February 10, 2026

Attn: wamchair@nyassembly.gov / financechair@nysenate.gov

RE: **Opposition to Capping Temporary Nurse Staffing Prices or Profits in New York**

Thank you for the opportunity to testify. Capping the prices or profits of temporary nurse staffing agencies in New York has broad implications to healthcare workforce companies that support New York healthcare systems and their patients. While well-intentioned, these caps would worsen staffing gaps, restrict patient access, and weaken hospitals' ability to respond to emergencies.

The American Association of International Healthcare Recruitment (AAIHR) is a national non-profit organization that advocates for the ethical recruitment of long-term foreign educated healthcare professionals who help healthcare facilities fill clinical workforce needs. AAIHR members are made up of healthcare workforce companies that recruit and staff and place foreign-educated healthcare professionals across the United States to help bridge the gap in healthcare staffing shortages in New York. The AAIHR submits this testimony on behalf of itself and its members.

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

The fundamental driver of temporary nurse staffing is not agency behavior. It 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.

New York Data Show Contract Nurse Use Has Not Exploded

Critically, 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.

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 serve different labor functions. Permanent hiring addresses predictable, ongoing need. Temporary staffing addresses unpredictable, urgent demand that meets the hospitals, nurses, and patients needs.

The Financial Data Are Clear: Most Dollars Go to Nurses, Not Agencies

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

In 2022, more than 76 percent of the travel nurse bill rate flowed directly to clinicians, including wages, bonuses, payroll taxes, housing, meals, and insurance. Over 52 percent of the bill rate was direct nurse compensation alone.

Agency gross margins—which must cover recruitment, credentialing, compliance, insurance, technology, and overhead—accounted for roughly 23 percent of the bill rate. Importantly, those margins have declined, not increased, since 2018, even as bill rates rose.

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

The Market Is Self-Correcting

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

The travel nurse market declined by approximately 27 percent in 2023 and another 10 percent in 2024. Inflation-adjusted bill rates are drifting back toward pre-pandemic levels. New York's own data reflect this normalization. Contract nurse spending as a share of total hospital labor costs is already declining.

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

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

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 – but even with that carve-out, the relief may be too late as by that time the facilities will likely already be grappling with severe staffing shortages in the middle of a potential healthcare crisis. 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.

Conclusion

New York's own data tell 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 of this important matter. We welcome the opportunity to discuss this matter with you in further detail.

Sincerely,

Patty Jeffrey

Patty Jeffrey
President, AAIHR

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.