Testimony of Jonathan Wolfson
Niskanen Center (Senior Fellow) & Institute for the American Worker (Visiting Fellow)

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Committee on Education and the Workforce
Subcommittee on Workforce Protections
Hearing on: "On Call for America: Strengthening Access Through Locum Tenens Providers"

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Chairman Mackenzie, Ranking Member Omar, and members of the Subcommittee on Workforce Protections: Good morning and thank you for having me today. It is an honor to testify before this subcommittee on the physician shortage and on how Congress can protect the important role that locum tenens providers play in addressing that shortage – while ensuring that those physicians retain the independent contractor status that makes locum tenens work possible and attractive in the first place. A locum tenens safe harbor is not a loophole around employment law; it is the legal infrastructure that lets a licensed clinician get to a patient who needs care now.

My name is Jonathan Wolfson. I am a Visiting Fellow at the Institute for the American Worker, where my work focuses on modern labor policy, worker freedom, independent contracting, and self-employment. I am also a Senior Fellow at the Niskanen Center, where I focus on healthcare workforce policy reforms at the intersection of healthcare, labor policy, and occupational licensing regulation. During the first Trump administration, I had the honor of serving as the head of the Office of the Assistant Secretary for Policy at the U.S. Department of Labor, where I served as the Regulatory Policy Officer, Regulatory Reform Officer, and chair of DOL's Regulatory Reform Task Force. In these roles, in my time in private law practice, and while developing and advancing policy reforms in states across the country, I have seen how employment law and regulation regularly affect workers, businesses, consumers, and, in this context, patients by creating barriers that make it harder (or incentives that make it easier) for American workers and the people who rely on them to thrive.

Today's hearing sits at the intersection of two policy areas that too often are treated as separate: healthcare workforce shortages and independent work. Like so many policy questions, they are not separate. The rules that determine whether a highly trained physician may accept a temporary assignment as a self-employed professional can determine whether a rural hospital has an emergency physician, nurse anesthetist, psychiatrist, hospitalist, pharmacist, or primary care doctor next week. Locum tenens providers — practitioners who temporarily "hold the place" of absent or unavailable providers — have long been one of the most practical tools available to fill the gaps that result from that shortage, particularly in rural and underserved communities. But the vital role locum tenens providers play is now threatened by regulatory and legal uncertainty about their status as independent contractors. When a hospital or locum tenens staffing company

fears the federal government may later decide that a temporary clinical assignment created an employment relationship, the rational response is often to cancel the contract, leave the shift unfilled, close the service line, or stop offering the opportunity at all.

I will focus my remarks on four key points. First, America faces a large and growing physician and advanced practice provider shortage that is especially acute in rural areas. Second, locum tenens physicians have long been a cornerstone of the strategy to address that shortage, and their use is growing rapidly. Third, locum tenens healthcare providers work as independent contractors, and that status reflects their actual working relationship with the facilities they serve – but there are real and growing threats to that classification. Finally, Congress should act to create a clear safe harbor confirming that locum tenens physicians and other locum tenens advanced healthcare professionals are independent contractors, protecting both providers and the patients who depend on their care.

1. America Faces a Large and Growing Physician Shortage, Particularly in Rural Areas

The United States does not have enough physicians, pharmacists, advanced practice registered nurses, physician assistants, psychologists, and other high-level healthcare providers where patients need them. This shortage shows up in primary care, in mental health, in specialty care, and in hospital-based services. It is also no longer simply a rural problem, even though rural communities still feel the shortage most acutely. The Association of American Medical Colleges projects that by 2036, the United States will be short as many as 86,000 doctors.[1] This shortage is not merely a future projection; it is a present reality that patients feel every day when they must wait weeks or months for an appointment or drive hours to see a specialist.

According to the Health Resources and Services Administration (HRSA), 108 million Americans currently live in a defined primary care health professional shortage area, and the country needs an additional 18,493 primary care providers to fill those needs.[2] Of the more than 1,400 geographic health professional shortage areas, the vast majority remain rural (942 are rural, 135 are non-rural, and approximately 400 are partially rural), but urban areas and suburbs are also increasingly facing primary care shortages.

