

## Locum Tenens, Independent Work, and Healthcare Access

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House Committee on Education and Workforce, Subcommittee on Workforce Protections  
On Call for America: Strengthening Access Through Locum Tenens Providers

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Good morning, Chairman Mackenzie and members of the Subcommittee on Workforce Protections. It is an honor to testify before you.

My name is Liya Palagashvili, and I am a labor economist at the Mercatus Center at George Mason University. I conduct research on the independent workforce, with a focus on worker classification laws and portable benefits.

Today, my testimony focuses on locum tenens clinicians—temporary healthcare providers who step in to fill staffing gaps at healthcare facilities—and the role independent clinical work can play in improving flexibility and access in the healthcare labor market. The five key themes are the following:

1. Locum tenens is best understood as a flexible labor-supply margin in a shortage-prone healthcare market. The data do not show that independent clinical work is replacing the traditional healthcare workforce.
2. The clinicians covered in locum tenens legislation H.R. 8347 are highly educated, high-income, licensed professionals, and the data show that nearly all self-employed covered clinicians are insured.
3. Independent clinical work may help retain late-career clinicians. Self-employed clinicians in these occupations are much older than their traditionally employed peers, suggesting that independent work may keep some experienced clinicians attached to the labor force.
4. Restrictive worker-classification laws can reduce independent-work opportunities without necessarily increasing traditional employment. My research on California's AB5 and broader ABC tests finds that these laws reduced both self-employment and overall employment, with no robust offsetting increase in traditional employment. My preliminary clinician-specific analysis is consistent with this concern: California's advanced-practice clinician self-employment share declined after AB5, while the same share rose in common-law control states.

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5. Nonmetro areas have far fewer covered clinicians per capita than metro areas, and flexible staffing arrangements can help address temporary vacancies, geographic mismatch, and episodic staffing needs.

The central point is that locum tenens helps address a labor-supply problem. When healthcare markets face vacancies, call-coverage needs, recruiting gaps, or shortages in rural areas, the relevant question is often not whether a facility will hire a permanent W-2 employee instead. The relevant question may be whether patients receive care at all.

### 1. Locum Tenens Is a Flexible Labor-Supply Margin, Not a Replacement for W-2 Employment

One challenge in studying locum tenens is that it is not an occupation in federal labor-market data, and no government surveys ask whether someone is working as a locum tenens clinician. For that reason, my analysis examines the occupations covered by the locum tenens legislation H.R. 8347 and compares traditional employment with self-employment as the observable independent-work margin. These occupations are physicians and surgeons, physician assistants, nurse practitioners, and certified registered nurse anesthetists (CRNAs).<sup>1</sup> Throughout this testimony, I refer collectively to physician assistants, nurse practitioners, and CRNAs as *advanced-practice clinicians*.

The first question is whether independent clinical work is overtaking or displacing traditional healthcare employment. The data do not support that claim.

In the Current Population Survey (CPS) data from 2019 to 2024, traditional employment remains the overwhelmingly dominant model in these clinical occupations, as shown in figure 1.<sup>2</sup> In 2024, there were roughly 1.37 million traditionally employed covered clinicians, compared with about 146,000 self-employed covered clinicians. Traditional employment was slightly higher in 2024 than in 2019, while self-employment remained a smaller but meaningful margin.<sup>3</sup>

The basic point is straightforward: Independent clinical work exists alongside a large and growing W-2 workforce in the same licensed occupations. It is not replacing the traditional workforce. Rather, it appears to serve a different function in the labor market.

These data are consistent with a broader pattern I have found in my prior research on independent work.<sup>4</sup> Independent work and traditional employment are often not in conflict. They can operate side by side, meeting different needs for workers and businesses.

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<sup>1</sup> In the Current Population Survey data, nurse practitioners are grouped with nurse midwives in OCC2010 code 3258. Where the data do not separately identify nurse practitioners, I include this combined category in the covered-clinician workforce.

<sup>2</sup> IPUMS Current Population Survey (database), accessed May 29, 2026, <https://cps.ipums.org/cps/>.

<sup>3</sup> Extending the analysis to 2015 does not change the conclusion. Traditional employment remains the dominant form of employment among covered clinicians throughout the period, while self-employment remains a smaller but meaningful labor-market margin.

<sup>4</sup> Liya Palagashvili, “Modernizing Labor Policy to Support Independent Work and Portable Benefits” (Testimony before the House Committee on Education and the Workforce, Subcommittee on Workforce Protections, Mercatus Center at George Mason University, May 20, 2025).

