TNAA/TOTALMED - WRITTEN TESTIMONY

OPPOSITION TO CAPPING TEMPORARY NURSE STAFFING PRICES OR PROFITS IN NEW YORK

Thank you for the opportunity to testify. As we will show below, capping the prices or profits of temporary nurse staffing agencies in New York would worsen staffing gaps, restrict patient access, and weaken hospitals' ability to respond to emergencies.

TNAA/TotalMed is a top 10 company in the healthcare staffing industry. Our core values center around providing an excellent experience for all our constituencies, our clinicians, our client medical facilities, the patients and our internal staff. TNAA/TotalMed includes travel nurse, travel allied, MSP, rapid/strike/emergency response, non-clinician healthcare staffing and per diem healthcare staffing across the US.

I. Temporary Staffing Is a Response to a Workforce Crisis—Not the Cause

The fundamental driver of temporary nurse staffing is the chronic, well-documented healthcare workforce shortage that predates COVID and has only intensified since. Temporary staffing did not create this shortage. It exists because the shortage is real.

According to the National Association of Travel Healthcare Organizations, the registered nurse workforce declined, nationally, by more than 100,000 nurses between 2020 and 2021, the largest drop in four decades. A troubling share of those departures were nurses under age 35, threatening long-term workforce stability. Looking ahead, the federal government projects more than 200,000 RN openings per year through at least 2031, driven by retirements, burnout, and exits from the profession.

COVID sharply accelerated burnout and attrition. Nurses reported high levels of stress, anxiety, depression, and PTSD—factors that permanently shrink supply. Hospitals turned to temporary staffing because permanent hiring cycles take months, while patient needs are immediate.

II. New York Data Shows Contract Nurse Use Has Not Exploded

New York's reported information contradicts the narrative that hospitals are increasingly substituting contract nurses for permanent staff.

Based on Centers for Medicare and Medicaid Services data from 2017 through 2019, before COVID, we estimate that New York hospitals spent less than 2 percent of total hospital labor costs on contract nurses. During the height of the pandemic, that figure rose—as expected during a once-in-a-century public health emergency—but even then, contract nurse spending peaked at 6.4 percent in 2022, before declining to 5.8 percent in 2023, which represents the most recent data available. (See chart below)

That is not runaway growth. It is a temporary, crisis-driven response—and it is already receding.

Also, contrary to the narrative, New York hospitals consistently relied far less on contract nurses than hospitals nationally. In 2022, contract nurse spending nationally exceeded 10 percent of hospital labor costs, while New York remained well below that level. The same pattern held in 2023.

Use of Contract Staff – New York v. U.S.

Hospitals	NY			US		
Year	Total Spend on Contract Hospital Staff	Total Spend on All Hospital Staff	Contract Spend as a % of Total Spend	Total Spend on Contract Hospital Staff	Total Spend on All Hospital Staff	Contract Spend as a % of Total Spend
2017	$ 602,467,858	$ 33,476,629,620	1.8%	$ 11,793,967,060	$ 337,163,145,259	3.5%
2018	$ 617,429,230	$ 34,413,419,812	1.8%	$ 12,187,711,885	$ 348,119,481,281	3.5%
2019	$ 668,704,019	$ 35,759,592,143	1.9%	$ 12,795,967,436	$ 359,600,418,569	3.6%
2020	$ 1,187,357,844	$ 37,734,622,486	3.1%	$ 15,954,909,535	$ 369,884,236,721	4.3%
2021	$ 1,628,873,510	$ 38,383,568,377	4.2%	$ 31,102,173,618	$ 393,475,379,571	7.9%
2022	$ 2,653,877,931	$ 41,209,552,830	6.4%	$ 43,507,377,848	$ 417,671,840,509	10.4%
2023	$ 2,593,624,018	$ 44,536,097,797	5.8%	$ 31,770,607,170	$ 446,473,435,609	7.1%

Source: Centers for Medicare and Medicaid Services Note: Medicare hospital cost reports do not disaggregate contract labor by clinical category. However, hospital association, state comptroller, and national health-system surveys show that temporary agency nurses account for the majority of hospital contract labor spend which closely tracks overall contract spend.