The rural shortage is particularly severe. My colleagues at the Niskanen Center have noted that roughly 20 percent of Americans live in rural areas, yet only 9 percent of physicians practice in them.[3] Across the country, three times as many doctors practice in urban areas, even after

[1] "The Complexities of Physician Supply and Demand: Projections From 2021 to 2036," Association of American Medical Colleges, March 2024, available at: https://www.aamc.org/media/75236/download?attachment.
[2] Health Resources and Services Administration, Health Workforce Shortage Areas Dashboard, (accessed 6/5/2026) available at https://data.hrsa.gov/topics/health-workforce/shortage-areas/dashboard.
[3] *See* Lawson Mansell and Kaj Gumbs, "Statement for the Record: Advancing the Next Generation of America's Health Care Workforce," Niskanen Center, March 9, 2026 available at https://www.niskanencenter.org/statement-for-the-record-advancing-the-next-generation-of-americas-health-care-workforce/; Daniel Siegel, "Recruitment challenges, solutions, and outlooks for the rural doc shortage," National Rural Health Association, July 17, 2025, available at: https://www.ruralhealth.us/blogs/2025/07/recruitment-challenges,-solutions,-and-outlooks-for-the-rural-doc-shortage.

adjusting for population and between 2017 and 2023 rural areas experienced an 11 percent net loss of family physicians.[4]

Several converging forces are making this shortage worse. Forty-two percent of our physician workforce is over 55 years old, and in the next decade, many of these doctors will begin transitioning into retirement or cutting back their hours.[5] Rural doctors are, on average, a year older than their urban counterparts, meaning rural communities will feel these retirements more acutely.[6] At the same time, our training pipeline cannot keep pace: in 2025, over 9,500 medical graduates failed to match to a residency program — an all-time high — leaving aspiring doctors with initial training sidelined during this shortage instead of treating patients.[7]

The shortage is projected to worsen as the population ages and as the physician workforce ages with it. In a 2025 Niskanen report on licensing pathways for internationally trained doctors, my coauthors and I noted the projected shortage could exceed 100,000 by 2036 if rural, low-income, and underserved communities used care at rates similar to suburban and higher-income communities.[8]

To put the magnitude of this challenge in perspective: to simply maintain the status quo shortage going forward, the United States would need to produce roughly 8,600 more doctors than those who retire each year. And even if more residency slots were opened to cover this gap, it could take seven to ten years before patients began to see meaningful improvement, given the length of physician training.

And while doctor shortages capture the headlines, there are also significant shortages for most other advanced practice healthcare providers, especially for professionals who provide primary care. The National Institute for Health Care Management reports that in addition to projected primary care doctor shortages in 47 states by 2037, there are current shortages of psychologists,

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[4] Lawson Mansell and Kaj Gumbs, "Statement for the Record: Advancing the Next Generation of America's Health Care Workforce," Niskanen Center, March 9, 2026 available at https://www.niskanencenter.org/statement-for-the-record-advancing-the-next-generation-of-americas-health-care-workforce/; Barbara Ficarra, "Physician Shortage in Rural Areas of the U.S. Worsened Since 2017," University of Rochester Medical Center, November 24, 2025 available at https://www.urmc.rochester.edu/news/story/physician-shortage-in-rural-areas-of-the-u-s-worsened-since-2017.

[5] Jonathan Wolfson, Lawson Mansell, and Katherine Hall, "Implementing New Licensing Pathways That Work for International Doctors and American Patients," Niskanen Center, December 11, 2025, available at https://www.niskanencenter.org/implementing-new-licening-pathways-that-work-for-international-doctors-and-american-patients/.

[6] Ryan J. Crowley et al., "Urban–rural differences in the age of US physicians," The Journal of Rural Health, July 29, 2025, available at https://doi.org/10.1111/jrh.70054.

[7] Jonathan Wolfson, Lawson Mansell, and Katherine Hall, "Implementing New Licensing Pathways That Work for International Doctors and American Patients," Niskanen Center, December 11, 2025, available at https://www.niskanencenter.org/implementing-new-licening-pathways-that-work-for-international-doctors-and-american-patients/. Author's calculations based on "Results and Data: 2025 Main Residency Match," National Resident Matching Program, May 29, 2025.

[8] Jonathan Wolfson, Lawson Mansell, and Katherine Hall, "Implementing New Licensing Pathways That Work for International Doctors and American Patients," Niskanen Center, December 11, 2025, available at https://www.niskanencenter.org/implementing-new-licening-pathways-that-work-for-international-doctors-and-american-patients/.

pharmacists, and nurse practitioners.[9] To make matters worse, these shortages are all expected to grow even larger by 2037. So while the doctor shortage and its implications deserve attention, the story is even more concerning when you consider that primary care provider shortages extend across most categories of the healthcare delivery team.

