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A direct care worker visa policy to support the aging US population

Tara Watson

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Tara Watson

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Abstract

Direct care workers—including home health aides, personal care aides, and nursing assistants—provide support in activities of daily living and long-term care for older people and those living with disabilities. With the rising number of older Americans, an estimated 1.28 million additional workers in the sector will be needed by 2036, an increase of about 35 percent over today's 3.69 million direct care workers. This proposal details a temporary direct care worker visa, the H-1D, that offers a targeted and flexible way to address the looming workforce challenge and to improve the quality of care available to people who need support.

Contents

Introduction

Over 20 million adults in the U.S. need long-term care or support in daily activities due to disabilities or other functional limitations associated with aging (Harootunian et al. 2023). Direct care workers—including home health aides, personal care aides, and nursing assistants—can provide these services in institutional settings or at home. In recent years, and exacerbated by the pandemic, growth in these professions has been constrained by low recruitment and retention, largely due to poor job quality and low wages (PHI 2025a). The result has been understaffing in institutional settings and unmet need in the home health market (Harootunian et al. 2023).

In the next decade, the gap between long-term needs and the capacity of the direct care workforce will grow, primarily due to the aging of the population. Between 2026 and 2036 the population 65 and older will grow from 65.6 million to 77.5 million people, and the number of people 85 and older is projected to grow from 6.8 million to 11.1 million people (Congressional Budget Office [CBO] 2026). As the population ages, the disabled population 65 and older is projected to grow by more than 6 million. Reflecting that shift, about 1.28 million additional workers will be needed in the sector by 2036, an increase of about 35 percent over today's 3.69 million direct care workers.

Improvements will need to be made in working conditions to attract more people to the industry, but this alone will not be sufficient. The solution to the emerging direct care workforce crisis should also include the targeted recruitment of immigrant labor. Immigrants are disproportionately represented in the direct care workforce, and the presence of immigrants has been shown to improve quality of care and to reduce mortality of older people. However, typical immigration flows will not fill the workforce gap because existing legal pathways are poorly targeted to direct care work and workers.

I propose a direct care worker visa, the H-1D visa, that offers a tailored and flexible way to address the looming demographic and workforce challenges. The H-1D visa is a temporary employment-based (EB) visa for immigrants who have at least two years of experience in direct care either in the U.S. or elsewhere to work in the United States in the direct care field. Like the H-1B visa, the H-1D would be structured as a three-year initial visa with an option for renewal. It would be dual intent (meaning it could serve as a stepping stone to a permanent visa) with the possibility of applying for legal permanent residence after six years and would include dependents. The visa would be additive to existing legal pathways and would be available to immigrants already living in the United States as well as to new immigrants. The program includes both safeguards to reduce the risk of exploitation and support for training and professional development for direct care workers. A pilot program would allow for 30,000 H-1D visas annually; the total number of visas would increase to 65,000 annually after three years, a level projected to meet about 35 percent of the needed growth in the direct care workforce over a decade. The program includes a commission to periodically review the numerical caps, allowing flexibility if the demographic or economic outlook changes.

The H-1D generates a meaningful new labor pathway with strong worker protections and an above-market wage floor. It allows for the recruitment of additional direct care workers from abroad as well as the stabilization and regularization of workers already contributing to the U.S. direct care sector. At the same time, the numeric cap is well below what would be necessary to fully address the direct care worker challenge through immigration alone, leaving room to grow the domestic workforce. This proposal focuses on direct care for older and disabled adults, given the predictable demographic transition that will generate sharp increases in demand for direct care over the next decade. A similar model could be considered for other high-need occupations; the success of this targeted program might help set the stage for broader immigration reforms.

The challenge

Overview of direct care

Direct care workers include home health aides, personal care aides, and nursing assistants, as defined by the Bureau of Labor Statistics (BLS).[1] These workers provide essential daily assistance to individuals with disabilities or illnesses, with the exact responsibilities of direct care professionals varying according to the needs of clients. Direct care broadly encompasses assisting patients with daily living activities, which can range from assisting with housekeeping or scheduling to administering prescribed medicine and monitoring vitals. Personal care aides are generally limited to nonmedical tasks, while home health aides and nursing assistants may provide some basic health services, often in conjunction with medical staff (Chidambaram et al. 2026).

A robust direct care workforce is important for meeting the needs of patients. Research demonstrates that increasing the supply of direct care workers improves not only the quantity of care available, but also the quality of care provided. Increasing the availability of direct care providers raises the likelihood of adults aging in place (Butcher et al. 2022; Huh et al. 2024; Jung and Mockus 2025), which most older adults say they would prefer (Lohmeyer 2024). Increased availability of direct care workers and other household service workers resulting from higher immigration also reduces negative health outcomes, including nursing home falls and overall mortality rates among older adults (Furtado and Ortego 2023; Grabowski et al. 2026a, 2026b). An adequate supply of direct care workers allows more older and disabled individuals to remain in a preferred setting for care and to receive better care in both noninstitutional and institutional settings.

In the 2024 American Community Survey (ACS), there were about 3.62 million workers reporting employment as a home health aide, personal care aide, or nursing assistant in the United States. Of these 3.62 million, approximately 2.3 million work in long-term care settings. Direct care workers in long-term care are predominantly female, and about half self-report as Black and/or Hispanic; roughly 66 percent work in home care settings (Chidambaram et al. 2026). Immigrants are also a large and growing share of this workforce: About one-third of direct care workers are immigrants and about 12 percent are noncitizens (Chidambaram et al. 2026).

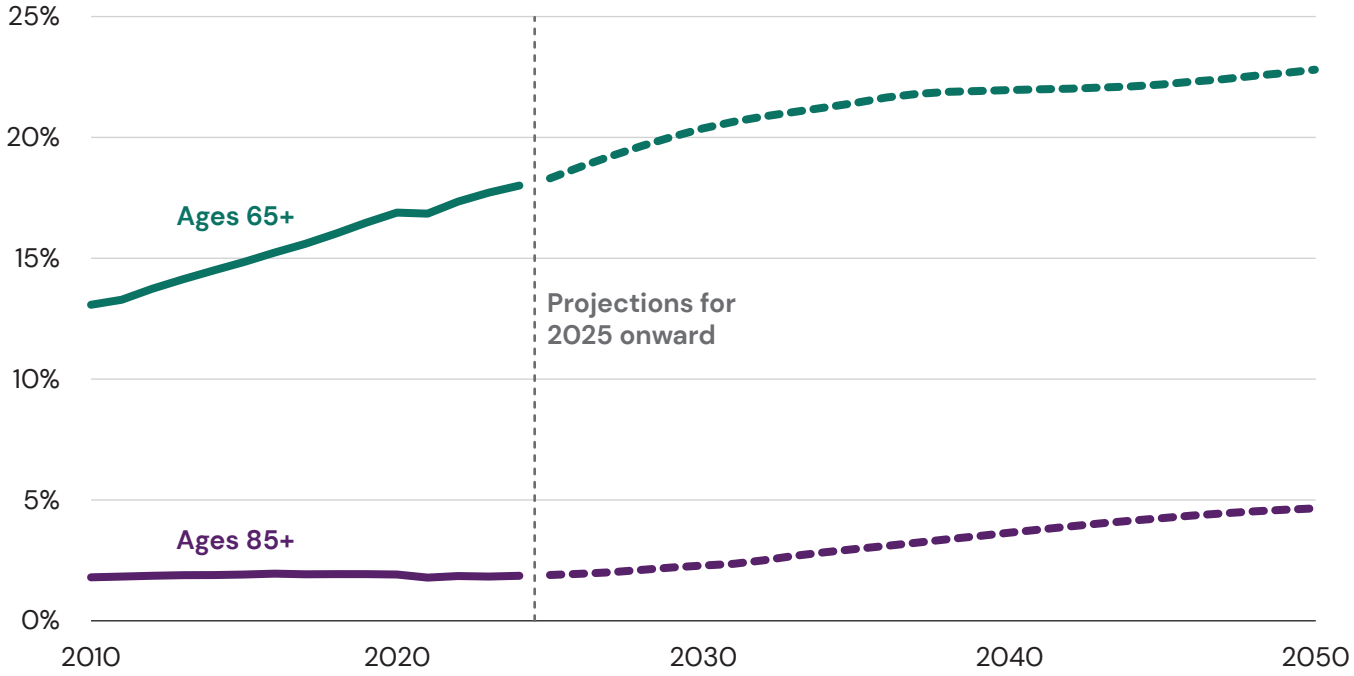
After declining during the pandemic, the number of direct care workers rebounded past 2018's value of 3.40 million in 2023, and sits at around 3.69 million today.[2] Though it is projected that this occupational category will grow rapidly, the profession of direct care faces longstanding demographic, recruitment, and retention constraints. The workforce is aging alongside the general population: In 2024, more than 40 percent of direct care workers were 50 and older, and 11 percent were 65 and older (Chidambaram et al. 2026). The profession is also characterized by high rates of vacancy and turnover (PHI 2025b).

Poor compensation is a key limitation in recruiting and retaining direct care workers. Over 65 percent of this workforce earned less than $35,000 in 2024, reflecting in part that direct care workers are more likely to work part-time than other adult workers (Chidambaram et al. 2026). In the U.S., wages in direct care remain lower than other occupations with similar or fewer educational requirements (Harootunian et al. 2023). Since Medicaid is the largest payer for long-term care services and supports, payment rates for direct care are constrained by the reimbursement rates set by state Medicaid programs for nursing homes and home health and personal care agencies, which in turn are constrained by state finances and federal funding levels. The combination of low wages and a high prevalence of part-time work restricts earnings and access to benefits (Chidambaram et al. 2026; PHI 2025a). More than one-third of direct care workers lived below 200 percent of the poverty line in 2023 (PHI 2025a). In 2024, about 10 percent of direct care workers did not have health insurance, about 50 percent were covered by private insurance (with about 20 percent of workers covered through their employer), and 35 percent were insured by Medicaid.[3]

Direct care jobs are characterized by minimal training and low occupational mobility or opportunities for advancement. While home health aides and nursing assistants must complete a minimum of 75 training hours to comply with federal standards, and more hours required in some states, personal care aides require no mandated training, limiting transferable credentials for job advancement (King et al. 2025).

FIGURE 1

Share of the population 65 and older and 85 and older



Source: ACS 2010–24; CBO 2026.

Note: Lines represent the share of the population that are 65 and older or 85 and older from 2010 to 2024, and each group's projected share from CBO data from 2025 onward.

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Long-term care and population aging

Structural issues in the direct care sector will be amplified by ongoing demographic shifts. Over the next 25 years, the U.S. population will face both significant population aging and slower domestic workforce growth. By 2050, people 65 and older will represent over one-fifth of the population, which is a nearly 25 percent increase from 2025; the share of people 85 and older will approach 5 percent of the population, an increase of nearly 150 percent (figure 1). Over that same period, the share of the population that is prime-aged (25–54) will stay roughly the same (CBO 2026).

