Hawaii, Maryland, Texas, and New Jersey—did the unauthorized share exceed 20 percent (see Figure 2).

FIGURE 2

Share of Legally Present Underutilized Immigrants with Health-Related Degrees, 2012–16



Source: MPI tabulation of U.S. Census Bureau data from the 2012–16 ACS and 2008 Survey of Income and Program Participation (SIPP), with legal status assignments developed in consultation with James Bachmeier of Temple University and Jennifer Van Hook of The Pennsylvania State University, Population Research Institute. For more on the methodology used, see MPI, “MPI Methodology for Assigning Legal Status to Noncitizen Respondents in U.S. Census Bureau Survey Data,” accessed July 15, 2020.

3 Conclusions

The analyses presented here make clear that the number of sidelined immigrant professionals with health and medical degrees is not just concentrated in a few gateway states but is widely distributed nationwide. Easing the entry of this dispersed, reserve corps of highly trained immigrants could help provide health-care systems what one commentator has described as accordion-like flexibility to address unmet demands as the COVID-19 crisis spreads, surging in rural and urban communities alike, many of which are chronically underserved by health professionals.²⁵ These highly educated immigrants offer both language and cultural skills that are not replicated in the current health-care labor force.²⁶ Moreover, the demand for such skills is only likely to grow as states turn to contact tracing as a strategy for bringing the COVID-19 contagion under control.

While the supply of and demand for health-care professionals to treat COVID-19 cases remain fluid, in the near and intermediate term it is almost certain that there will be a rapidly rising demand for contact tracers: Some estimate that demand could rise to

more than 340,000. The value of these unlicensed positions to underutilized health-care professionals will depend on the pay they provide, their duration, and whether the experience they offer can be translated into stackable credentials and pathways to successful health careers.

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With the disease spreading particularly fast among Latino and other immigrant and minority communities, broad demand for the kind of cultural and linguistic skills that many underutilized immigrants with health degrees offer should be high not just in tracing networks, but in other emergency and nonemergency settings. The value of bringing these skills to this very sensitive work is only reinforced by high levels of fear stemming from the current policy environment, anti-immigrant rhetoric, and broad expansion of the public-charge rule chilling many from accessing health-care services.

Appendix. State Responses in Expanding Licensing Opportunities for Internationally Trained Health Professionals

In one striking response to the COVID-19 pandemic, governors in eight states in Spring 2020 issued executive policies that sought, among other things, to enable overwhelmed health systems to deploy internationally trained physicians and other professionals by adjusting complex and demanding licensing requirements. (By and large, licenses that regulate the number and type of professionals entering the workforce in health care and other sectors fall under the authority of state governments.)

These state executive orders and proclamations, signed in March and April 2020 by six Democrat and two Republican governors, differed along several dimensions: the professions covered; length of practice in the home country and in the United States; recency of U.S. practice; scope of permitted practice; and duration of licenses. Table A-1 provides an overview of the type of actions taken by these states.

A look at five states illustrates the ways in which these states' initiatives vary. The reforms undertaken by Massachusetts were comparatively limited: restricted to physicians, permitting them to practice after two (versus the usual three) years of postgraduate training in the United States or Canada. Michigan's order extended beyond physicians to include physician assistants, nurses, and respiratory therapists, requiring that they be in good standing in another country with five years' experience and with one year of experience in the last five years. Pennsylvania allows licensed practitioners from other states and countries to provide services via telemedicine. Idaho, by invoking existing legislation called the *Idaho Medical Practice Act*, allows physicians and physician assistants licensed in other countries to practice in the state during emergencies such as the COVID-19 pandemic. Nevada issued the most expansive order: extending from physicians to a wide range of clinical and nonclinical professions, requiring only a license in another country or that the applicant be a medical or nursing student. Licenses must be approved by the state's Chief Medical Officer.