Patients experience these numbers as delays. They wait months for primary care, specialty appointments, behavioral health treatment, and needed procedures. Hospitals experience these numbers as service-line fragility. If a facility cannot staff an emergency department, an anesthesia schedule, a neonatal service, a psychiatry unit, or a primary care clinic, then even a hospital that has beds, equipment, and community demand may still be unable to provide care. Providers experience the same numbers as burnout. The fewer clinicians available to share the load, the more call, overtime, weekend coverage, and administrative strain fall on the physicians, nurses, and other professionals who remain.[10]

In the meantime, policymakers have pursued several near-term strategies to address these shortages, including standard of care or scope of practice reforms that allow nurse practitioners, physician assistants, and pharmacists to treat patients up to the limits of their training and experience[11]; new licensing pathways for internationally trained physicians[12]; and subsidies for additional training programs. [13] And the medical profession has created an additional solution: locum tenens temporary providers.[14] Each of these strategies is intended to provide more care to more patients and alleviate current and future shortages and has its own unique value.

Locum tenens should be understood as a necessary complement to long-term workforce reform. Long-term supply reforms ask how to produce more clinicians over time. Locum tenens answers a more immediate question: how can the healthcare system get an already licensed clinician to a patient who needs care now? Locum tenens providers have the flexibility, speed, and reach to be deployed quickly to fill gaps wherever they arise.

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[9] National Institute for Healthcare Management, "Addressing Health Care Workforce Shortages," July 16, 2025, available at https://nihcm.org/publications/addressing-health-care-workforce-shortages.

[10] National Institute for Healthcare Management, "Addressing Health Care Workforce Shortages," July 16, 2025, available at https://nihcm.org/publications/addressing-health-care-workforce-shortages.

[11] Tim Frost and Jonathan Wolfson, Toward Pharmacist Full Practice Authority, Cicero Institute, Nov. 6, 2024, available at https://ciceroinstitute.org/research/toward-pharmacist-full-practice-authority/; Tim Frost and McKenzie Richards, Unlocking Pharmacist Innovation: 2025 Policy Strategies for Full Practice Authority, Cicero Institute, Aug. 2025, available at https://ciceroinstitute.org/research/2025-policy-strategies-for-full-practice-authority/

[12] Jonathan Wolfson, McKenzie Richards; More than an Insurance Card: State Policy Can Improve Patient Access to Healthcare Providers. *Innovations: Technology, Governance, Globalization* 2025; 14 (1-2): 82–89, available at https://doi.org/10.1162/INOV.a.273.

[13] *See* Lawson Mansell and Kaj Gumbs, "Statement for the Record: Advancing the Next Generation of America's Health Care Workforce," Niskanen Center, March 9, 2026 available at https://www.niskanencenter.org/statement-for-the-record-advancing-the-next-generation-of-americas-health-care-workforce/.

[14] Randy Jotte et al., "Locum Tenens: An Evolving Paradigm of Care" Mo Med., Sep-Oct 2023, 120(5):333-337, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10569392/; Daniel M. Blumenthal et al., "Association Between Treatment by Locum Tenens Internal Medicine Physicians and 30-Day Mortality Among Hospitalized Medicare Beneficiaries," *JAMA* 318(21):2119–2129 (2017).

2. Locum Tenens Physicians Have Been a Cornerstone of the Strategy to Fill Medical Provider Gaps and Their Use Is Growing

Locum tenens originated in the 1970s as a solution to the practical rural healthcare workforce challenge of how to fill in for rural doctors when they were away from the office. The Health Systems Research Institute (HSRI) developed an initiative to offer continuing education to rural physicians: the Rural Outreach Physician Education program (ROPE) to bring rural doctors to the University of Utah for continuing medical education. But to allow rural physicians to attend, HSRI decided to solve the ever-present concern of dedicated doctors who asked: "What am I to do about my patients? I can't leave my practice unattended." The program assembled a network of doctors to temporarily cover rural practices while the rural physicians attended educational programs.[15]

From those origins, locum tenens has grown into a vital and substantial sector of the healthcare workforce. Locum tenens physicians, advanced practice registered nurses, physician assistants, and pharmacists fill both short- and longer-term gaps at hospitals, clinics, and practices across the country, allowing facilities to remain open and patients to receive care that might otherwise be unavailable. These temporary providers deliver care where the alternative might be no coverage at all. And the data indicate that patient outcomes when treated by locum tenens doctors are generally similar to outcomes when treated by a non-locum tenens doctor.[16] Locum tenens arrangements also provide an important release valve for provider burnout: they allow full-time physicians to take necessary breaks while ensuring their patients continue to receive care during provider absence.