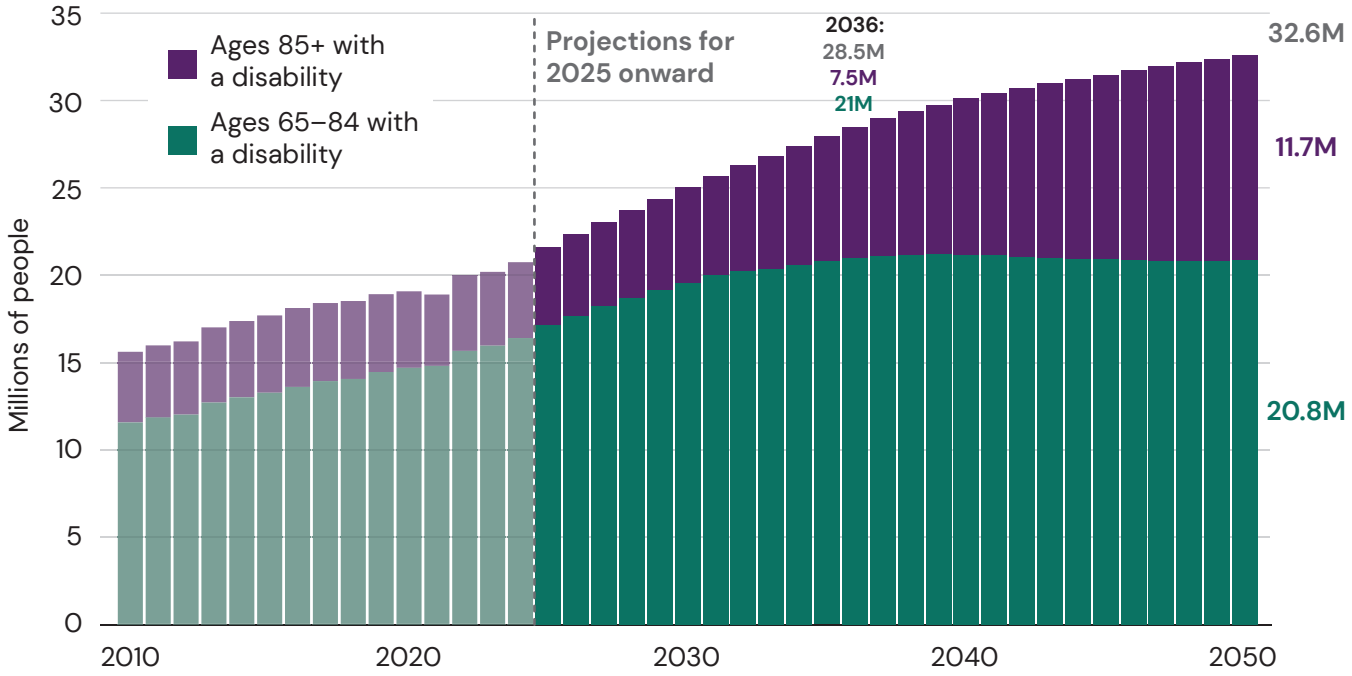
As people age, their likelihood of developing and needing care for a disability increases. If age-specific disability rates were to remain constant, the number of people who are 65 or older and who have a disability would increase to around 28.5 million in the next decade, an increase of about 28 percent. Similarly, the number of people who are 85 and older with a disability would increase by almost 2.9 million to exceed 7.5 million, an increase of 62 percent (figure 2). The overall number of people living with a disability would increase by about 12 percent due to population aging alone. The need for direct care workers could grow more slowly than described here if age-specific disability rates improve, as appears to have been the case over recent decades (Einav and Finkelstein 2026), but would still grow sharply as the population ages.

The projected aging of the population will drive a corresponding need for long-term care. There are several approaches to quantifying the number of workers that will be needed. For example, BLS incorporates projections of direct care demand to develop projected employment over the next decade. BLS projects that, from 2024 through 2034, there will be 9.7 million openings in direct care, reflecting both new positions and openings from people leaving existing positions. Overall, BLS projects growth of 770,000 direct care jobs over the 2024–34 decade (BLS 2025a). Another estimate from the National Center for Health Workforce Analysis focuses more narrowly on long-term services and supports and suggests that 625,000 additional direct care workers will be needed between 2023 and 2038, reflecting an increase of 40 percent in national demand over those 15 years (National Center for Health Workforce Analysis 2025).

Alternatively, one can use existing patterns observed across states to assess the relationship between the change in the disabled population and the change in the number of direct care workers. Using observed state-level relationships between growth in the older disabled population and growth in the direct care workforce, the estimated need is projected to

FIGURE 2

Number of people 65 and older and 85 and older with a disability



Source: ACS 2010–24; CBO 2026.

Note: Sum of bars (gray) represents the number of people 65 and older with a disability. Disability projections are made under the assumption that disability rates by one-year age bucket from the 2024 ACS remain constant. These shares are applied to CBO's projected population of each respective age group through 2050.

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grow by approximately 1.28 million additional workers by 2036 (see figure 3).[4] By 2050, 2.12 million more direct care workers will be needed than in 2026. As discussed below, the projected workforce growth will be inadequate to meet the estimated increase of 1.28 million direct care workers over the 2026–36 decade.

How is direct care structured and financed?

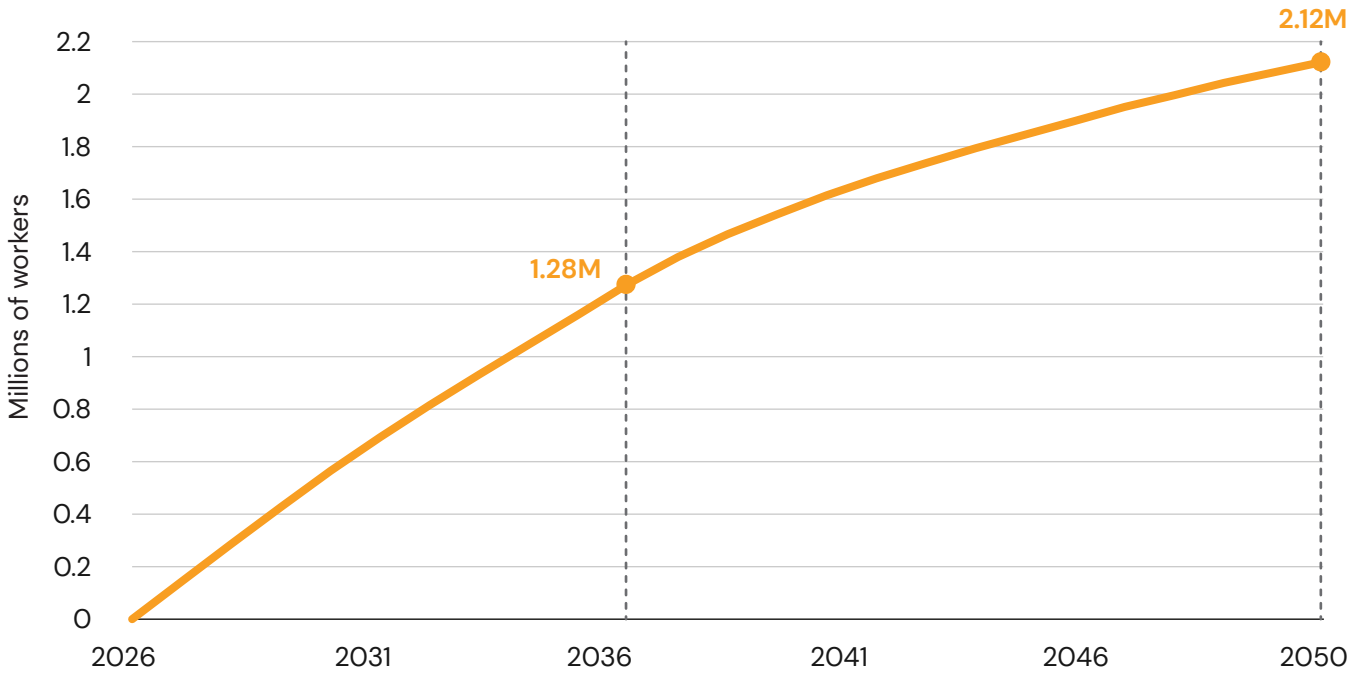
Some individuals receive direct care services in institutions such as nursing homes. The Medicaid program covers 44 percent of costs in these facilities and is the primary payer for 63 percent of residents (Chidambaram et al. 2025). State Medicaid programs determine the reimbursement rates that facilities receive, which indirectly constrain spending on patient care. Other patients either finance their care through long-term care insurance or, more commonly, pay out of pocket if they do not qualify for Medicaid. (Medicare covers only short-term and acute care, such as recovery from surgery.)

While some states regulate staffing levels in long-term care facilities, federal rules do not include specific staffing ratios, instead requiring that staffing is sufficient (Skinner et al. 2025). A 2024 federal rule outlined minimum staffing standards for nursing homes at 2.45 nursing aide hours and 0.55 registered nurse hours per resident day, but that standard had been rolled back before the rule took widespread effect (Chidambaram et al. 2024; Span 2026). The rollback was spurred at least in part by pushback from nursing homes, which argued that staffing shortages made meeting robust standards untenable (Span 2026). (According to a KFF report [Chidambaram et al. 2024], in 2023 only 19 percent of facilities met all staffing regulations under the 2024 rule.) As this series of events illustrates, staffing shortages not only reduce care quality directly, but can also undermine policy efforts to improve the quality of care.

In addition, individuals often receive direct care services at home or in noninstitutional community-based settings. Medicaid covers such services through state Home- and Community-Based Services (HCBS) programs, operating to varying degrees in all states. For public programs, state-determined payment rates determine funding to providers, although an increase in these rates does not necessarily translate to an increase in wages. A Centers for Medicare & Medicaid Services (2024) regulation, "Ensuring Access to Medicaid Services," requires states to publish fee-for-service rates and schedules and hourly fee-for-service HCBS payment rates as well as demonstrate

FIGURE 3

Projected growth in direct care workforce demand indexed to 2026



Source: ACS 2024; CBO 2026; author's calculations.

Note: The orange line shows projected employment if the direct care workforce is responsive to the growth of the population 65 and older with disabilities and the age-sex-specific disability rate remains constant.

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that 80 percent of payment rates are going toward compensation for providers (Centers for Medicare & Medicaid Services 2024). States, meanwhile, have addressed direct care wages by requiring providers to pass through a certain portion of reimbursement payments to workers, increasing provider rates, or tying direct care wages to the state's minimum wage. (See box 1 for examples of how some state Medicaid programs and private providers are trying to address direct care workforce challenges.)

Other families hire help privately, either through a regulated home care agency or through the informal gray market. Families typically pay for these services out of pocket, an expense that can exceed $40,000 annually for 30 hours per week of care, making cost increases difficult for families to absorb (Reinhard et al. 2023). Even in the private-pay market, the state Medicaid system is dominant enough that it influences market wages and costs (Burns et al. 2025).

Immigration is an important tool to fill in the direct care workforce

As noted above, there is an anticipated need to fill an estimated 1.28 million additional direct care workers over the next decade stemming from the increase in the older population requiring care. In recent years, there has been steady growth in the sector, with many of the additional jobs filled by immigrants. While U.S.-born workers hold more than two-thirds of direct care jobs, the number of U.S.-born workers in the field has grown very slowly. From 2019 to 2024, the estimated number of direct care jobs held by U.S.-born workers increased by less than 1 percent (13,000), remaining at roughly 2.5 million, while the estimated number held by foreign-born workers increased by about 13 percent from 940,000 to about 1.06 million. About 85 percent of the overall workforce growth came from 113,000 direct care workers who have entered the country since 2019 (see figure 4). As of 2024, immigrants comprised 29 percent of the workers in the sector, far more than their share of the population (about 16 percent) or of the workforce overall (19 percent).