At the time of this writing, these policies were beginning to be implemented in earnest, except in Michigan. Citing a change of priorities in relief efforts, on July 13, the governor of Michigan rescinded the executive order that allowed licensing of eligible internationally trained health professionals.²⁷ According to the World Education Services, as of July 9, 2020, approximately 1,000 internationally trained physicians had applied for a license in New Jersey, the state that is the farthest along in policy implementation.²⁸ Of them, 32 were approved. According to the Idaho State Board of Medicine, nine foreign physicians (with licenses outside of the United States or Canada) registered with the Board of Medicine to practice in the state during the COVID-19 emergency as of July 10, 2020.²⁹

Although the number of immigrant professionals who have been able to obtain licenses under the emergency orders was fairly small at this writing, these policies arguably embody an expanded state awareness of the potential value of internationally trained health professionals, many of whom—as demonstrated in this fact sheet—are underutilized. The orders also represent a widened appreciation of the value of recognizing internationally earned credentials and experience that goes beyond earlier efforts documented by the Migration Policy Institute.³⁰

TABLE A-1
State Efforts to Open Medical Licensing, as of mid-July 2020

	Colorado	Idaho	Massachusetts
Date enacted	April 15, 2020	March 18, 2020	April 9, 2020
Type of policy	Governor's executive order	State Board of Medicine Proclamation, invocation of <i>Medical Practice Act 54-1804</i> in response to Governor's March 13, 2020 emergency declaration	Governor's emergency order
Professions included	Advanced practice nurses, certified registered nurse anesthetists, nurses, physicians, physician assistants, respiratory therapists	Physicians, physician assistants	Physicians
Requirements		Licensed in good standing in another country	
Licensure			
Experience	Minimum of one year of post-graduate training or practice in a foreign country		
Education			Graduate of an international medical school who has completed at least two years of postgraduate medical training (residency) in the United States or Canada
Other	Passed examinations by the National Board of Medical Examiners, National Board of Osteopathic Medical Examiners, Federation of State Medical Boards, or other examination approved by the Colorado Medical Board		
License			
Type	Temporary license	Waiver of licensure	Full license
Validity period	Until December 31, 2020	Public-health emergency	Two years
Practice scope	Delegated medical services under the direct supervision of a licensed physician, other than prescribing medications	Unlimited	Unlimited
Duration of the licensing expansion	Until August 29, 2020	Public-health emergency	Until rescinded or the state of emergency is terminated
Agencies responsible for policy implementation	Colorado Department of Regulatory Agencies (must promulgate and issue temporary emergency rules), Colorado Medical Board	Idaho Board of Medicine	Massachusetts Board of Registration in Medicine

TABLE A-1 (cont.)

State Efforts to Open Medical Licensing, as of mid-July 2020

	Michigan	Nevada	New Jersey
Date enacted	April 26, 2020	April 1, 2020	April 1, 2020
Type of policy	Governor's executive order	Governor's emergency directive	Governor's executive order
Professions included	Physicians, physician assistants, registered professional nurses, licensed practical nurses, respiratory therapists	Physicians, physician assistants, nurse practitioners, advanced practice registered nurses, registered nurses, licensed practical nurses, emergency medical technicians, advanced emergency medical technicians, respiratory care practitioners, paramedics, pharmacists, pharmacy technicians, medical students, nursing students, medical laboratory directors or technicians, and licensed or certified behavioral health professionals	Physicians
Requirements	Licensure	Licensed in good standing in another country	Licensed in good standing in another country
	Experience	At least five years of practical experience and practiced for at least one year in the last five years	At least five years of practical experience and practiced for at least one year in the last five years
	Education		
	Other		Has received a waiver and exemption of professional licensing requirements from the state Chief Medical Officer
License	Type	Foreign license waiver	Waiver of licensure
	Validity period	Declared states of emergency and disaster	State of emergency
	Practice scope	Not specified	May practice outside the scope of their specialization, within the limits of their competency, to the extent necessary to bolster Nevada's healthcare system during the COVID-19 crisis
Duration of the licensing expansion	Rescinded July 13, 2020, per Executive Order 2020-150	Until modified or terminated by a subsequent directive	Duration of the state of emergency or public-health emergency, whichever is longer
Agencies responsible for policy implementation	Michigan Department of Licensing and Regulatory Affairs	Nevada Chief Medical Officer and professional licensing boards	New Jersey Division of Consumer Affairs

TABLE A-1 (cont.)