The growth of locum tenens in recent years has been remarkable. According to CHG Healthcare's 2025 State of Locum Tenens report, the number of locum tenens doctors in the United States has more than doubled in the last decade, growing from 26,325 physicians in 2015 to 55,872 in 2024.[17] Going into 2024, 56 percent of healthcare organizations projected using the same or more locum tenens as in 2023; by the end of that year, some 81 percent had used the same or more, a full 25 percentage points higher than they had anticipated.[18] And 80 percent of healthcare organizations expected their locum tenens use to remain the same or increase in 2025.[19]

The locum tenens model is also growing beyond physicians. The use of locum tenens advanced practice providers (advanced practice registered nurses, physician assistants, psychologists, and

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[15] Kevin Kealey, "A history of locum tenens: The origins of a new approach to healthcare," CompHealth, April 13, 2017, available at https://comphealth.com/resources/the-origin-of-locum-tenens; see also Aodhnait S. Fahy et al., "Locum Tenens and Pediatric Surgery: A Position Statement and Practice Guidelines From the American Pediatric Surgical Association (APSA)," Journal of Pediatric Surgery, Vol. 59, Issue 10, October 2024, available at https://www.sciencedirect.com/science/article/abs/pii/S0022346824002987.

[16] Randy Jotte et al., "Locum Tenens: An Evolving Paradigm of Care" Mo Med., Sep-Oct 2023, 120(5):333-337, available at https://pmc.ncbi.nlm.nih.gov/articles/PMC10569392/.

[17] CHG Healthcare, "State of Locum Tenens 2025 Full Report," available at https://chghealthcare.com/documents/State_of_Locum_Tenens_2025_Full_Report.pdf.

[18] CHG Healthcare, "State of Locum Tenens 2025 Full Report," available at https://chghealthcare.com/documents/State_of_Locum_Tenens_2025_Full_Report.pdf.

[19] CHG Healthcare, "State of Locum Tenens 2025 Full Report," available at https://chghealthcare.com/documents/State_of_Locum_Tenens_2025_Full_Report.pdf (citing CHG Healthcare Client Awareness and Perception Study, January 2025).

pharmacists) is growing at nearly twice the rate of physician locum tenens. In 2020, advanced practice provider job searches filled with locum tenens in only 1.2 percent of cases; by 2024, that figure had grown to 8.1 percent.[20]

The National Rural Health Association (NRHA) has recognized that locum tenens has become a strategic pillar in maintaining access to care in rural communities and supporting care continuity. Rural hospitals and clinics operating at the intersection of chronic staffing shortages, limited recruitment pipelines, long credentialing timelines, and high provider burnout have come to rely on locum tenens not as an emergency measure but as a strategic tool in their workforce planning strategy.[21] Rural communities continue to represent a substantial share of locum physician demand, accounting for 27 percent of assignments in 2025.[22] NRHA has also noted that a meaningful share of locum tenens assignments serve rural communities and that advanced practice provider locum tenens work is growing as rural facilities use team-based care to preserve access.

Telemedicine is another critical pathway to improve healthcare access, especially in rural areas. And many locum tenens staffing organizations provide doctors and other advanced practitioners to deliver telemedicine to patients across the country.[23]

In short, locum tenens is not a temporary patch on a permanent problem; it is a permanent and growing part of the healthcare access solution. In many areas, the choice is not between a permanent healthcare provider and a locum tenens healthcare provider. The choice is between a locum tenens healthcare provider and no provider at all. Any policy that undermines locum tenens would directly harm the patients who depend on it.

3. Locum Tenens Clinicians Work as Independent Contractors — and That Status Is at Risk

Independent work is not a marginal feature of the American economy. MBO Partners' 2025 State of Independence report estimates that 72.9 million Americans worked as independents, that the significant majority do so by choice, and that large majorities report being happier or planning to remain independent or grow their independent businesses.[24] These workers are not all in the same industry, and they do not all want the same things. Some are entrepreneurs building businesses. Some are freelancers. Some are semi-retired professionals. Some are parents or caregivers who need flexibility. Some are highly skilled specialists who use independent work to serve multiple clients, earn more, or control their schedules.