Over the coming decade, the current U.S.-born and immigrant populations in the United States will be aging due to longer lifespans and declining fertility. If we hold direct care participation rates constant for the current age-by-sex population among the existing U.S. workforce and incorporate mortality projections, we find that the direct care workforce would fail to keep up with increasing demand, losing approximately 50,000 workers over the next decade in the absence of immigration.

Absent policy changes, status quo immigration is also unlikely to meet the additional demand for direct

BOX 1

Active state and private initiatives to improve direct care staffing

Category	Examples of active initiatives
Wages	
Wage pass-throughs	Require a certain dollar amount or percentage of state Medicaid funds to go toward compensation (Illinois Act on the Aging)
Broad wage increases	• Mandate a minimum wage or wage floor for direct care (CA: SB 525) • Implement provider rates increases or increased reimbursement rates (NV: SB 511) • Tie labor reimbursement for direct care providers to a percentage of the state minimum wage (ME)
Bonus incentives	Provide bonuses or supplemental payments tied to recruitment and retention (MN: Care Force Incentive Program)
Training	
Increased training and credentialing opportunities	Partner with local postsecondary educational institutions to provide training opportunities for direct care workers (NC)
Training-based bonuses	Provide one-time bonuses or wage increases for workers who complete specified certifications (TN: E-Badge Academy)
Worker outreach	
Connecting patients and nontraditional providers	Connect local health care students directly with patience (CareYaya)
Expanded marketing efforts	Improve online marketing and career fair presence (ME: Careers with Purpose)
Matching service registries	Offer public online platforms to connect workers and self-directing patients (Carina)

Source: Angell et al. 2024; Ciolfi et al. 2025; Dickinson and Zhou 2026; Haumschild and Lapido 2026; Illinois Act on the Aging 2025; Maine Revised Statutes 2021; Malik 2024; Nevada Department of Health and Human Services 2024; North Carolina Department of Health and Human Services 2025; author interviews.

Note: Examples for each category do not represent an exhaustive list of states or private organizations implementing that policy.

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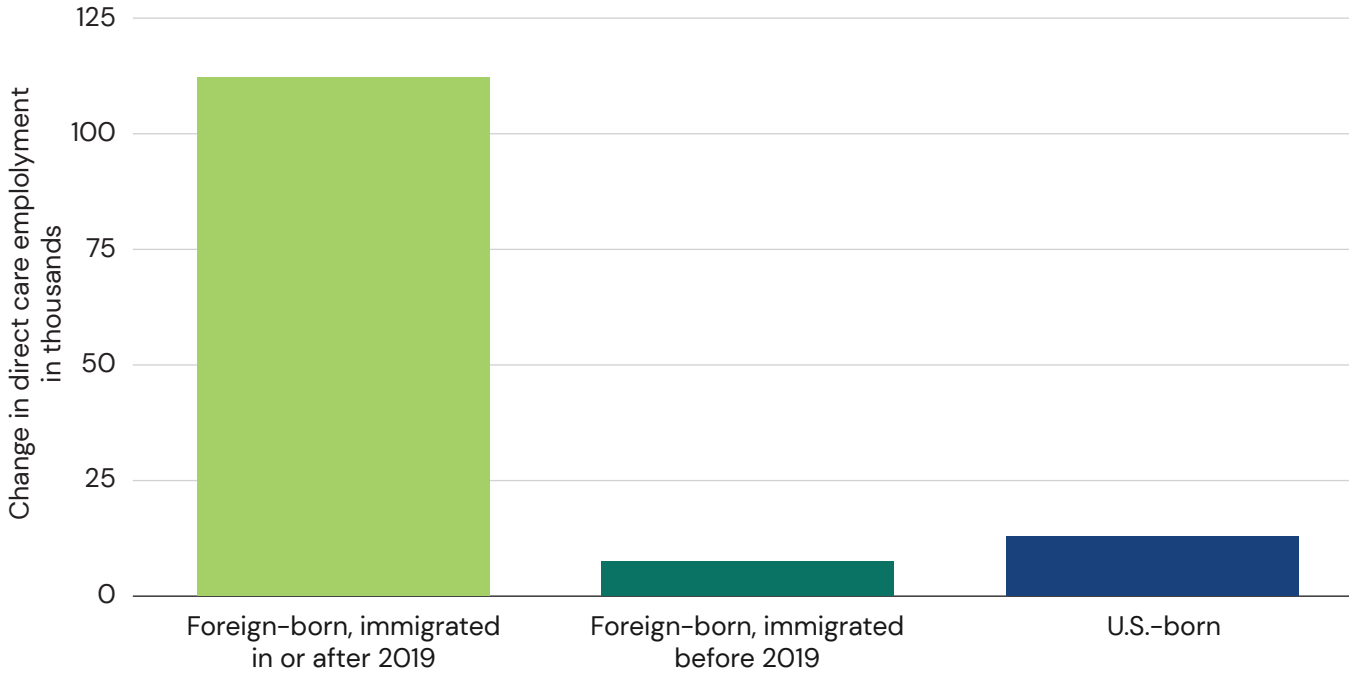
care workers. CBO projects net immigration to average just under 1 million people per year over the next decade. These are levels that were typical in the years before Covid (CBO 2026); flows averaging 1 million would represent a rebound from very low or negative net migration in 2025.[5] To assess the workforce impact of normal immigration flows, the analysis relies on estimates from Grabowski et al. (2026b), suggesting that each 1,000 additional migrants 54 and younger yields 29 additional direct care workers in a local area, implying that regular immigration flows in that age bracket of about 8.4 million over 10 years could yield about 240,000 additional direct care workers.[6]

In sum, if immigration recovers to typical levels, about 240,000 of the anticipated 1.28 million additional direct care jobs should be filled by that inflow, depending on the propensity of those new immigrants to work in the sector. The remaining gap is 1.04 million direct care positions unfilled by normal immigration flows. Using the Grabowski et al. (2026b) estimate, filling the gap solely through a more expansive general immigration policy would require welcoming about 35.9 million immigrants over the next 10 years, or net migration of around 3.6 million per year in addition to the roughly 1 million annual net inflow projected by CBO (2026).

There are strong economic arguments for broadly expanding legal pathways to this extent (Watson 2022). However, Congress has not passed major immigration legislation for three decades and the current political environment is unfavorable. In the current environment of heightened enforcement and weaker humanitarian protections, direct care workers who would have otherwise migrated to or stayed in the U.S. without status may make a different assessment about their security and economic prospects. While waiting for comprehensive immigration reform that would broadly boost legal migration, this proposal offers a targeted immigration channel that is designed to address the specific and immediate need for direct care workers.

FIGURE 4

Cumulative employment in direct care by nativity and time of immigration, indexed to 2019



Source: ACS 2019–24; author's calculations.

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Alternative approaches to addressing workforce challenges

One question is whether these needs could instead be met by making direct care jobs more desirable by improving pay, working conditions, and career ladders. This approach is likely an important complement to immigration reforms, but back-of-the-envelope math suggests plausible wage increases are unlikely to meet demand on their own.

The barriers to improving wages for direct care workers stem in part from the financing system. On the public side, Medicaid reimbursement rates are fixed at the state level. While raising reimbursement rates does not necessarily yield an increase in worker wages (Miller et al. 2024), targeted payment reforms have been shown to increase direct care wages, raise staffing levels, and improve patient health (Baughman and Smith 2010; Foster and Lee 2015). However, Medicaid payment rates are both influenced by federal reimbursement rates and constrained by state fiscal conditions. Families paying privately, without Medicaid, are constrained by their financial resources.

There is little direct evidence on how much wages would need to increase to boost the supply of direct care. Existing research finds labor supply elasticities for home health aides and child care workers ranging from 0.5 to 1 (a 1-percent wage increase leads to a 0.5-percent to 1-percent increase in labor supply).[7] Under the assumption of a labor supply elasticity of 1, policies that increase real wages by 35 percent in the direct care sector could fill the 1.28 million worker gap, potentially pulling workers out of other care economy professions or encouraging them to postpone retirement. If the elasticity is at the lower end of the estimates—in other words, if it is only 0.5—it would take a 70 percent wage bump to fill the gap through improved working conditions alone. Absent significant increases in public spending, wage increases this large are infeasible.

Smaller and more-feasible increases in wages for direct care workers could increase supply and will likely be needed to meet demand in coming decades even with increased immigration. Additionally, improvements in factors other than wages could also help improve retention and expand labor supply. PHI, a research and advocacy organization, notes that standardized credentialing across states, as well as improved training and career pathways, would be likely to encourage more workers to stay in the field (PHI 2025b).

Shortages in direct care may also be ameliorated by improving and integrating health technologies (Suresh and Pallas-Brink 2025). Existing examples include those that help lift and transport residents, assist in mobility, and monitor residents' safety or vitals. The broad adoption of such technology in nursing homes in Japan has been associated with an *increase* in employment and allows the reallocation of care worker inputs to human-specific tasks that support quality care (Lee et al. 2025). While technology can supplement direct care work and may improve quality of care, it cannot supplant the hands-on nature of health aide work and cannot alone address gaps in care.

In sum, technology and worker compensation are important tools to meet the growing demand for quality care, but this approach will need to be supplemented with a supply of labor beyond the existing workforce.

Current legal pathways are not well suited to direct care

Immigration to the U.S. includes both permanent (green card) pathways and temporary pathways. Existing channels for permanent migration to the United States are highly constrained. Family-based immigration, which often includes less-educated workers who might be attracted to the direct care field, is impeded by annual and per-country caps, which generate large backlogs. For example, the Mexican sister of a U.S. citizen who completed initial paperwork for a family-based green card in April 2001, a quarter century ago, can expect her application to be processed in July 2026 (U.S. Department of State 2026).

Permanent employment-based visas (EB visas) are available in theory, but rarely reach non-college-educated workers in practice. Only one small piece of the EB system, the "other workers" component of the EB-3 visa, is a potential pathway for jobs that do not require specialized skills or education; it is capped at 10,000 visas annually. In addition, with the exception of two shortage occupations (not including direct care), permanent employment visas require employers to undergo the cumbersome Permanent Labor Certification (PERM) certification process. Under PERM, employers must document that there are insufficient U.S. workers; as of August 2026, the process takes over 300 days to complete on average (U.S. Department of Labor 2026). Some efforts are underway to expand the list of Schedule A shortage occupations (a list that has not been updated since 1991), but the small number of visas available for the category of other workers would still be a barrier, even if the PERM requirement were to be streamlined (Malde 2024).

A temporary immigration pathway is less onerous for potential employers; however, the existing options are not a good fit for the direct care sector. Temporary employment visas like H-visas are ill-suited for direct care because they are restricted to highly educated workers (H-1B) or to agricultural, seasonal, or temporary work (H-2A and H-2B). The H-1C visa, which was specifically designed to address nursing shortages, expired in 2009 (see box 2). The J-1 visa is often used for au pairs, but it is typically limited to one year and is intended for cultural exchange rather than as a labor pathway. Adapting the J-1 to the direct care sector has been suggested (Harootunian et al. 2023), but that approach would come with rapid turnover that is usually not in the best interest of clients. A new visa pathway can help meet the urgent and sustained needs in the direct care workforce.