Figure 1. Traditional employment and self-employment among covered clinicians, 2019–2024



Source: Author’s analysis of IPUMS CPS Basic Monthly data, 2019–2024.

Values are weighted annual average monthly employment counts among employed individuals in covered occupations. Covered occupations are OCC2010 codes 3060 (physicians and surgeons), 3110 (physician assistants), 3256 (nurse anesthetists), and 3258 (nurse practitioners and nurse midwives). Traditional employment includes wage/salary private, nonprofit, and federal/state/local government workers. Self-employment includes incorporated and unincorporated self-employed workers.

That distinction matters in healthcare. A hospital or clinic facing a temporary vacancy, seasonal demand, parental leave, a recruiting gap, a call-coverage problem, or an unexpected departure may not be choosing between a locum tenens clinician and a permanent employee. The choice may be between temporary coverage and no coverage at all.

## 2. Workforce Profile: Highly Educated, High Income, and Insured

The clinicians covered by H.R. 8347 are not the typical workers at the center of misclassification debates. My analysis of CPS data shows that among self-employed covered clinicians, 99.6 percent have at least a bachelor’s degree, and 98.7 percent have a master’s, professional, or doctorate degree.<sup>5</sup> This is not a workforce with low educational attainment or limited professional credentials. These are highly educated, licensed professionals who provide medical care in a highly regulated environment.

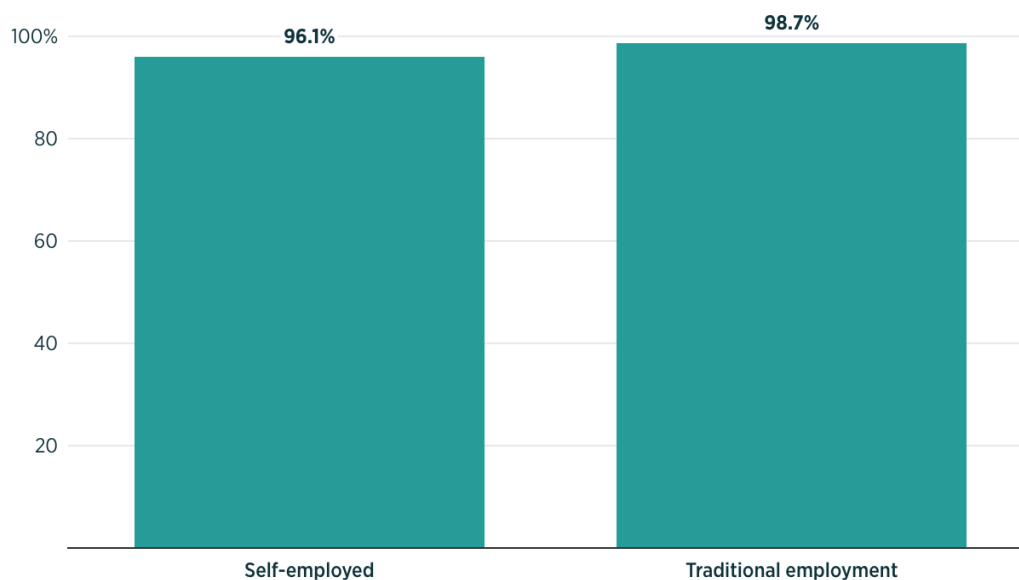
These are also high-paying occupations. According to Bureau of Labor Statistics (BLS) occupational wage data, physicians and surgeons are among the highest-paid occupations, with median wages equal to or greater than \$239,200 per year. Physician assistants had a median annual wage of \$133,260 in May 2024. Among the advanced-practice clinicians covered by H.R. 8347, nurse anesthetists—the BLS occupation category corresponding to CRNAs—are particularly highly compensated, with a median

<sup>5</sup> IPUMS CPS (database), accessed May 29, 2026, <https://cps.ipums.org/cps/>.

annual wage of \$223,210 in May 2024, more than four times the national median annual wage for all occupations. Nurse practitioners had a median annual wage of \$129,210.<sup>6</sup>

One common objection to independent contracting is that independent workers may lack access to benefits. However, the Census Bureau data do not show a largely uninsured independent clinician workforce, as figure 2 illustrates. In the 2024 American Community Survey, 96.1 percent of self-employed covered clinicians report having health insurance. Among traditionally employed covered clinicians, the insured rate is 98.7 percent.<sup>7</sup>

Figure 2. Health insurance coverage among covered clinicians by work arrangement, 2024



Source: Author's analysis of IPUMS USA, 2024 ACS. Covered occupations are physicians and surgeons, physician assistants, nurse anesthetists, and nurse practitioners.

