Holland & Hart

Healthcare in the West Is on Life Support: Legislative and Immigration Barriers Leave Physician Gaps Unfilled

Cindy DeLancey

Of Counsel & Government Affairs Director
307.778.4277
Cheyenne
cldelancey@hollandhart.com

Samantha Wolfe

Partner
303.295.8479
Denver
sdwolfe@hollandhart.com

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Across the Mountain West—Colorado, Idaho, Montana, New Mexico, Utah, and Wyoming—physician shortages are straining healthcare systems, particularly in rural and frontier communities. In response, state legislatures in the west have increasingly explored ways to integrate internationally trained physicians into the local workforce. But despite growing momentum, many of these state-level efforts, including promising legislation out of Wyoming, continue to run up against a familiar wall: restrictive federal immigration policy.

Legislative Push in Wyoming Falls Short

One of the most notable recent efforts was Wyoming's *Expanding Physician Access Act* (Senate File 0155), introduced during the 2025 general legislative session. The Senate File sought to allow internationally trained physicians to obtain provisional medical licenses if they met rigorous criteria—including holding a reputable medical degree, maintaining an active license for five years, completing at least seven years of post-graduate training or practice, demonstrating English fluency, and securing a job offer from a Wyoming healthcare provider.

The bill passed the state Senate without issue, reflecting bipartisan recognition of the growing crisis in rural healthcare. However, it failed to advance on the House floor after passing out of the Labor, Health & Social Services committee in the House, underscoring the legislative and political complexities of tackling workforce shortages through non-traditional licensing pathways.

Senator Ogden Driskill, one of the bill's sponsors, emphasized how personal this issue is in rural Wyoming. “In Crook County, we've had just one doctor for years,” he said. “That's a lot to put on one person—they can't be available 24/7.” He added that while Wyoming lacks some of the amenities that typically attract physicians, communities like his would gladly welcome qualified international medical graduates (IMGs) if given the chance.

Driskill shared that his wife, “Zannie” Rosanne Driskill, recently had to travel over 100 miles to receive treatment for breast cancer—a reality many rural families face when specialty care isn't locally available. Fortunately, Zannie is now doing well and on the mend. But the experience

underscored for the Driskills just how critical it is to improve healthcare access across Wyoming's remote and isolated communities.

Despite the bill's setback, Driskill is hopeful the Senate File will pass in the next session. “There was lots of support for this concept, even the Freedom Caucus folks were supportive,” he noted. “This is model legislation that could work across state lines.”

A Case for Regional Collaboration

Driskill also floated the idea of forming a legislative coalition made up of rural states facing similar healthcare access issues. “It really helps to have the states get together,” he said, though he acknowledged the challenges of coordination. Still, the idea reflects a growing realization that solutions may lie not in isolated state actions, but in collective advocacy for meaningful federal reform.

Other states in the region have taken different approaches:

- **Colorado and New Mexico** have focused on expanding their **Conrad 30 Waiver** programs, which allow international physicians on J-1 visas to remain in the US in exchange for working in underserved areas. But with only 30 slots per state, these efforts only scratch the surface.
- **Montana, Idaho, and Utah** have invested in creating more **residency slots** and healthcare workforce development programs, though such initiatives take years to yield results.
- Meanwhile, **H-1B and O-1 visas**, often used by IMGs, remain difficult to access due to federal limitations on sponsorship, prevailing wage requirements, and annual caps.

Immigration Barriers Still Block the Path

Even when states create provisional licensing pathways, federal immigration policies remain a major roadblock. Without a valid visa, internationally trained physicians simply cannot practice in the US—even if they're otherwise fully qualified. Key immigration pathways include:

- **H-1B Visa:** Requires completion of all three steps of the **US Medical Licensing Examination (USMLE), Educational Commission for Foreign Medical Graduates (ECFMG)** certification, and a sponsoring employer. But the annual cap and strict wage requirements make this visa difficult to secure.
- **J-1 Visa and Conrad 30 Waiver:** While this is the most common path for IMGs in residency, it comes with a two-year home residency requirement unless waived—creating a bottleneck for physicians who want to stay.
- **O-1 Visa:** Reserved for those with “extraordinary ability,” it is an option for high-achieving researchers and specialists, but not broadly applicable to general practitioners.
- **TN Visa:** Limited to Canadian and Mexican citizens under the United States-Mexico-Canada Agreement (USMCA) and is often

restricted in scope when it comes to clinical care.

Charting a Path Forward

Given the shared struggles across the Mountain West, policymakers at both the state and federal levels may want to consider the following strategies:

- **Expand Residency Programs:** Increasing residency slots in rural areas would allow more IMGs to enter the workforce through traditional training pipelines.
- **Enhance J-1 Waiver Opportunities:** Pushing for more waiver slots or encouraging additional federal agencies to sponsor J-1 physicians could significantly increase retention.
- **Align State and Federal Policies:** States can't solve this problem alone. Coordinated efforts to align licensure eligibility with immigration options would reduce red tape and make state programs more effective.

A Regional Crisis Demands a Regional Response

Wyoming's *Expanding Physician Access Act* was an ambitious attempt to solve a real problem—but its failure reflects a broader truth that lasting solutions will require coordinated efforts beyond a single state. Without federal immigration reform and regional collaboration, even the most well-crafted legislation may fall short and will result in a “patch work” of legislative attempts that can be complex for the public and providers to follow.

As Senator Driskill and others in the Mountain West continue this fight, their efforts may offer a blueprint for how rural states can work together to bridge the healthcare gap—and bring much-needed care to the communities that need it most.