Experiences of other countries using immigration as a tool to address workforce shortages

Several high-income countries have experimented with immigration routes for direct care occupations. For example, in 2025 Canada implemented a pilot program for permanent residence pathways for home care workers (Government of Canada/Gouvernement du Canada 2025a). The annual cap was for 2,610 workers, and the program had to stop accepting new applications soon after opening due to overwhelming demand (Government of Canada/Gouvernement du Canada 2025b; Singer 2025). New Zealand also has an uncapped program offering permanent residence to care workers; requirements for a secure job offer at a reasonable wage (28.25 New Zealand dollars, or $16.69 in U.S. dollars) keeps the program to a modest size—as of August 2026, 2,268 applications have been accepted since the program's inception (New Zealand Immigration 2023, 2026). The U.K. attempted a permanent direct care pathway on a pilot basis starting in late 2021. The program quickly grew to over 100,000 workers in 2023 (U.K. Home Office 2024). Concerns about worker treatment as well as about the number of dependents coming with the workers led to the disallowing of dependents and implementation of other program restrictions, followed by closing entry applications for care workers, including care workers for older adults, altogether (Das 2025; Savitski 2025). Other economies, including Hong Kong and Australia, have temporary programs for care workers (Australian Department of Home Affairs 2026; Hong Kong Immigration Department 2025).

The international experiences to date highlight some important considerations for U.S. policy design. There is a tension between making the program straightforward and cost-effective for employers and

BOX 2

The H-1C nursing visa

The Immigration Nursing Relief Act of 1989 created an H-1A visa that expired in 1995 and was succeeded by the H-1C visa, created by the Nursing Relief for Disadvantaged Areas Act of 1999 and extended through 2009 by Congress (Immigration Nursing Relief Act 1989; Nursing Relief for Disadvantaged Areas Act 1999; Nursing Relief for Disadvantaged Areas Reauthorization Act 2005). The H-1C classification expired on December 20, 2009, with all visas expiring by the end of 2012.

The H-1C visa provided temporary immigration status to foreign-born individuals for three years with no renewal. Congress restricted the total number of H-1C visa issuances to 500 visas per fiscal year (Nursing Relief for Disadvantaged Areas Act 1999).

Workers were required to have a nursing license in the U.S. or have a foreign nursing license and pass the Commission on Graduates for Foreign Nursing Schools Exam to be eligible, as well as be authorized by the relevant state's Board of Nursing. Eligible employers were Subpart D hospitals in designated health professional shortage areas, with at least 190 acute care beds, a Medicare population of no less than 35 percent, and a Medicaid population of no less than 28 percent (U.S. Citizenship and Immigration Services 2026).

Similar to the current requirements for labor certifications, employers were required to complete wage attestations and file a petition for a nonimmigrant worker, who, upon approval, was eligible to apply for a nonimmigrant visa. Visas were not portable: A change in employer required another certification and petition process.

The highly restrictive nature and process of the H-1C visa meant that it was generally easier for prospective immigrants to apply for an EB green card than for an H-1C visa. From FY1999 to FY2012, the State Department reported issuing a total of just over 1,000 H-1C visas, with a maximum of 212 visas issued in FY2002 (U.S. Department of State 2002, 2007, 2008, 2010, 2015).

ensuring adequate protections to reduce the risk of exploitation of immigrant labor and undercutting of domestic workers. If wage and regulatory requirements are relaxed, there is likely to be a high level of interest from employers, and policymakers should plan for excess demand. Concerns around the potential for exploitation must be addressed up front to ensure the protection of workers and the success of the program. At the same time, the program should not be so bureaucratically cumbersome as to dissuade participation, and should be right-sized to meaningfully ease the direct care worker shortage.

The proposal

H-1D direct care worker visa

I propose a new temporary visa, the H-1D visa, that would be available to foreign-born individuals entering the United States or currently residing in the United States to work in direct care. This visa would be analogous in administrative structure to the dual-intent H-1B: It would be valid for three years with the opportunity to renew eligibility once for a total period of six years, after which the worker could apply for permanent residency. Workers 21 to 54 years old with two or more years of direct care experience, or equivalent verified coursework/training; demonstration of basic English language literacy; and no criminal history in the U.S. or elsewhere would be eligible.

The H-1D visa would be sponsored by an employer, but employer switching would be allowed if the individual continued to work in the direct care field with a sponsoring employer. In the case that an H-1D visa holder loses their job or works fewer than 200 hours over a 60-day period, they would have a 60-day grace period to find a new employer, file a change of status or extension, or depart. Grace periods would also be allowed for illness or family leave. Any number of grace periods would be allowed per valid visa term, recognizing the volatile nature of employment and hours in the direct care profession.

In addition to those living abroad, immigrants living in the United States would be eligible to apply for an H-1D visa and to transition to the H-1D without leaving the country. This would likely include those who have no legal status, either due to entry without inspection or to an expired status, and those with some measure of temporary protection but no clear path to permanency, such as those under the Deferred Action for Childhood Arrivals program, those on Temporary Protected Status, those admitted under humanitarian parole, or those in the asylum queue. Including immigrants who reside in the U.S. in the program would encourage existing U.S.-based direct care workers to stay in the direct care field and would facilitate the normalization of status among those who meet other requirements.

Spouses and unmarried children under 21 of the visa holder would be eligible to enter the U.S. on a derivative visa. Adult derivatives would be eligible for a temporary work visa. Child derivatives would freeze their eligibility at the age of arrival to mitigate the issue of aging out of status, such as was the case with the documented dreamers issue (American Immigration Council 2024). In the event that the principal visa holder departs the U.S. after job loss or for another reason, derivative family members are also required to depart the U.S.; this requirement is waived in cases of death of the principal or other extreme situations. The proposal's inclusion of dependents reflects the value of keeping families together and would likely mitigate mental health difficulties faced by immigrant caregivers in other systems who leave their families behind (Bubola and Lautaru 2025).

As in the case of the H-1B, a challenge arises after the two three-year visa stints because there are an inadequate number of permanent EB visa slots to meet the needs of dual intent visa holders. In the H-1D case, workers would likely be required to use the category of other workers within EB-3, which is limited to 10,000 green card slots per year across all occupations not qualified as professional or skilled (i.e., an occupation that requires two years of training, education, or work experience). This requirement would create a significant backlog during which temporary renewals would be available, putting H-1D workers at risk of losing status if their age and health prevents them from working while waiting in the green card queue. The maximum age to qualify for an H-1D visa is capped at 54 in recognition of the fact that it may take many years under current law to obtain permanent status, during which time the visa holder would need to continue to work in the direct care field in order to stay in the United States.

In recognition of the pressing needs in the direct care sector, legislators should circumvent this issue by allowing direct care workers who have successfully completed two H-1D visa terms and have ongoing employment in the field to be eligible for a green card without being subject to EB caps, by allowing them to qualify as skilled professionals under EB-3, or by adopting a proposal in the DIGNIDAD (Dignity) Act of 2025 that caps the waiting period for a permanent visa to ten years (DIGNIDAD [Dignity] Act of 2025). Ensuring a route to a green card by modifying the current EB process is important for a successful program that provides a legitimate path to permanency.

The key features of the proposed H-1D visa are summarized in table 1, which also compares those features to other existing and prior visa programs.

TABLE 1

Comparison of H-1D visa and other employment visas in the U.S.

	Description	Eligibility (language, age, education, etc.)	Annual caps (most recent)	Length and pathway to lawful permanent residence status	Treatment of dependents	Employer wage requirements	Non-wage employer responsibilities
H-1D	Temporary visa for direct care workers.	Basic English literacy, ages 21-54, 2 years of direct care experience or equivalent training.	30,000 in FY2027–29, 65,000 in FY2030 onwards.	3 years with opportunity for renewal for a total of 6 years. Dual-intent: workers may apply for lawful permanent resident (LPR) status.	Eligible for admission to U.S. on derivative visa. Adult family members eligible for employment authorization.	Employers must pay at least the 75th percentile of local occupational wages.	Provide health insurance, commit to a minimum of 25 hours per week, document a transportation plan, as well as paying set minimum wage.
H-1B	Temporary visa for workers with a bachelor's or higher who will be working in a specialty occupation.	Bachelor's degree or equivalent.	65,000 visas with an additional 20,000 available for workers with master's degrees or higher.	3 years with opportunity for renewal for a total of 6 years. Dual-intent: Workers may apply for LPR status.	Eligible for admission on H-4 visas. Certain family members may file for employment authorization when the H-1B worker begins process of seeking permanent residency.	Labor Condition Application attestation required. Employers must pay the greater of the wage paid to similarly qualified workers or the prevaling wage rate.	Pay for return transportation in the case of early termination.
H-2A	Temporary visa for agricultural workers with a job offer for a temporary, seasonal position.	Job specific.	None.	Maximum of 3 years. Visa resets after continued absence from the U.S. of 60 days. No pathway to LPR status.	Eligible for admission on H-4 visas. Family members are not eligible for employment authorization.	Temporary employment certification required. Employers must pay the adverse effect wage rate.	Provide housing, workers' compensation insurance coverage, and transportation and sustenance benefits. Commit to guaranteeing work for 75 percent of the total work days.
H-2B	Temporary visa for nonagricultural workers with a job offer for a temporary, seasonal position.	Job specific.	66,000 with supplementary 64,716 added for FY2026.	Maximum of 3 years. Visa resets after continued absence from the U.S. of 60 days. No pathway to LPR status.	Eligible for admission on H-4 visas. Family members are not eligible for employment authorization.	Temporary labor certification required. Employers must pay the prevailing wage rate.	Provide transportation and sustenance benefits under certain conditions and pay a set minimum wage. Commit to guaranteeing work for 75 percent of the total work days.
H-1C	Temporary visa for registered nurses in a health professional shortage area.	Nursing license or equivalent.	500 per fiscal year. Capped at 50 per state for states with population greater than 9 million and 25 per state with lower populations.	Maximum of 3 years. Dual-intent: Workers may apply for LPR status.	Eligible for admission on H-4 visas. Family members are not eligible for employment authorization.	Labor attestation required that wages will be the same as similarly employed nurses by the facility and will not adversely affect similarly employed nurses.	Demonstrate their eligibility.
J-1 Au Pair Visas	Temporary visa for au pairs providing child care for U.S. host families.	English proficiency, secondary school graduate or equivalent, between the ages of 18-26, demonstration of employment experience.	Determined at the sponsor level. 16,840 J-1 visas for au pairs were used in 2025.	1 year, with maximum extension to a total of 2 years. No pathway to LPR status.	Dependents are not eligible for admission.	Sponsors are pre-designated.	Ensure the participant has suitable health insurance.
EB-3	Three permanent residency streams for workers with a bachelor's degree or equivalent, two years training or experience, and "other" workers who don't fulfill either criteria.	Job specific.	About 40,000 total, with 10,000 allocated to "other" workers.	Provides LPR status.	Spouses and unmarried children receive LPR status.	PERM required. Employers must pay the prevailing wage rate.	

Source: Papademetriou et al. 2009; U.S. Citizenship and Immigration Services 2026; U.S. Department of Labor 2012, n.d.; U.S. Department of State n.d.

THE HAMILTON PROJECT

BROOKINGS

Number and allocation of visas

The H-1D program would be additive to existing immigration pathways. It would be available to applicants from abroad as well as to those immigrants who are already living in the United States. Eligible applicants would include the estimated 14 million people living in the country without regular status, either with partial protection from deportation or without any protection (Kramer and Passel 2025). An initial pilot period would last three years with 30,000 H-1D visas issued annually: Ten thousand would be open to all, and another 20,000 would be reserved for workers with two years of home health experience (or equivalent coursework/training) in the United States. The pilot period is designed to allow logistical challenges to be identified and overcome before bringing the program to scale, and to prioritize the continued employment of immigrant direct care workers already in the U.S. whose employment could be stabilized through status adjustment. After three years, the annual cap for new H-1D visas increases to 65,000, available to those from within or outside the United States.