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[20] CHG Healthcare, "State of Locum Tenens 2025 Full Report," available at https://chghealthcare.com/documents/State_of_Locum_Tenens_2025_Full_Report.pdf.

[21] Melinda Giese “How strategic use of locum tenens can drive revenue and keep care local,” National Rural Health Association Rural Health Voices Blog, April 30, 2026, available at https://www.ruralhealth.us/blogs/2026/04-april/how-strategic-use-of-locum-tenens-can-drive-revenue-and-keep-care-local.

[22] Melinda Giese, "Why locum tenens is becoming a strategic imperative for rural health," National Rural Health Association Rural Health Voices Blog, February 3, 2026, available at https://www.ruralhealth.us/blogs/2026/02-feb/why-locum-tenens-is-becoming-a-strategic-imperative-for-rural-health.

[23] *See*, e.g., Megan Lee, “A physician’s guide to telehealth locum tenens” March 12, 2025, available at https://locumstory.com/spotlight/telehealth-locum-tenens.

[24] MBO Partners, “State of Independence 2025,” September 2025 available at https://www.mbopartners.com/state-of-independence/.

Locum tenens healthcare professionals fit naturally into this independent work reality. They have long been understood to work as independent contractors, not employees of the facilities where they practice. This classification is not an accident or an artifact of tax planning. It reflects the actual nature of the locum tenens relationship: these healthcare providers choose their own assignments, set their own availability, move between multiple facilities, retain autonomy over their clinical practice, and bear the entrepreneurial risk of building and maintaining an independent practice. They negotiate their own contracts, obtain their own licenses in multiple states, and in many cases operate through their own professional entities. The facility needs clinical coverage; the clinician wants flexibility, additional income, professional variety, the chance to serve communities that need help, or all of the above. Those needs can align best through a contract for services rather than a traditional ongoing employment relationship.

The independent nature of much locum tenens healthcare provider work is central to why the model functions. The independent contractor classification for locum tenens physicians has been recognized by the IRS, which traditionally treats locum tenens providers as independent contractors rather than employees.[25] And in general, federal employment law regulators have also treated locum tenens healthcare providers as independent workers, not employees.[26]

But this clarity is under threat. Over the past several years, federal and state policymakers have increasingly sought to tighten the standards for independent contractor classification in ways that could sweep in locum tenens physicians, even though those physicians are paradigmatic independent workers who have freely and deliberately chosen that status.[27] For example, under the PRO Act[28] or a bill like California's AB5, absent a carveout, locum tenens doctors likely would not be able to meet the independent contractor definition.[29] The problem is that policymakers too often assume that independent work is suspect unless proven otherwise, even when the worker is a highly compensated, licensed professional whose skill is in short supply and whose professional judgment is protected by state law and medical ethics.[30]

The Department of Labor's recent independent-contractor policy illustrates the costs of regulatory instability. In 2024, the DOL under President Biden adopted a rule that moved away from the clearer 2021 approach and returned to a more open-ended, multi-factor analysis. In 2025, the DOL under President Trump announced that, while reviewing the 2024 rule, it would not apply that rule in its own enforcement work. In 2026, DOL proposed rescinding the 2024 rule and replacing it with a standard closer to the 2021 rule, again emphasizing control and

[25] *See,* e.g., AllStar Healthcare Solutions, "H.R. 7881 Would Permanently Classify Locum Tenens Providers as Independent Contractors," Blog (accessed 6/6/2026), available at https://allstarhealthcaresolutions.com/blog/h-r-7881-would-permanently-classify-locum-tenens-providers-as-independent-contractors/.
[26] Matt Baade, "The Freedom Of Independent Contractors," Consilium, Jan. 10, 2021, available at https://consiliumstaffing.com/the-freedom-of-independent-contractors/.
[27] National Association of Locum Tenens Organizations, "PRO ACT" (accessed 6/6/2026), available at https://nalto.memberclicks.net/assets/docs/memberresourcespage/NALTO PRO Act Paper.pdf.
[28] H.R.20 - Richard L. Trumka Protecting the Right to Organize Act of 2025
[29] National Association of Locum Tenens Organizations, "PRO ACT" (accessed 6/6/2026), available at https://nalto.memberclicks.net/assets/docs/memberresourcespage/NALTO PRO Act Paper.pdf.
[30] *See*, e.g., Jonathan Wolfson, "If Mamdani Wins, the Gig (Work) is Up," RealClearPolitics, Oct. 10, 2025, available at https://www.realclearpolitics.com/articles/2025/10/03/if_mamdani_wins_the_gig_work_is_up_153357.html.