III. Temporary Staffing Complements Permanent Staff—It Does Not Displace Them

The CMS data matters because it makes an essential point: New York hospitals are not replacing permanent nurses with temporary ones. They are using temporary staffing sparingly, as a pressure valve, when permanent positions cannot be filled fast enough to maintain safe care.

Temporary staffing supports continuity of care by filling acute, unpredictable gaps—patient surges, medical leave, retirements, seasonal fluctuations, and emergencies. Permanent hiring cannot respond to those needs in real time.

Travel nurses also provide geographic and clinical flexibility, deploying to hotspots and high-acuity settings such as ICUs and emergency departments. This flexibility prevents burnout among permanent staff and helps hospitals maintain staffing ratios without losing local nurses to exhaustion or forced overtime.

In addition, many local “per diem” nurses already have permanent nursing jobs with hospitals and often work short-term temporary assignments to supplement their income. Restricting the use of temporary nursing staff would have a negative effect on their ability to earn the additional income they need.

Temporary and permanent staff are not competitors. They are complimentary and serve different labor functions. Permanent hiring addresses predictable, ongoing need. Temporary staffing addresses unpredictable, urgent demand that meets the hospital, nurse, and patient needs.

IV. The Financial Data Is Clear

A. Most Dollars Go to Nurses, Not Agencies

There is a perception that rising hospital costs reflect excessive agency profits. The data does not support that claim.

The National Association of Travel Healthcare Organizations works with Staffing Industry Analysts on the Travel Nurse Trends and Insights annual report, most recently release was in June 2025. According to that report, the percentage of the travel nurse bill rate that flowed directly to clinicians has increased consistently over the years from 71.3 percent in 2019 to 76.2 percent in 2024. These amounts include wages, bonuses, payroll taxes, housing, meals, and insurance.

Agency gross margins—which must cover recruitment, credentialing, compliance, clinical support, insurance, technology, and overhead has decreased consistently over the same time frame from 24.8 percent in 2019 to 19.3 percent. Importantly, those margins have declined, not increased, as bill rates have risen and costs have increased. (See chart below)

Components of travel nurse pay rate as % of bill rate

Percentage of Bill Rate (%)	2019	2020	2021	2022	2023	2024
Hourly wages, bonuses, payroll taxes	38.0%	41.7%	50.3%	52.3%	48.5%	44.9%
Housing and meals & incidentals reimbursement (non-taxable)	33.3%	29.7%	21.4%	20.7%	26.4%	31.3%
Gross margin	24.8%	24.6%	24.2%	23.3%	20.5%	19.3%
Sales, general and administration expense	13.9%	12.3%	8.8%	8.6%	11.2%	13.6%
Earnings before interest taxes depreciation and amortization	10.9%	12.4%	15.4%	14.7%	9.3%	5.8%

Source: SIA NATHO Travel Nurse Benchmarking Surveys, 2021-2024

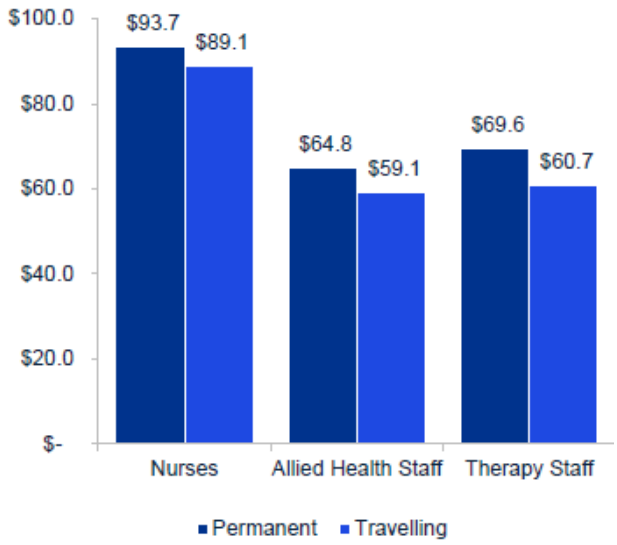
Hospitals paid more during COVID because nurses had to be paid more to accept dangerous, high-acuity assignments—not because agencies captured excess profits.