The cap is calibrated to meet roughly 35 percent of projected demand for growth in the direct care workforce over the coming decade. To assess the impact of the visas (30,000 in 2027 through 2029, and 65,000 annually thereafter) on the pool of workers available by the end of the decade, it is necessary to make some assumptions about the duration of a visa holder's stay in the sector. The program is structured so that there is a pathway for workers to stay long term; the requirement that visa holders have at least two years of experience in the sector is likely to result in substantially lower attrition than for the direct care workforce as a whole. Nonetheless, some H-1D visa holders are likely to leave if they learn that the program is not a good fit for them. Under reasonable assumptions, about 445,000 people could be added to the direct care visa workforce by the end of 2036. (Some of these workers might otherwise have participated in the sector without a regular immigration status, likely with less job stability.)[8]

In the absence of policy change, people already in the U.S. are expected to have declining numbers in the sector. Those arriving through regular immigration flows will be able to fill about 240,000 jobs over the next decade, netting about 190,000 (15 percent) of the projected 1.28 million additional jobs, under the strong assumption that general immigration flows return to more typical levels. The remaining 50 percent of the gap would need to be addressed with improved wages and working conditions to attract and retain workers; alternatively, the annual H-1D cap could be increased to about 105,000 annually. I propose the lower cap of 65,000 to allow for the possibility that demand projections are too high and to allow complementary policies improving wages and conditions to play a role in attracting the needed workforce.

There is an asymmetry to the proposed cap: If demand for direct care workers is lower than projected, visas will presumably go unused, whereas if demand is higher, additional visas will not become available. For this reason, policymakers might consider incorporating automatic adjustment. For example, one alternative would be to tie the cap to the recent growth in size of the population that is older and disabled. Multiplying average annual growth in the 65 and older disabled population by 0.1 would generate a cap roughly comparable to the proposed policy, but would allow for automatic adjustment as demographic conditions change. On the other hand, policymakers might prefer more clarity than the demand-adjusted cap allows.

After the first five years, a bipartisan commission should be appointed with the power to set the annual cap and other program parameters for the subsequent five-year period. Considerations in determining the cap should include growth in the domestic workforce, general immigration flows, and the economic demand for direct care. The commission could also choose to make the program uncapped for some segments of the applicant pool, such as those planning to work in underserved areas, those in the family-based migration backlog, or those in the asylum queue.

To allocate visas, a lottery analogous to the traditional H-1B lottery would take place. Firms, families, or intermediaries would submit petitions on behalf of specific workers. To improve timeliness, the lottery will be held three times per year with the slots available equally allocated across the three lotteries. The lottery application fee would be $215, which is the current H-1B lottery fee, and would be adjusted for inflation. Those not successful in the lottery would be entered in the subsequent two lotteries without additional fees or paperwork. Legislators could choose to give higher lottery weight to some segments of the applicant pool, such as those planning to work in underserved areas, those with high wage offers, those in the family-based migration backlog, or those already living in the U.S.

If the applicant is selected in the lottery, the employer would be required to pay a fee of $2,200. The fees cannot be passed on to the worker, and are adjusted annually for inflation. The fees would be used to offset U.S. Citizenship and Immigration Services processing costs ($1,000), to support U.S. Department of Labor auditing for program compliance ($600), and to contribute to the U.S. Department of Health and Human Services fund for general training and professional development of direct care workers ($600). This training fund would bring in $39 million annually under full implementation. Legislators could consider reduced fees in shortage regions or for specific immigrant populations such as those described above, or could increase fees for those with a prior immigration violation. The

cost of visas for derivatives is included in these fees, as are renewals or transfers to a new employer.

Employer responsibilities

In addition to the fees, the employer would need to make several other commitments to participate in the lottery. The firm, regardless of size, would be required to offer the worker and dependents health insurance, defined as adequate and affordable by the Affordable Care Act's employer shared-responsibility provisions.[9] The health insurance requirement might seem surprising given that only about 20 percent of direct care workers currently obtain insurance through their employers. However, because temporary visa holders are typically ineligible for Medicaid and will be newly ineligible for Affordable Care Act premium tax credits under the One Big Beautiful Bill Act of 2025, this requirement helps address otherwise unaddressed health care needs of H-1D visa holders. In lieu of implementing this requirement, policymakers could choose to allow H-1D visa holders to participate in subsidized Affordable Care Act marketplace plans.

The firm would commit to providing a minimum of 25 hours per week of employment. Initial minimum wages would be set at the 75th percentile of occupational wages in a given location, according to the most recent BLS Occupational Employment and Wage Statistics data (BLS 2025b), and could not be reduced in nominal terms. For example, the most recent (May 2025) 75th percentile local Home Health and Personal Care Aide hourly wages generally range from $12 to $25 across metropolitan and nonmetropolitan areas (BLS 2025b). Using 75th percentile rather than median wage helps avoid displacement of domestic workers and could create helpful upward pressure on wages; the 75th percentile wage is about 10 percent higher than the median wage on average (BLS 2025b). To ensure the wage keeps up with market conditions and inflation, the wage would be reassessed with a job change or with each renewal of the visa. Wages would also have to satisfy local, state, and federal minimum wage requirements. Standard Social Security and Medicare taxes would apply, as they do for H-1B visa holders.

The employer is not required to provide transportation to the worksite but must document a transportation plan to ensure the worker can safely access the worksite(s), including a plan for the worker to secure a driver's license if applicable. The employer is required to provide documentation of the worker's English literacy and experience in the sector, which could include a letter from a prior employer and proof of wage receipt in the prior position. Employers would also need to secure liability insurance. If the worker transitions away from the initial employer, the new employer would also need to attest to these requirements but would not need to pay additional fees.

The program would include random audits of a subset of employers to ensure compliance with the requirements. H-1D holders would have the same protections and legal rights as other workers, and would, where authorized by law, have legal representation for labor or immigration disputes through dedicated federally supported services or other supports, as has been envisioned under Migration Policy Institute (MPI)'s proposed bridge visa program (Gelatt and Chishti 2024). Workers would receive information on their rights in their preferred language. Employers violating the provisions would be barred from H-1D sponsorship.

Recruitment could happen through one of two channels: For foreign recruitment, the government would maintain a list of vetted U.S. and foreign firms, and new immigrants would be required to use a firm from the list. Vetted firms would be required to follow applicable U.S. law and could not directly charge the worker for any recruitment or application fee. This provision is designed to reduce the risk of malfeasance in the recruitment process. Recruiters violating the provisions would be barred from future visa recruitment. Some foreign nations might choose to develop certification systems to meet U.S. requirements.

For H-1D applicants already based in the U.S., the initial pilot of three years would require a U.S. firm to recruit directly or through a U.S.-based intermediary. These entities would not be permitted to charge the worker any recruitment or application fee to participate in the program; the employer would be responsible for any costs. After the pilot period, individual household employers or Medicaid self-directed services participants could sponsor a visa and would be subject to the same fees and requirements. It is anticipated that intermediary firms would often help client households with recruitment of workers, prior experience verification, navigating the lottery, and ensuring other employer requirements are met. These intermediary firms would also be a natural way for workers to find a new job if an initial placement ended.

Estimated impacts of proposal

If the proposed program is implemented and fully subscribed, there would likely be about 445,000 direct care workers in the United States in 2036 beyond the number that would be expected in the absence of the program. The relatively high wages and benefits associated with the visa might mean visa holders are more likely to work in higher-end, private pay settings. Even if true, the overall increase in supply is likely to expand access to care workers in Medicaid-funded segments of the market.

As noted above, prior literature demonstrates that expansions in the workforce due to immigration reduce the probability that older adults live in institutional settings, improve quality of care in institutional

settings, and generate lower mortality for older adults. Grabowski et al. (2026b) estimate that a 1,000-person increase in immigration to a local area would result in 100 additional health care workers, of which 29 would be health aides, and 9.8 fewer deaths among older adults. If health aides account for a proportional share of mortality reductions, adding 445,000 direct care workers nationally could result in about 45,000 fewer deaths among people 65 and older in 2036. Even if health aides have only a third of the effect on mortality of other health care workers, the proposal could prevent about 15,000 deaths.

Benefits may also extend beyond the well-being of the older population. For example, increased availability of professional care may reduce burdens on family caregivers, and in some cases might allow them to increase their own labor supply. Visa recipients and their families would also benefit from the opportunity to live and work in the United States (National Academies of Sciences, Engineering, and Medicine 2016).

The fiscal impacts of visa recipients likely would be positive. Workers would contribute Social Security; Medicare; federal, state, and local income taxes; property taxes; and sales taxes. Under the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, temporary visa holders are typically not considered to be qualified immigrants, and therefore are ineligible for most major federal safety net programs such as the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, and Medicaid. The Cato Institute notes that the average immigrant arriving at age 25 without a high school diploma or equivalent offers positive fiscal benefits to the country (Nowrasteh et al. 2023).

Questions and concerns

Will the existing domestic direct care workforce be displaced?

A potential concern with EB visas is fear of job market impacts on existing workers in the field. Though the labor market impacts of immigration on the American workforce are generally considered to be positive, the workers most likely to be adversely affected (i.e., existing U.S.- and foreign-born direct care workers) are those most directly competing with the new workers (Gelatt 2024).

Several features of the market should help assuage these concerns. First, direct care wages are highly constrained by public policy and family budget constraints, and therefore are unlikely to change much in either direction due to market pressure alone. Second, the rapid growth in demand will ensure continued opportunity in the field even with expanded supply. The proposal also specifies an above-market wage floor for H-1D workers, at the 75th percentile of the occupational wages in the local area. This should mitigate undercutting issues that are believed to be present in the H-2A agricultural visa program, for which a 2025 interim final rule sets wages for most farmworkers at the 17th percentile of occupational wages (Congressional Research Service 2025). Finally, the commission structure offers an opportunity to change the number of visas as conditions evolve.

The empirical evidence supports the notion of minimal crowd-out. Grabowski et al. (2026b) estimate that a 1,000-immigrant increase in the population 54 and younger yields 33.1 additional foreign direct care workers and a statistically insignificant reduction of 4.9 domestic direct care workers. Evidence from the H-2B program, a temporary labor pathway for nonagricultural temporary work, also suggests minimal displacement of the U.S.-born workforce (Amuedo-Dorantes et al. 2023; Amuedo-Dorantes et al. 2021).

As noted above, the plan proposed here provides only a partial solution to the coming direct care workforce crisis. Policymakers will need to take action to improve wages and working conditions for the domestic workforce and to ensure robust general migration flows in addition to implementing a direct care worker visa. While it is true that a direct care visa could make the need for improvements in the direct care sector less politically urgent, it will also make the scale of the problem one that could be addressed with more moderate fiscal impacts. In other words, the challenge is large enough that a both-and solution is required.

Are the proposed wages and benefits too generous?

As noted above, the program has been structured to minimize the risk of displacement of the existing workforce. By using the 75th percentile wage threshold and requiring health insurance, it is possible that the program could instead level up labor conditions for domestic workers. This, in turn, could improve retention rates among both existing workers and visa holders, and could also bolster the quality of care that clients receive (Chidambaram et al. 2025).

The trade-off is that the package may be unduly onerous for employers, who in turn might decline to participate in the program. The risk of this happening is mitigated by the strong demand conditions, but if program participation is weak, parameters could be modified in the future by the commission.

How does this proposal compare to existing proposals?