Notably, the gap between self-employed and traditionally employed covered clinicians in insurance coverage is small, only 2.6 percentage points. Whatever concerns policymakers may have about misclassification in other labor markets, this workforce is empirically different: Covered clinicians are highly educated, well compensated, and licensed, and nearly all are insured.

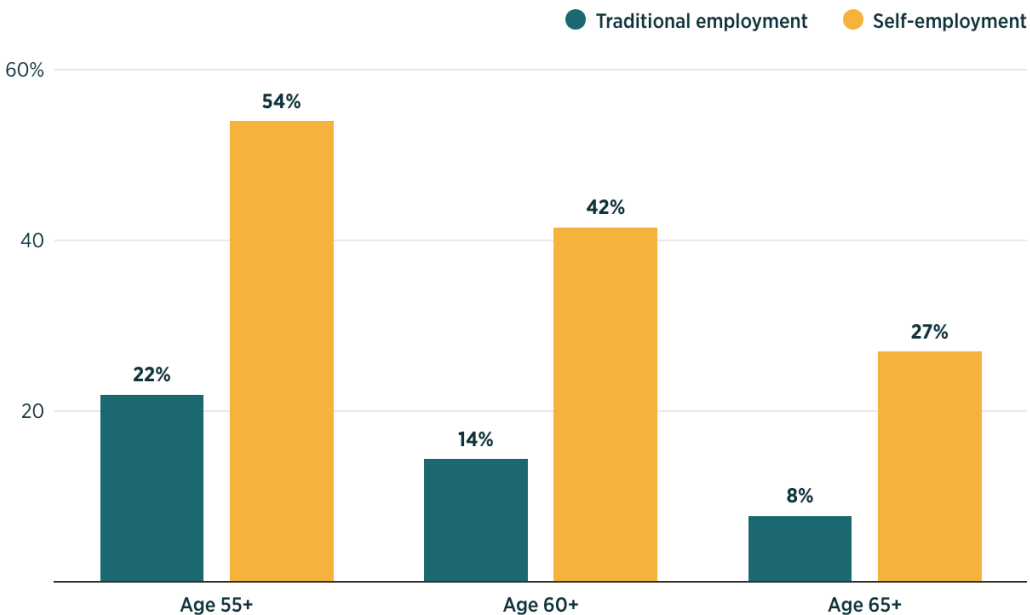
### 3. Independent Clinical Work May Keep Late-Career Clinicians Attached to the Workforce

Self-employed covered clinicians are much older than traditionally employed covered clinicians, as figure 3 shows. In CPS data from 2019 to 2024, more than half of self-employed covered clinicians are age 55 or older, and more than one-quarter are age 65 or older. By contrast, among traditionally employed covered clinicians, about 22 percent are age 55 or older, and only about 8 percent are age 65 or older.

<sup>6</sup> US Bureau of Labor Statistics, "May 2024 National Occupational Employment and Wage Estimates," *Occupational Employment and Wage Statistics*.

<sup>7</sup> IPUMS American Community Survey (database), accessed May 29, 2026, <https://usa.ipums.org/usa/>.

Figure 3. Age profile of covered clinicians by work arrangement, 2019–2024



Source: Author’s analysis of IPUMS CPS Basic Monthly data, 2019–2024. Values are weighted person-month shares among employed covered clinicians. Covered occupations and work-arrangement definitions are the same as in figure 1.

This finding is important because it changes the relevant policy counterfactual. In a shortage-prone healthcare labor market, the counterfactual is not necessarily that self-employed clinicians would become permanent W-2 employees if independent work were restricted. For many late-career clinicians, the counterfactual may be fewer hours, earlier retirement, or exiting practice altogether.