State Efforts to Open Medical Licensing, as of mid-July 2020

	New York	Pennsylvania
Date enacted	March 23, 2020	March 18, 2020
Type of policy	Governor's executive order	Governor's suspension of relevant laws
Professions included	Physicians, physicians-in-training	Professionals in chiropractic, dentistry, medicine, nursing, optometry, pharmacy, podiatry, psychology, osteopathic medicine, nursing home administration, occupational therapy, physical therapy, social work, therapy and counseling, and speech-language pathology and audiology
Requirements		Licensed in good standing in another country
Licensure		
Experience		
Education	Graduates of foreign medical school with at least one year of graduate medical education (residency)	
Other		
Type	Limited permit	Waiver of licensure
Validity period	Two years	State of emergency
Practice scope	Patient care in certain institutions, under the supervision of a New York State licensed and currently registered physician	Telemedicine
Duration of the licensing expansion	Through July 21, 2020	State of emergency
Agencies responsible for policy implementation	New York State Department of Health	Pennsylvania Licensing Boards

Sources: For **Colorado**, see Colorado Department of Regulatory Agencies, "Rule 145 – Emergency Rules and Regulations Regarding Temporary Licensure" (regulation 3 CCR 713-45, accessed July 19, 2020); State of Colorado, Office of the Governor, "Ordering the Temporary Suspension of Certain Statutes and Rules to Expand the Healthcare Workforce for Hospitals and Other Inpatient Treatment Facilities Due to the Presence of COVID-19" (executive order D 2020 038, April 15, 2020); Colorado Department of Regulatory Agencies, "Executive Order Questions and Answers," updated April 15, 2020. For **Idaho**, see Idaho State Board of Medicine, "Idaho State Board of Medicine Proclamation" (proclamation, March 13, 2020); Idaho State Board of Medicine, "Frequently Asked Questions – COVID-19," accessed July 19, 2020; author correspondence with Anne K. Lawler, Executive Director, Idaho State Board of Medicine, June 18–July 15, 2020. For **Massachusetts**, see Commonwealth of Massachusetts, Office of the Governor, "Order Providing Accelerated Licensing of Physicians Educated in Foreign Medical Schools" (executive order, March 9, 2020); Massachusetts Board of Registration in Medicine, "Important Information Regarding Limited Licensing During the State of Emergency," accessed July 19, 2020. For **Michigan**, see State of Michigan, Office of the Governor, "Temporary Relief from Certain Restrictions and Requirements Governing the Provision of Medical Services" (executive order no. 2020–61, April 26, 2020); State of Michigan, Office of the Governor, "Temporary and Limited Relief from Certain Licensing and Certification Requirements Applicable to COVID-19 Response: Rescission of Executive Order 2020-61" (executive order no. 2020–150, July 13, 2020). For **Nevada**, see State of Nevada, Executive Department, "Declaration of Emergency Directive 011" (emergency directive, April 1, 2020). For **New Jersey**, see State of New Jersey, Office of the Governor, "Executive Order No. 112" (executive order, April 1, 2020); New Jersey Division of Consumer Affairs, "Temporary Emergency Licensure of Foreign Physicians Supporting New Jersey's COVID-19 Response: Guidance and Frequently Asked Questions (FAQs)," updated June 9, 2020. For **New York**, see State of New York, Executive Chamber, "Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency" (executive order no. 202.10, March 23, 2020); State of New York, Executive Chamber, "Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency" (executive order no. 202.18, April 16, 2020); State of New York, Executive Chamber, "Continuing Temporary Suspension and Modification of Laws Relating to the Disaster Emergency" (executive order no. 202.44, June 21, 2020); New York Office of Professions, "License Requirements—Limited Permits," updated May 26, 2020. For **Pennsylvania**, see Pennsylvania State Department, "Licensed Health Care Practitioners Can Provide Telemedicine Services to Pennsylvanians during Coronavirus Emergency" (news release, March 18, 2020); author correspondence with a representative of the Pennsylvania State Board of Medicine Licensure, June 19–22, 2020.

Endnotes

- 1 Madeline Holcombe, Holly Yan, and Steve Almasy, “Louisiana Governor Says Progress against Coronavirus Has Been Wiped Out in Past Three Weeks,” CNN, July 8, 2020.
- 2 Ted Mellnik, Laris Karklis, and Andrew Ba Tran, “Americans Are Delaying Medical Care, and It’s Devastating Health-Care Providers,” *The Washington Post*, June 2, 2020.
- 3 Randy Capps, Jeanne Batalova, and Julia Gelatt, *COVID-19 and Unemployment: Assessing the Early Fallout for Immigrants and Other U.S. Workers* (Washington, DC: Migration Policy Institute, 2020). An accompanying Migration Policy Institute (MPI) Data Hub tool permits tracking unemployment rates by nativity and gender among workers in health services and other industries.
- 4 U.S. Bureau of Labor Statistics (BLS), “The Employment Situation—June 2020” (news release, BLS, Washington, July 2, 2020).
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