It is widely recognized that the existing legal migration system is inadequate to meet U.S. economic and workforce needs. Several recent proposals have aimed to offer small adjustments or alternatives to the system. For example, MPI developed a bridge visa program that would offer a comprehensive and flexible approach to legal work pathways, including for direct care workers (Gelatt and Chishti 2024). Other examples of innovation include a community partnership visa developed by the American Academy of Arts and Sciences, which would allow local areas to recruit to fill specific needs (American Academy of Arts and Sciences 2025), an idea related to the Heartland visa proposed by the Economic Innovation Group for high-skill workers (Lettieri et al. 2024). If sufficiently expansive, these programs could serve as alternatives to an occupation-specific visa like the one proposed here. But, in the current climate, it may be easier for Congress to rally around an urgent workforce need.

There are several examples of proposed reforms in the direct care space specifically. For example, the

Bipartisan Policy Center suggests a package of reforms to address the direct care workforce shortage, including a dedicated temporary immigration pathway and other small adjustments that would facilitate direct care workers using existing visas (Harootunian et al. 2023). PHI also describes a caregiver visa built on the MPI bridge visa that contains several of the principles incorporated here: a pathway to permanency, the ability of workers to bring dependents, and strong worker protections (Espinoza 2023). The current proposal builds on an idea outlined in a previous Brookings piece (Watson 2024).

In June 2026, Rep. Gabe Vasquez introduced the Careworker Visa Act (Office of Rep. Gabe Vasquez 2026). It is similar in spirit to the proposal described here, but differs in several ways, including the following: Its visa includes child care workers whereas the current proposal does not, it allows for a transition to permanency after three years rather than after six years as proposed here, it is limited to small employers, and its annual cap is 100,000 rather than 65,000.

Could the proposed visa be a model for targeted visas for other high-demand occupations?

As noted above, there is a pressing need for an overhaul of the legal migration system, and taking the narrow approach of focusing on one occupation could inhibit the broader effort. On the other hand, enactment of a visa for a shortage occupation such as direct care could serve as a proof of concept for the opening up of other targeted visa pathways. In addition, it is at least possible that an incremental, broadly appealing reform could open up dialogue in the immigration space more broadly.

Conclusion

There is a looming crisis in the direct care workforce, with an anticipated 1.28 million additional workers needed by 2036. Population aging will substantially increase the demand for direct care over the next decade, while the existing U.S.-born and immigrant workforce will not grow quickly enough to meet that demand. Evidence shows that the supply of direct care workers has measurable impacts both on the ability of older Americans to stay in their home and on their health and well-being.

Improving wages, working conditions, training, and career ladders is essential, but even meaningful improvements are unlikely to close the full projected gap. At the same time, current immigration channels are poorly matched to direct care jobs. This proposal suggests a new dual-intent temporary visa, the H-1D, that would provide a pathway for foreign-born workers already living in the U.S. or applying from abroad to work in the U.S. direct care sector. The H-1D proposal is designed as a targeted response to a specific and predictable workforce challenge. A dedicated direct care visa would add a carefully regulated pathway for experienced direct care workers, combining new labor supply with wage standards, portability, family unity, worker protections, and a route to permanency. The proposal could address about a third of the projected direct care workforce gap after 10 years.

Congress is long overdue to pass comprehensive immigration reform, including major reforms to the legal immigration system. Despite some near misses, it has been unable to do so for decades, and the current moment remains unfavorable. While there is some risk that incremental reforms lighten political pressure to do something bigger, it is also possible that a successful bipartisan effort on a comparatively small immigration issue could engender future communication and compromise. This H-1D example could serve as a model for addressing shortages in other occupations, or for broader reform of EB pathways, such as those proposed by MPI's bridge visa (Gelatt and Chishti 2024).

The proposed visa will also help address a specific labor force challenge that will soon reach crisis levels in the absence of policy action. The baby boom generation and their families are approaching a time when care needs will become acute, and there will not be enough paid or unpaid caregivers for them. At the same time, many experienced caregivers around the world would welcome the opportunity to put their skills to use in the U.S. Immigration will need to be part of the solution to preserve high-quality, accessible care for the nation's older adults.

Endnotes

1 The BLS defines the direct care workforce based on the 2018 Standard Occupational Classification. States use a variety of names, skills, and competencies to define direct care work; offer training; and calculate Medicaid reimbursement rates. See Chiri et al. (2025) for an overview of the classification of the direct care workforce. Ruffini et al. (2026) also include psychiatric aides in the definition of DCWs.

2 The current estimate of 3.69 million direct care workers comes from applying rates of participation in the sector by sex, age, and immigrant status as measured by the ACS (2024) to Congressional Budget Office population estimates for 2026. BLS (2025b) reports 5.4 million direct care workers in 2024. The discrepancy between the two totals, 3.69 million and 5.4 million, may be due to differences in occupational coding and the challenge of counting workers who have inconsistent and complex work arrangements.

3 Insurance estimates are from the National Health Interview Survey, which groups home health aides, psychiatric aides, and nursing assistants. Chidambaram et al. (2026) report comparable rates of uninsurance, private insurance, and Medicaid coverage for home health aides, personal care aides, and nursing assistants.

4 For every additional disabled person 65 and older in a U.S. state between 2018 and 2024 there were an additional 0.207 direct care workers. Though direct care workers also provide important support to the disabled population 64 and younger, there is no statistically significant relationship between the state change in the number of people under 65 and the state change in the number of direct care workers. Applying projections based on population aging and age-specific disability weights, this estimate implies that the 2026–36 growth in the number of direct care workers needed will be 1.28 million.

5 CBO (2026) estimates net migration in 2025 was around 410,000; Edelberg et al. (2026) estimate net migration for that year at -10,000 to -295,000, and flows are likely to stay negative for 2026.

6 The Grabowski et al. (2026b) analysis includes psychiatric aides in their definition of direct care workers.

7 A study of home health sector minimum wage exemptions in the 2012 to 2018 period shows that increasing the legal wage boosts the employment of home health aides in areas with highly concentrated (low competition) care sectors but does not change employment overall (Yan et al. 2023). The implied labor supply elasticity from that study is in the 0.6–0.7 range; this means that a 1-percent boost in wages yields 0.6–0.7 percent more labor supply. In a study of the child care sector, which employs a similar workforce, wage increases reduced turnover with an elasticity of around -0.8 (Brown and Herbst 2023). A 2012 review by CBO (2012) concludes from the Earned Income Tax Credit literature that overall labor market participation elasticities for low-income workers are in the 0.3 to 1.2 range.

8 U.S.-based status adjusters (assumed 20,000 in 2027 through 2029 and 32,500 thereafter) have an assumed annual retention rate of 95 percent in their first three years and 98 percent thereafter. International recruits (assumed 10,000 in 2027 through 2029 and 32,500 thereafter) are similar, but retention in their first year is only 90 percent.

9 Under the Affordable Care Act's employer shared-responsibility provisions, an adequate health insurance plan is one which covers an average of at least 60 percent of allowable health care expenses, and an affordable plan is one under which an individual is not required to pay more than an annually adjusted share of their income toward the premium for self-only coverage (Congressional Research Service 2019).

References

American Academy of Arts and Sciences. 2025. *Community Partnership Visas: How Immigration can Boost Local Economies*. Community Partnership Visa Working Group. https://www.amacad.org/sites/default/files/publication/downloads/2025_core_community-partnership-visas.pdf

American Immigration Council. 2024. "Documented Dreamers: An Overview." https://www.americanimmigrationcouncil.org/fact-sheet/documented-dreamers-overview/

Amuedo-Dorantes, Catalina, Esther Arenas-Arroyo, Parag Mahajan, and Bernhard Schmidpeter. 2023. "Low-Wage Jobs, Foreign-Born Workers, and Firm Performance." Discussion Paper 16438. IZA Institute of Labor Economics. https://www.jstor.org/stable/resrep57369?seq=1

Amuedo-Dorantes, Catalina, Esther Arenas-Arroyo, and Bernhard Schmidpeter. 2021. "Immigration Enforcement and the Hiring of Low-Skilled Labor." *AEA Papers and Proceedings* 111: 593–97. https://www.aeaweb.org/articles?id=10.1257/pandp.20211115

Angell, Sarah, Lina Stepick, and Kezia Scales. 2024. *Direct Care Workforce State Index: Mapping Workforce Policies and Outcomes*. PHI. https://www.phinational.org/resource/direct-care-workforce-state-index-mapping-workforce-policies-and-outcomes/

Australian Department of Home Affairs. 2026. "Labour Agreements: Industry Labour Agreements." Australian Government. Last updated June 23. https://immi.homeaffairs.gov.au/visas/employing-and-sponsoring-someone/labour-agreements/types-of-labour-agreements/industry-labour-agreements

Baughman, Reagan A., and Kristin Smith. 2010. "The Effect of Medicaid Wage Pass-Through Programs on the Wages of Direct Care Workers." *Med Care* 48 (5): 426–32. https://pubmed.ncbi.nlm.nih.gov/20393361/

Brown, Jessica H., and Chris M. Herbst. 2023. "Minimum Wage, Worker Quality, and Consumer Well-Being: Evidence from the Child Care Market." Discussion Paper 16257. IZA Institution of Labor Economics. https://docs.iza.org/dp16257.pdf

Bubola, Emma, and Andrada Lautaru. 2025. "When Caregiving Makes Women Ill." *New York Times*, October 29. https://www.nytimes.com/2025/10/29/world/europe/when-caregiving-makes-women-ill.html

Bureau of Labor Statistics (BLS). 2025a. "Employment Projections, 2024-34." U.S. Department of Labor. https://www.bls.gov/emp/data/projections-archive.htm

Bureau of Labor Statistics (BLS). 2025b. "Occupational Employment and Wages Statistics." U.S. Department of Labor. https://www.bls.gov/oes/home.htm

Burns, Alice, Maiss Mohamed, Priya Chidambaram, Abby Wolk, and Molly O'Malley Watts. 2025. "Payment Rates for Medicaid Home Care: States' Responses to Workforce Challenges." KFF. https://www.kff.org/medicaid/payment-rates-for-medicaid-home-care-states-responses-to-workforce-challenges/

Butcher, Kristin F., Kelsey Moran, and Tara Watson. 2022. "Immigrant Labor and the Institutionalization of the U.S.-Born Elderly." *Review of International Economics* 30 (5): 1375–413. https://doi.org/10.1111/roie.12607

Centers for Medicare & Medicaid Services (CMS). 2024. "Ensuring Access to Medicaid Services." 42 CFR Parts 431, 438, 441, and 447. https://www.federalregister.gov/documents/2024/05/10/2024-08363/medicaid-program-ensuring-access-to-medicaid-services

Chidambaram, Priya, Alice Burns, Tricia Neuman, and Robin Rudowitz. 2024. "With Current Staffing Levels, About 1 in 5 Nursing Facilities Would Meet Fully-Implemented Minimum Staffing Standards in the Final Rule." KFF. https://www.kff.org/medicaid/nursing-facilities-staffing-levels-standards-final-rule/

Chidambaram, Priya, Alice Burns, Tricia Neuman, and Robin Rudowitz. 2025. "5 Key Facts about Nursing Facilities and Medicaid." KFF. https://www.kff.org/medicaid/5-key-facts-about-nursing-facilities-and-medicaid/

Chidambaram, Priya, Drishti Pillai, and Alice Burns. 2026. "Who Are Direct Care Workers and How Might Federal Policy Changes Impact the Workforce?" KFF. https://www.kff.org/medicaid/who-are-direct-care-workers-and-how-might-federal-policy-changes-impact-the-workforce/