This pattern is consistent with research showing that many older Americans remain willing to work at or after normal retirement age, but their labor-force participation often depends on whether there are flexible job opportunities available.<sup>8</sup> Independent work can be especially valuable for workers nearing retirement because it allows them to reduce hours, choose assignments, or continue working without committing to a traditional full-time or part-time employment schedule. In prior testimony before the Senate Special Committee on Aging, I discussed how independent work can provide income opportunities and flexibility for older Americans who may no longer want—or be able—to work in a standard nine-to-five job.<sup>9</sup>

Healthcare is a clear example of this broader pattern. A late-career physician, nurse practitioner, physician assistant, or CRNA may not want a full-time permanent role. But that same clinician may be willing to take temporary assignments, cover shifts, or serve communities facing shortages. In that case, independent work expands labor supply.

<sup>8</sup> John Ameriks et al., “Older Americans Would Work Longer If Jobs Were Flexible,” *American Economic Journal: Macroeconomics* 12, no. 1 (2020): 174–209.

<sup>9</sup> Liya Palagashvili, “Independent Work Provides Income Opportunities for Millions of Older Americans” (Testimony before the Senate Special Committee on Aging, Mercatus Center at George Mason University, April 20, 2023).

The hours and multiple-job data tell a similar story. Self-employed covered clinicians are more likely to work part time and more likely to hold multiple jobs. Among covered clinicians, 9.2 percent of self-employed workers report multiple jobholding, compared with 6.7 percent of traditionally employed workers. Among advanced-practice clinicians, the gap is larger: 17.7 percent of self-employed advanced-practice clinicians report multiple jobholding, compared with 8.6 percent of traditionally employed advanced-practice clinicians.

While the CPS data do not identify whether a second job is a locum assignment, the pattern is consistent with independent work serving as a supplemental labor-supply margin. It allows clinicians to supply hours and assignments that they may not offer under a permanent employment model.

The counterfactual—fewer hours, earlier retirement, or exit from practice—has the steepest cost in communities that already have the fewest clinicians and the least capacity to replace them.

#### 4. Restrictive Classification Laws Can Reduce Work Opportunities

Worker classification laws are often motivated by legitimate concerns about misclassification. But overly restrictive classification rules can also limit legitimate independent work.

In my research on California’s AB5, my coauthors and I examined the employment effects of the country’s strictest worker-classification law.<sup>10</sup> AB5 adopted a strict ABC test that made it much more difficult for workers to qualify as independent contractors.<sup>11</sup> We found that after AB5 went into effect, self-employment in California fell by 10.5 percent in nonexempt occupations, and overall employment fell by 4.4 percent. We found no robust evidence that traditional employment increased enough to offset these losses.

This finding is important because the stated goal of worker-reclassification laws is often to convert independent contractors into employees. But the evidence from California suggests that these laws may not simply change the composition of work: They can reduce work opportunities altogether.

My broader national research on ABC tests finds a similar pattern. States that adopt ABC tests experience declines in overall employment, W-2 employment, and self-employment.<sup>12</sup> This research suggests that classification rules should be carefully tailored. A rule that is too restrictive may not produce more employees; it may instead reduce the total amount of work available.

The healthcare-specific evidence from California is more limited, but it is consistent with this concern. California exempted physicians and surgeons from AB5, but physician assistants, nurse practitioners, and nurse anesthetists were not separately listed as exempt occupations in the AB5 exemption mapping. Using CPS data for comparison and applying the same general empirical framework as our

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<sup>10</sup> Liya Palagashvili et al., “Assessing the Impact of Worker Reclassification: Employment Outcomes Post-California AB5” (Mercatus Working Paper, Mercatus Center at George Mason University, January 31, 2024).

<sup>11</sup> An ABC test narrows the definition of what is considered as an acceptable contracting relationship between a worker and a hiring party. Generally, ABC tests presume that workers are W-2 employees unless they meet a much stricter standard to qualify as independent contractors. As a result, many legitimate forms of independent, freelance, or gig work are effectively restricted.

<sup>12</sup> Liya Palagashvili and Revana Sharfuddin, “New Study: From Gig to Gone—ABC Tests and the Shrinking of Work,” *Labor Market Matters* (Substack), January 10, 2025.

broader AB5 study, my preliminary analysis finds that California’s advanced-practice clinician self-employment share declined after AB5, while the same share rose in common-law control states.<sup>13</sup>

This healthcare-specific analysis should be interpreted cautiously because the advanced-practice clinician self-employed sample in California is small. But the analysis is consistent with the broader research and the broader concern: When classification rules restrict independent work, some work arrangements may not convert into W-2 jobs. They may simply disappear or fail to grow.