opportunity for profit or loss as core factors.[31] I have spoken in support of the two primary factor test for its clarity. Such a streamlined approach makes it easier for businesses that want to hire independent workers and opens work for more independent workers. But whatever one's view of any single rule, the larger point is hard to miss: the meaning of independent contractor status under federal wage-and-hour regulation has changed repeatedly with changes in administration. That is not a stable foundation for patient access. Further, courts may still rely on the 2024 rule's analysis, and future administrations may attempt to revive restrictive classification standards. Without a clear statutory safe harbor, locum tenens providers and the facilities that retain them will continue to face legal and regulatory uncertainty.

The consequences of reclassification would be severe. If locum tenens physicians were reclassified as employees, the facilities retaining them would be required to comply with burdensome paperwork requirements, withhold payroll taxes, and comply with a host of employment regulations that would dramatically increase the cost and complexity of locum tenens arrangements. Many facilities — particularly small rural hospitals and clinics operating on thin margins — could no longer afford to use locum tenens at all. And many locum tenens physicians, who have chosen this model precisely because of the flexibility, autonomy, and earning potential it provides, would have little interest in converting to employment relationships with multiple facilities. The likely result would be a sharp reduction in locum tenens supply at exactly the moment when rural and underserved communities need it most.

The stakes are high. CHG Healthcare estimates that locum tenens clinicians support roughly 118 million patient visits each year — as many as one in three U.S. patients annually.[32] Those visits include care in the very settings where shortages are most acute: emergency medicine, primary care, psychiatry, obstetrics, anesthesia, and other critical services.[33] These providers practice across nearly every medical specialty, including primary care, emergency medicine, surgery, psychiatry, and obstetrics — the specialties most critically needed in rural and underserved areas. In many rural and underserved communities, those visits may be the difference between care today and no care at all.

If a rural hospital needs a pharmacist to cover two weekends each month to give permanent staff a break, it may not be able to justify hiring another full-time pharmacist. If a nurse anesthetist or emergency physician wants to take discrete assignments across multiple facilities, that provider may not want an employment relationship with each facility. If a locum tenens firm places physicians in multiple states for temporary assignments, forcing employment status into every

[31] U.S. Department of Labor, Wage and Hour Division, 'Department of Labor proposes rescinding Biden-era independent contractor rule,' February 26, 2026, https://www.dol.gov/newsroom/releases/whd/whd20260226; U.S. Department of Labor, Wage and Hour Division, 'Wage and Hour Division announces enforcement position for independent contractor rule,' May 1, 2025, https://www.dol.gov/newsroom/releases/whd/whd20250501.

[32] CHG Healthcare, "State of Locum Tenens 2025 Full Report"; see also All Star Healthcare Solutions, "H.R. 7881 Would Permanently Classify Locum Tenens Providers as Independent Contractors," available at https://allstarhealthcaresolutions.com/blog/h-r-7881-would-permanently-classify-locum-tenens-providers-as-independent-contractors/.

[33] CHG Healthcare, "State of Locum Tenens 2025 Full Report"; see also All Star Healthcare Solutions, "H.R. 7881 Would Permanently Classify Locum Tenens Providers as Independent Contractors," available at https://allstarhealthcaresolutions.com/blog/h-r-7881-would-permanently-classify-locum-tenens-providers-as-independent-contractors/.

relationship can add tax, benefits, scheduling, collective bargaining, wage-and-hour, and administrative obligations that do not fit the actual arrangement. The result can be fewer assignments, fewer covered shifts, and less access to care.

A safe harbor is especially important because healthcare is different. In a hospital, many indicia of "control" are not employment control at all. They are patient-safety obligations. A hospital must credential and privilege a physician. It must require documentation, HIPAA compliance, infection-control protocols, peer review, medical-record standards, and adherence to Medicare, Medicaid, and state licensure rules. And it may need a physician to work a particular shift because patients need care at particular times. The law should not punish hospitals for doing what patient safety requires.