Chiri, Giuseppina, Abbie Levinson, Ella Shenkar, et al. 2025. *Definitions and Occupational Characteristics of Direct Support Professionals: Environmental Scan and State Interview Findings Report*. RTI International. Prepared for the Office of the Assistant Secretary for Planning and Evaluation (ASPE) at the U.S. Department of Health and Human Services. https://aspe.hhs.gov/sites/default/files/documents/97952b77e7410a29d755158e4aed46bd/dsp-definitions-occupational-characteristics.pdf

Ciolfi, Mary Lou, Kimberly Snow, and Catherine Taylor. *Direct Care & Support Professional Advisory Council: Evaluation Report*. Consortium for Aging Policy Research and Analysis. https://www.mainedirectcarepros.org/wp-content/uploads/2025/12/Direct_Care__Support_Professional_AC_Evaluation_Report.pdf

Congressional Budget Office (CBO). 2012. "A Review of Recent Research on Labor Supply Elasticities." Authored by Robert McClelland and Shannon Mok. Working Paper 2012-12. https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/workingpaper/10-25-2012-recentresearchonlaborsupplyelasticities.pdf

Congressional Budget Office (CBO). 2026. "Demographic Projections." Dataset, January 7. https://www.cbo.gov/data/budget-economic-data#13

Congressional Research Service. 2019. *The Affordable Care Act's (ACA's) Employer Shared Responsibility Provisions (ESRP).* Authored by Ryan J. Rosso. R45455. https://www.congress.gov/crs-product/R45455

Congressional Research Service. 2025. *New Adverse Effect Wage Rate (AEWR) Methodology for Temporary Employment of H-2A Nonimmigrants in the United States*. Authored by Elizabeth Weber Handwerker. IF12408. https://www.congress.gov/crs-product/IF12408

Das, Shanti. 2025. "Flawed UK Visa Scheme Led to 'Horrific' Care Worker Abuse, Says Watchdog." *The Guardian*, March 16. https://www.theguardian.com/world/2025/mar/16/flawed-uk-visa-scheme-led-to-horrific-care-worker-abuse-says-watchdog

Dickinson, Eli, and Chengcheng Zhou. 2026. *NADSP E-Badge Evaluation: 2025 Monitoring Report*. TennCare. https://www.tn.gov/content/dam/tn/tenncare/documents/NADSPEBadgeEvaluationReport2025.pdf

Edelberg, Wendy, Stan Veuger, and Tara Watson. 2026. "Macroeconomic Implications of Immigration Flows in 2025 and 2026: January 2026 Update." Brookings Institution. https://www.brookings.edu/articles/macroeconomic-implications-of-immigration-flows-in-2025-and-2026-january-2026-update/

Einav, Liran, and Amy Finkelstein. 2026. "Elderly Health and Longevity in the US: Evidence and Implications." Working Paper 35346. National Bureau of Economic Research. https://www.nber.org/papers/w35346

Espinoza, Robert. 2023. *Bridging the Gap: Enhancing Support for Immigrant Direct Care Workers and Meeting Long-Term Care Needs*. PHI. https://www.phinational.org/wp-content/uploads/2023/09/PHI-Bridging-the-Gap-2023.pdf

Foster, Andrew D., and Yong Suk Lee. 2015. "Staffing Subsidies and the Quality of Care in Nursing Homes." *Journal of Health Economics* 41: 133–47. https://pubmed.ncbi.nlm.nih.gov/25814437/

Furtado, Delia, and Francesc Ortega. 2023. "Does Immigration Improve Quality of Care in Nursing Homes?" *Journal of Human Resources* 61 (1): 1–40. https://jhr.uwpress.org/content/early/2023/07/03/jhr.0720-11063R2

Gelatt, Julia. 2024. "Immigrants and the U.S. Economy." Migration Policy Institute. https://www.migrationpolicy.org/explainer/immigrants-us-economy

Gelatt, Julia, and Muzaffar Chishti. 2024. "A New Way Forward for Employment-Based Immigration: The Bridge Visa." Migration Policy Institute. https://www.migrationpolicy.org/research/employment-immigration-bridge-visa

Government of Canada/Gouvernement du Canada. 2025a. "Ministerial Instructions Regarding the Processing of Applications under the Home Care Worker Immigration Pilot Program (Child Care) and Home Care Worker Immigration Pilot Program (Home Support)." *Canada Gazette* 159 (12). https://gazette.gc.ca/rp-pr/p1/2025/2025-03-22/html/notice-avis-eng.html

Government of Canada/Gouvernement du Canada. 2025b. "Pausing Home Care Worker Immigration Pilots Application Intake." https://www.canada.ca/en/immigration-refugees-citizenship/news/notices/pausing-home-care-worker-immigration-pilots-application-intake.html

Grabowski, David C., Jonathan Gruber, and Brian E. McGarry. 2026a. "Immigration, the Long-Term Care Workforce, and Elder Outcomes in the US." *American Journal of Health Economics* 12 (3): 413–59. https://doi.org/10.1086/737645

Grabowski, David C., Jonathan Gruber, and Brian E. McGarry. 2026b. "Is Immigration Good for Health? The Effect of Immigration on Older Adult Mortality in the United States." Working Paper 34791. National Bureau of Economic Research. https://www.nber.org/papers/w34791

Harootunian, Lisa, Kamryn Perry, Allison Buffett, Marilyn Serafini, Brian O'Gara, and G. William Hoagland. 2023. *Addressing the Direct Care Workforce Shortage: A Bipartisan Call to Action*. Bipartisan Policy Center. https://bipartisanpolicy.org/wp-content/uploads/2023/11/BPC-Direct-Care-Workforce-Report-Final.pdf

Haumschild, Sarah, and Jake Lapido. 2026. "MN Care Force Incentive Operations Manual." Minnesota Department of Human Services. https://pcg.filecamp.com/s/c/T0ut6FkkBrS2pInp/x/VemJA4t2EBchEwrx

Hong Kong Immigration Department. 2025. "Special Scheme to Import Care Workers for Residential Care Homes." Government of the Hong Kong Special Administrative Region of the People's Republic of China. https://www.immd.gov.hk/eng/services/visas/imported_careworker.html

Huh, Jason, Kwanghyun Kim, and Dominikas Mockus. 2024. "Immigrant Labor Force and Living Arrangements of Elderly Natives." Working Paper 4983115. Available at SSRN: http://dx.doi.org/10.2139/ssrn.4983115

Illinois Act on the Aging. 2025. 20 Ill. Comp. Stat. 105/. https://www.ilga.gov/Legislation/ILCS/Articles?ActID=224&ChapterID=5&Chapter=EXECUTIVE%20BRANCH&MajorTopic=GOVERNMENT

Immigration Nursing Relief Act of 1989. 1989. Pub. L. No. 101-238, 103 Stat. 2099. https://www.congress.gov/bill/101st-congress/house-bill/3259/text

Jung, Youngjoo, and Dominikas Mockus. 2025. "From Lawn Care to Home Care: Undocumented Immigration and Aging in Place." *American Journal of Health Economics* 11 (3). https://www.journals.uchicago.edu/doi/abs/10.1086/728717

King, Jessica, Kenzia Scales, and Susan Chapman. 2025. *Training Standards for Personal Care Aides Across States: An Assessment of Current Standards and Leading Examples*. University of California San Francisco Health Workforce Research Center on Long-Term Care. https://healthworkforce.ucsf.edu/file/trainingstandardspcasacrossstatesreport

Kramer, Stephanie, and Jeffrey S. Passel. 2025. "What the Data Says about Immigrants in the U.S." Pew Research Center. https://www.pewresearch.org/short-reads/2025/08/21/key-findings-about-us-immigrants/

Lee, Yong, Toshiaki Iizuka, and Karen Eggleston. 2025. "Robots and Labor in Nursing Homes." *Labour Economics* 92: 102666. https://www.sciencedirect.com/science/article/pii/S0927537124001623?via%3Dihub

Lettieri John, Connor O'Brien, and Adam Ozimek. 2024. "Heartland Visas: A Policy Primer." Economic Innovation Group. https://eig.org/heartland-visas-a-policy-primer/

Lohmeyer, Suzette. 2024. "Older Adults Want to Age-in-Place, But Many Don't Expect They'll Be Able to." *AARP*, December 10. https://www.aarp.org/home-living/home-community-preferences-survey-2024/?msockid=2d7cf059c3a7603a08cae6cbc2f061e8

Maine Revised Statutes. 2021. Title 22, Chapter 1627 §§ 7401-04.

Malde, Jack. 2024. "Reviving Schedule A: A Path to Easing Labor Shortages Through Immigration." Bipartisan Policy Center. https://bipartisanpolicy.org/article/reviving-schedule-a-a-path-to-easing-labor-shortages-through-immigration/

Malik, Aisha. 2024. "CareYaya is enabling affordable home care by connecting healthcare students with elders." *TechCrunch*, November 2. https://techcrunch.com/2024/11/02/careyaya-is-enabling-affordable-home-care-by-connecting-healthcare-students-with-elders/

Miller, Katherine E. M, Norma B. Coe, Amanda R. Kreider, Allison Hoffman, Katherine Rhode, and Pilar Gonalons-Pons. 2024. "Increasing Expenditures on Home- and Community-Based Services: Do Home Care Workers Benefit?" *Health Services Research* 60 (S2): e14399. https://onlinelibrary.wiley.com/doi/10.1111/1475-6773.14399

National Academies of Sciences, Engineering, and Medicine. 2016. *Families Caring for an Aging America*. The National Academies Press. https://www.nationalacademies.org/publications/23606?gclid=COHjg46mptECFQ6BaQodq34A1g

National Center for Health Workforce Analysis. 2025. "Long-Term Services and Support: Demand Projections, 2023-2038." Bureau of Health Workforce, Health Resources and Services Administration, U.S. Department of Health and Human Services. https://bhw.hrsa.gov/sites/default/files/bureau-health-workforce/data-research/ltss-projections-factsheet.pdf

Nevada Department of Health and Human Services. 2024. "Rate Increases for Personal Care Services (PCS) and PCS-Like Services." Nevada Medicaid Web Announcement 3270. Division of Health Care Financing and Policy, Nevada Medicaid Provider Portal. Updated February 12. https://www.medicaid.nv.gov/Downloads/provider/web_announcement_3270_20240130.pdf

New Zealand Immigration. 2023. "Care Workforce Work to Residence Visa." Ministry of Business, Innovation, and Employment, New Zealand Government. https://www.immigration.govt.nz/visas/care-workforce-work-to-residence-visa/

New Zealand Immigration. 2026. "Statistics — Resident Decisions by Financial Year." Ministry of Business, Innovation, and Employment, New Zealand Government, July 9. https://www.immigration.govt.nz/about-us/research-and-statistics/statistics/

North Carolina Department of Health and Human Services. 2025. "NCDHHS Partners with the North Carolina Community College System to Offer Free Training to Strengthen the Direct Support Professional Workforce." Press release, August 5. https://www.ncdhhs.gov/news/press-releases/2025/08/05/ncdhhs-partners-north-carolina-community-college-system-offer-free-training-strengthen-direct

Nowrasteh, Alex, Sarah Eckhardt, and Michael Howard. 2023. "The Fiscal Impact of Immigration in the United States." Cato Institute. https://www.cato.org/white-paper/fiscal-impact-immigration-united-states