B. Travel Staff Is Not More Expensive Than Permanent Staff

In a recently published report, *U. S. Nursing, Allied Health and Therapy labor Costs Study*, from KPMG, KPMG stated “after accounting for all ‘baked-in’ costs, traveling labor delivers measurable savings and strategic value. All-in costs for traveling nurses average approximately $89/hour, lower than $94/hour for permanent nurses. Traveling allied health

and traveling therapy staff are approximately 9% and 13% less expensive than their permanent counterparts, respectively" (*see* charts below):

Hourly, all-in cost for permanent and traveling staff



Source: KPMG's 2025 U.S. Nursing, Allied Health and Therapy Staff study

Detailed hourly costs for permanent and traveling nursing staff

	Permanent Nurses	Traveling Nurses
Base Wages	$45	
Other Payroll Costs[1]	$13	
Benefits and Insurance	$9	
Risk Management Costs	$3	
Recruitment Costs	$7	
Training Costs	$8	
Non-productive costs	$9	
All-In Total Costs	$94	$89

Source: KPMG's 2025 U.S. Nursing, Allied Health and Therapy Staff study

Travel healthcare rates are already less than the comparable full cost of a permanent staff provider – rate or margin caps will deter agencies and healthcare providers away from New York.

IV. The Market Is Self-Correcting

As crisis demand receded, the temporary staffing market normalized without legislative intervention.

According to Staffing Industry Analysts, at their annual Healthcare Staffing Summit presented information that the travel nurse market declined by 36 percent in 2023, another 37 percent in 2024 and they projected an additional decline of 12% for 2025. Inflation-adjusted bill rates have drifted back to near pre-pandemic levels. (See chart below)

New York's own data reflects this normalization. Contract nurse spending as a share of total hospital labor costs is already declining.

US Travel Nurse Market Size ($Billions) and Y/Y growth

	2019	2020	2021	2022	2023	2024	2025P	2026P
Travel nurse	8.7	11.4	29.9	44.6	28.6	18.0	15.8	16.3
Year-over-year chg.	15%	32%	162%	49%	-36%	-37%	-12%	3%

Source: SIA, US Staffing Industry Pulse Survey, May 2025

V. Price or Margin Caps Will Worsen Shortages and Harm Patients

In light of this evidence, proposals to cap prices or profits would undermine the very mechanisms that allow hospitals to function during staffing crises.

If agencies cannot sustain viable margins, they will be less able to:

- Pay competitive wages to attract nurses to high-acuity or underserved settings
- Respond quickly to local surges in demand without operating at a loss
- Serve rural hospitals, safety-net facilities, and long-term care providers where margins are already thin

In addition, when agencies hit their bottom margin the compensation for the clinicians will decline. Traveling clinicians have choices and if the compensation package to take an assignment in New York is not commiserate with options they have in other parts of the country, they will go elsewhere. New York healthcare facilities will be left short staffed or low quality staffed.

The result will not be savings—it will be fewer nurses at the bedside in New York.

History confirms this risk. States such as Massachusetts and Minnesota imposed rate caps only to suspend or raise them during COVID when hospitals could not staff safely under rigid limits. Oregon's more recent law explicitly includes emergency exceptions, recognizing that inflexible caps fail when demand spikes. Healthcare does not operate on a fixed schedule. Policy must allow flexibility when lives are at stake.

The good news is that existing New York law already provides a remedy for alleged pricing abuses. General Business Law § 396-r and just released rules published by the Attorney General prohibit charging excessive prices for goods and services during abnormal market disruptions and public emergencies. This would allow the state to address such issues on a case-by-case basis without aggravating the nursing shortage or harming patients.

VI. Conclusion

New York's own data tells a clear story. Contract nurse use has remained a small and declining share of hospital labor spending. Temporary staffing is not crowding out permanent jobs. It is filling unavoidable gaps created by a real workforce shortage.

Capping prices or profits would reduce flexibility, deter nurses from high-need assignments, and ultimately restrict patient access to care. The better path forward is to invest in nurse education, retention, and workforce resilience, and address alleged pricing under existing law on a case-by-case basis—not through blunt rate caps that aggravate the shortage we are trying to solve.

Thank you for your time and consideration.