Further, absent clear carveouts, locum tenens doctors can run afoul of the "ABC Test" for misclassification. The "ABC test," proposed in the PRO Act[34] and adopted by California's AB-5 in 2019[35] asks three questions:

> (1) Is the worker free from the control and direction of the hiring entity in the performance of the work, both under the contract for the performance of the work and in fact?
> (2) Does the worker perform work that is outside the usual course of the hiring entity's business?
> (3) Is the worker customarily engaged in an independently established trade, occupation, or business of the same nature as the work performed for the hiring entity?[36]

Any worker who cannot answer "yes" to all three questions is to be classified as an "employee" or else risks being punished for "misclassification." Because locum tenens healthcare experts deliver healthcare services and the businesses that hire them also deliver healthcare services, it is hard to imagine locum tenens doctors passing the independent contractor test. But a specific carveout would give certainty to businesses that hire locum tenens doctors and the healthcare practitioners who offer locum tenens services alike.[37]

It is worth noting that some opposition to independent contractor classification is driven by a general suspicion of independent work arrangements. But many of those concerns run counter to the facts on the ground. First, critics may not realize that most independent workers in America are not digital platform gig workers, but are self-employed workers across a variety of industries.[38] Second, opponents may misunderstand how pleased most independent workers are with their status and how uninterested those workers are in becoming employees.[39] Third, those

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[34] H.R.20 - Richard L. Trumka Protecting the Right to Organize Act of 2025
[35] *See* California Labor and Workforce Development Agency, "ABC Test," (accessed 6/5/2026) available at https://www.labor.ca.gov/employmentstatus/abctest/.
[36] *See* California Labor and Workforce Development Agency, "ABC Test," (accessed 6/5/2026) available at https://www.labor.ca.gov/employmentstatus/abctest/.
[37] Note that California has carved out doctors from application of their ABC test under AB5. California Labor Code § 2783. *See* Margot Roosevelt and Ryan Faughnder, "California has a new law for contract workers. But many businesses aren't ready for change," Los Angeles Times, Sept. 29, 2019, available at https://www.latimes.com/business/story/2019-09-27/ab5-independent-contractors-how-businesses-are-responding.
[38] MBO Partners, "State of Independence 2025," September 2025 available at https://www.mbopartners.com/state-of-independence/.
[39] MBO Partners, "State of Independence 2025," September 2025 available at https://www.mbopartners.com/state-of-independence/.

objections misunderstand that many independent workers who already have access to health insurance benefits through a spouse, parent, or other job would highly prefer to trade access to duplicative benefits for additional cash compensation – something much easier to do as a contractor than as an employee.[40] All of these facts hold even more true for locum tenens healthcare providers.

Most importantly in the locum tenens context, a healthcare provider is not a delivery driver or freelance graphic artist building a logo. These are highly trained physicians, pharmacists, advanced practice registered nurses, and physician assistants with years of education and experience who are making deliberate, informed choices about how to structure their professional lives. Any policy argument in favor of restricting independent contractor status lacks application to a locum tenens anesthesiologist who earns well above the median physician income and negotiates directly with multiple hospital systems. Applying the same classification rules to these fundamentally different situations does not protect workers; it simply removes their freedom to choose how they work while also hurting the patients who rely on the care those experts can deliver.

4. Congress Should Create a Safe Harbor for Locum Tenens Physicians and Other Locum Tenens Health Professionals

In light of these challenges, Congress should create a federal safe harbor confirming that locum tenens physicians and other high-level healthcare professionals including pharmacists, advanced practice registered nurses, psychologists, and physician assistants, may provide temporary healthcare services as independent contractors when they choose to do so. This policy would protect providers, staffing firms, facilities, and ultimately patients from the consequences of efforts to subject these highly paid and highly capable professionals to misclassification investigations and litigation, and would send a clear signal that Congress values the critical role locum tenens plays in addressing the healthcare provider shortage.

This proposal need not resolve every debate over independent work. Congress can decide a narrower question: whether highly trained, licensed healthcare professionals who choose temporary assignments should lose that opportunity because a patient-safety rule, credentialing requirement, or shift schedule is mistaken for employment control.

A well-designed safe harbor should accomplish several things. First, it should provide clear language exempting properly structured locum tenens arrangements from employee classification under the Fair Labor Standards Act (FLSA), the National Labor Relations Act (NLRA), and the Internal Revenue Code (IRC). The safe harbor should reflect the actual characteristics of the locum tenens relationship: a defined-term or assignment-based engagement, clinical autonomy, the absence of an ongoing employment relationship, and compensation on a per-assignment basis. Second, the safe harbor should include a principle of worker choice, recognizing that the independent contractor classification for locum tenens exists because physicians have freely chosen it, and that the law should respect that choice. Third, the safe harbor should be durable: it should not be subject to override by agency rulemaking or

[40] MBO Partners, "State of Independence 2025," September 2025 available at https://www.mbopartners.com/state-of-independence/.

administrative reinterpretation, which has in recent years produced the whipsawing legal environment I described earlier.