Nursing Relief for Disadvantaged Areas Act of 1999. 1999. Pub. L. No. 106-95, 113 Stat. 1312. https://www.congress.gov/bill/106th-congress/house-bill/441/text

Nursing Relief for Disadvantaged Areas Reauthorization Act of 2005. 2005. Pub. L. No. 109-432, 120 Stat. 2900. https://www.govinfo.gov/content/pkg/PLAW-109publ423/pdf/PLAW-109publ423.pdf

Office of Rep. Gabe Gasquez. 2026. "Rep. Gabe Vasquez Introduces Careworker Visa Act to Address Childcare and Eldercare Worker Shortage, Bring Down Costs." Press release, June 9. https://vasquez.house.gov/media/press-releases/rep-gabe-vasquez-introduces-careworker-visa-act-address-childcare-and

Papademetriou, Demetrios G., Doris Meissner, Marc R. Rosenblum, and Madeleine Sumption. 2009. "Aligning Temporary Immigration Visas with US Labor Market Needs: The Case for a New System of Provisional Visas." Migration Policy Institute. https://www.migrationpolicy.org/sites/default/files/publications/Provisional_visas.pdf

PHI. 2025a. "Direct Care Workers in the United States: Key Facts 2025." https://www.phinational.org/resource/direct-care-workers-in-the-united-states-key-facts-2025/

PHI. 2025b. "The Path Forward: Preserving, Strengthening, and Reimagining Care in the United States." https://www.phinational.org/resource/the-path-forward-preserving-strengthening-and-reimagining-care-in-the-united-states/

Reinhard, Susan, Rodney Harrell, Carrie Blakeway Amero, et al. 2023. "Innovation and Opportunity: A State Scorecard on Long-Term Services and Supports for Older Adults, People with Physical Disabilities, and Family Caregivers." AARP Public Policy Institute. https://ltsschoices.aarp.org/scorecard-report/innovation-and-opportunity

Savitski, Andrei. 2025. "International Recruitment of Care Workers Has Ended, The Impact May Be Disastrous." Work Rights Centre. https://www.workrightscentre.org/publications/2025/international-recruitment-of-care-workers-has-ended-the-impact-may-be-disastrous/

Singer, Colin R. 2025. "IRCC Releases Application Intake and Requirements for New Home Care Worker Pilots." Immigration.ca. https://immigration.ca/ircc-releases-application-intake-and-requirements-for-new-home-care-worker-pilots/

Skinner, Robert J., Jiani Yu, Mark A. Unruh, Robert Tyler Braun, Hye-Young Jung, Phyllis Johnson, Rahul Fernandez, and David G. Stevenson. 2025. "State variation in staffing and characteristics of nursing homes most impacted by new federal standards." *Health Affairs Scholar* 3 (8): qxaf145. https://doi.org/10.1093/haschl/qxaf154

Span, Paula. 2026. "These 3 Policy Moves are Likely to Change Health Care for Older People." *KFF Health News,* January 23. https://kffhealthnews.org/aging/long-term-care-nursing-homes-medicare-ai-prior-authorization/

Suresh, Sharmila, and Jara Pallas-Brink. 2025. "Reimagining Care: Technology-Enabled Strategies to Address the Direct Care Workforce Shortage." *Innovation in Aging* 9 (S2). https://pmc.ncbi.nlm.nih.gov/articles/PMC12763205/

U.K. Home Office. 2024. "Sponsored Work Entry Clearance Visas by Occupation and Industry (SOC 2010), Year Ending March 2024." Dataset. https://www.gov.uk/government/statistical-data-sets/immigration-system-statistics-data-tables#sponsored-work-visas-by-occupation-and-industry

U.S. Census Bureau (Census). 2010–24. "American Community Survey." U.S. Department of Commerce.

U.S. Citizenship and Immigration Services. 2026. "Temporary (Nonimmigrant) Workers." Accessed September 1, 2026. https://www.uscis.gov/working-in-the-united-states/temporary-nonimmigrant-workers

U.S. Congress. 2025. DIGNIDAD (Dignity) Act of 2025. H.R. 4393, 119th Cong., 1st sess. Introduced in House July 15, 2025. https://www.congress.gov/bill/119th-congress/house-bill/4393

U.S. Department of Labor. n.d. "Fact Sheet #78: General Requirements for Employers Participating in the H-2B Program." Department of Labor, Wage and Hour Division. Accessed September 1, 2026. https://www.dol.gov/agencies/whd/fact-sheets/78-h2b-overview

U.S. Department of Labor. 2012. "Employer Guide to Participation in the H-2A Temporary Agricultural Program." Department of Labor, Employment and Training Administration. https://www.dol.gov/sites/dolgov/files/ETA/oflc/pdfs/h-2a_employer_handbook.pdf

U.S. Department of Labor. 2026. "PERM Processing Times (as of 8/31/2026)." https://flag.dol.gov/processingtimes

U.S. Department of State. n.d. "J-1 Visa Basics." Accessed September 1, 2026. https://j1visa.state.gov/basics

U.S. Department of State. 2002. "Nonimmigrant Visas Issued by Classification (Including Crewlist Visas and border Crossing Cards): Fiscal Years 1997–2001." Data table. Bureau of Consular Affairs. https://travel.state.gov/content/dam/visas/Statistics/FY2002%20table%20XVI.pdf

U.S. Department of State. 2007. "Nonimmigrant Visas Issued by Classification (Including Crewlist Visas and Border Crossing Cards): Fiscal Years 20022006." Data table. Bureau of Consular Affairs. https://travel.state.gov/content/dam/visas/Statistics/FY06AnnualReportTableXVIB.pdf

U.S. Department of State. 2008. "Nonimmigrant Visas Issued by Classification (Including Crewlist Visas and Border Crossing Cards): Fiscal Years 2003–2007." Data table. Bureau of Consular Affairs. https://travel.state.gov/content/dam/visas/Statistics/FY07AnnualReportTableXVIB.pdf

U.S. Department of State. 2010. "Nonimmigrant Visas Issued by Classification (Including Crewlist Visas and Border Crossing Cards): Fiscal Years 2005–2009." Data table. Bureau of Consular Affairs. https://travel.state.gov/content/dam/visas/Statistics/FY09AnnualReport_TableXVI_B.pdf

U.S. Department of State. 2015. "Nonimmigrant Visas Issed by Classification (Including Crewlist Visas and Border Crossing Cards): Fiscal Years 2010–2014." Data table. Bureau of Consular Affairs. https://travel.state.gov/content/dam/visas/Statistics/AnnualReports/FY2014AnnualReport/FY14AnnualReport-TableXVIB.pdf

U.S. Department of State. 2026. "Visa Bulletin for July 2026." No. 16, Vol. XI. Bureau of Consular Affairs. https://travel.state.gov/content/travel/en/legal/visa-law0/visa-bulletin/2026/visa-bulletin-for-july-2026.html

Watson, Tara. 2022. "Why and How to Expand US Immigration" In *Economic Policy in a More Uncertain World*, edited by Melissa S. Kearney and Amy Ganz. Aspen Institute. https://doi.org/10.5281/zenodo.14026847

Watson, Tara. 2024. "How Immigration Reforms Could Bolster Social Security and Medicare Solvency and Address Direct Care Workforce Issues." Brookings Institution. https://www.brookings.edu/articles/how-immigration-reforms-could-bolster-social-security-and-medicare-solvency-and-address-direct-care-workforce-issues/

Yan, Di, Helena Temkin-Greener, Ronni Pavan, Hao Yu, and Shubing Cai. 2023. "Did Minimum Wage Policy Changes Impact Home Health Workforce?" *Home Health Care Management & Practice* 35 (3): 206–12. https://pubmed.ncbi.nlm.nih.gov/38031569/

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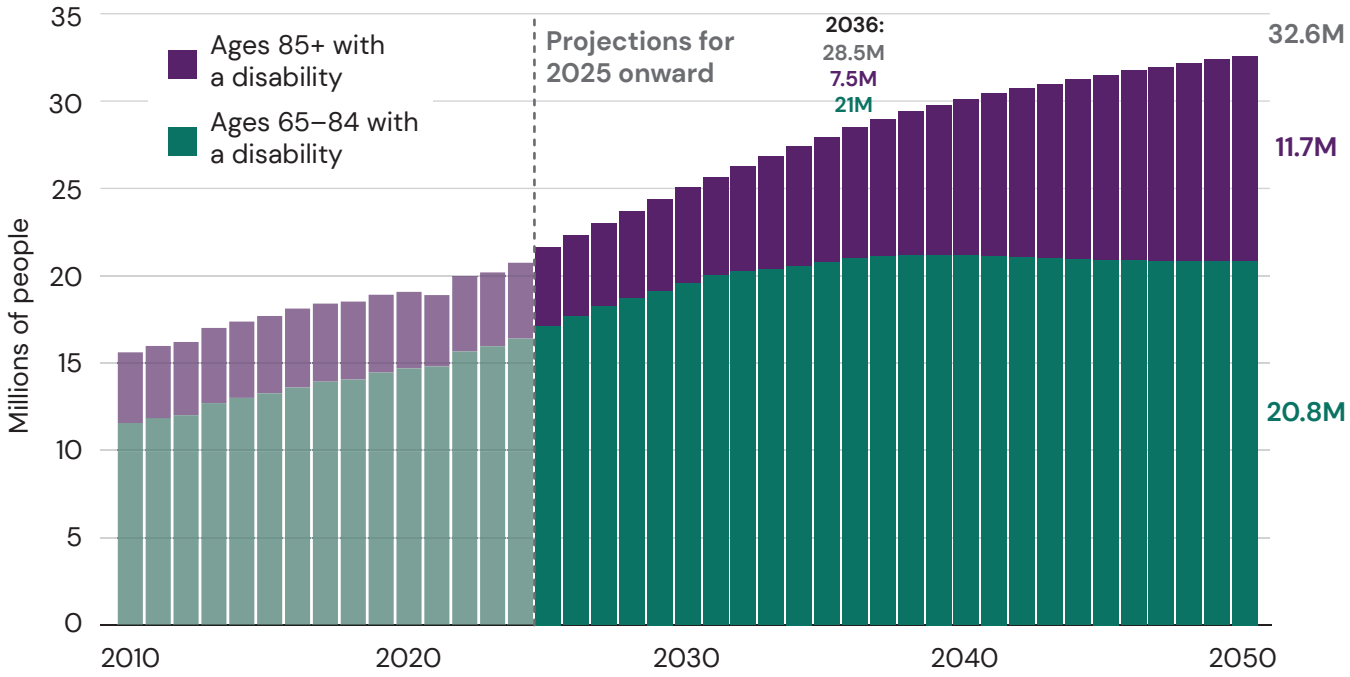
Direct care workers—including home health aides, personal care aides, and nursing assistants—provide support in activities of daily living and long-term care for older people and those living with disabilities. With the rising number of older Americans, an estimated 1.28 million additional workers in the sector will be needed by 2036, an increase of about 35 percent over today's 3.69 million direct care workers. This proposal details a temporary direct care worker visa, the H-1D, that offers a targeted and flexible way to address the looming workforce challenge and to improve the quality of care available to people who need support.

Number of people 65 and older and 85 and older with a disability



Source: ACS 2010–24; CBO 2026.

Note: Sum of bars (gray) represents the number of people 65 and older with a disability. Disability projections are made under the assumption that disability rates by one-year age bucket from the 2024 ACS remain constant. These shares are applied to CBO's projected population of each respective age group through 2050.

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