Congress has shown some interest in this issue. The Healthcare Provider Shortage Minimization Act would codify locum tenens providers' status as independent contractors under the IRS code.[41] The RURAL Healthcare Act would similarly codify locum tenens providers' status as independent contractors under the FLSA and NLRA.[42] Taken together, these bills provide the right architecture: tax-law clarity, wage-and-hour clarity, labor-law clarity, and a single federal rule that facilities, staffing firms, clinicians, and patients can rely on

Some critics may argue that a sector-specific safe harbor for locum tenens is unnecessary because the current administration has signaled a more permissive approach to independent contractor classification. But as I have argued in prior testimony before Congress and state legislatures, specific legislation is critical to ensuring that enforcement actions are based on the will of the legislature, not the mere whims of a regulatory body. Workers, businesses, and healthcare facilities need clarity, not the anxiety of perpetual regulatory change. A durable statutory safe harbor is the only way to provide that clarity.[43]

It is also worth addressing a related point: locum tenens physicians often do not need the FLSA's protections. The FLSA's minimum wage and overtime requirements are designed to protect workers in positions of vulnerability who lack bargaining power. Locum tenens physicians are among the most highly educated and highly compensated workers in the American economy. Their skills are in extraordinary demand — as the shortage data I have described make clear. They are not compelled to accept assignments at any particular facility, and no facility can compel them to accept terms they find unacceptable. These are not workers who need the government to set a minimum wage. They are workers who need the government to stay out of the way and let them practice medicine where they want.

The broader point bears emphasis: independent work is not a marginal or problematic phenomenon in the American economy. As of 2025, approximately 72.9 million Americans work as independent contractors, freelancers, or other forms of self-employed workers.[44] A substantial majority of these workers have chosen independent work by preference, not

[41] H.R.1160 - Health Care Provider Shortage Minimization Act of 2025.
[42] H.R.8347 - RURAL Healthcare Act.
[43] The Institute for the American Worker has supported important worker opportunity policies (now proposed as federal legislation such as the Modern Worker Empowerment Act) (*See*, e.g., Institute for the American Worker summary available at https://i4aw.org/resources/modern-worker-empowerment-act/) because the FLSA and NLRA do not clearly define independent contractor status in a way that works for the modern economy. The central idea is simple: workers and businesses need clarity, and the law should focus on the worker's control over the work and the worker's opportunity and risk inherent in entrepreneurship. The Institute has also supported portable-benefits reforms (now proposed as the Modern Worker Security Act) (*See*, e.g., Institute for the American Worker summary available at https://i4aw.org/resources/modern-worker-security-act/), which would allow businesses to contribute to benefits for independent workers without the mere provision of those benefits being used as evidence of employment. Both ideas are relevant here. Locum tenens physicians need classification clarity, and Congress should not punish entities that offer support such as malpractice coverage, travel, housing, training, or access to benefits by treating those supports as proof that the physician is really an employee.
[44] MBO Partners, "State of Independence 2025," September 2025 available at https://www.mbopartners.com/state-of-independence.

necessity. The same is true for locum tenens physicians, who routinely cite flexibility, professional autonomy, and the opportunity to practice in settings and communities they find rewarding as their primary reasons for choosing this model.

Conclusion

The physician shortage is not an abstraction. It is an emergency department unable to fill next week's night shift. It is a rural hospital deciding whether it can keep obstetrics open. It is a patient waiting months for a specialist. It is a burned-out clinician looking at another weekend on call and wondering how much longer he or she can continue.

Congress and state legislatures should pursue long-term reforms that expand the healthcare workforce. They should support responsible licensing pathways for internationally trained physicians, modernize graduate medical education, and allow healthcare professionals to practice to the full extent of their training. And policymakers should also protect the tools that help patients right now. Locum tenens is one of those tools.

Rather than allowing employment-law uncertainty to reduce access to physicians, Congress should create a clear, narrow safe harbor for locum tenens healthcare professionals who choose to work as independent contractors. Doing so would protect patients, respect worker choice, help hospitals and clinics staff critical services, and bring federal law closer to the realities of the modern healthcare workforce.

I am grateful to the subcommittee for focusing on this important issue and for your ongoing commitment to policies that strengthen the American healthcare workforce. I look forward to your questions.