That point matters for H.R. 8347 because the bill includes not only physicians, but also nurse practitioners, physician assistants, and CRNAs. If classification uncertainty limits the ability of these clinicians to take temporary independent assignments, the effect may be felt most in communities already struggling to recruit permanent staff.

## 5. Access Problems Are Geographic, Not Just National

Healthcare labor markets face a basic economic problem: Demand can change quickly, but supply adjusts slowly. Training a physician, nurse practitioner, physician assistant, or CRNA takes years. Licensing and credentialing are necessary for patient safety, but they also make short-run labor supply less flexible. At the same time, healthcare demand is uneven across geography.

The Health Resources and Services Administration, an agency within the US Department of Health and Human Services, reports that about 20 percent of the US population resides in primary-care health professional shortage areas (HPSAs), and more than 34 federal programs rely on HPSA, medically underserved area (MUA), or medically underserved population (MUP) designations to determine eligibility or funding preferences.<sup>14</sup>

My analysis of the American Community Survey (ACS) shows the same access problem from another angle, as figure 4 illustrates. According to the 2020–2024 ACS five-year sample, metro areas have about 506 covered clinicians per 100,000 residents.<sup>15</sup> Nonmetro areas have about 259 covered clinicians per 100,000 residents—roughly half as many.

The physician gap is even larger. Metro areas have about 347 physicians and surgeons per 100,000 residents, compared with about 134 per 100,000 in nonmetro areas. Advanced-practice clinicians are also less available in nonmetro areas, though the gap is smaller: Metro areas have about 159 advanced-practice clinicians per 100,000 residents, compared with about 125 per 100,000 in nonmetro areas.

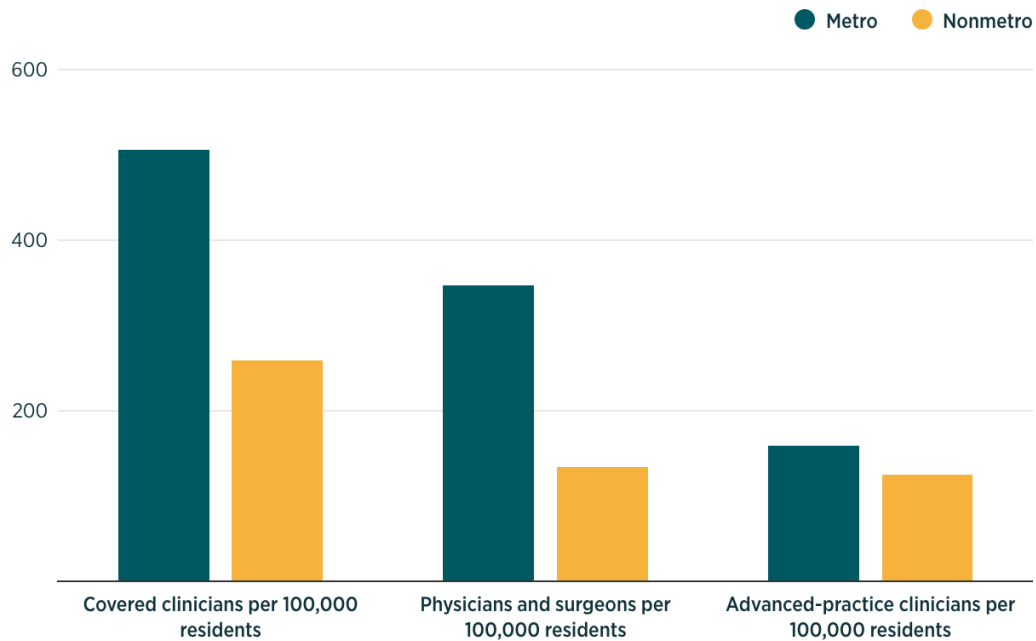
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<sup>13</sup> Author’s analysis of IPUMS CPS Basic Monthly data using the same general comparison-state framework and work-arrangement definitions as Palagashvili et al.’s broader AB5 study. The clinician-specific estimates are descriptive and should be interpreted cautiously because the California self-employed advanced-practice clinician sample is small.

<sup>14</sup> Health Resources and Services Administration, “Health Workforce Shortage Areas,” US Department of Health and Human Services, accessed June 3, 2026, <https://data.hrsa.gov/topics/health-workforce/shortage-areas>.

<sup>15</sup> IPUMS ACS (database), accessed May 29, 2026, <https://usa.ipums.org/usa/>.

Figure 4. Covered clinicians per 100,000 residents by metro status, 2020–2024



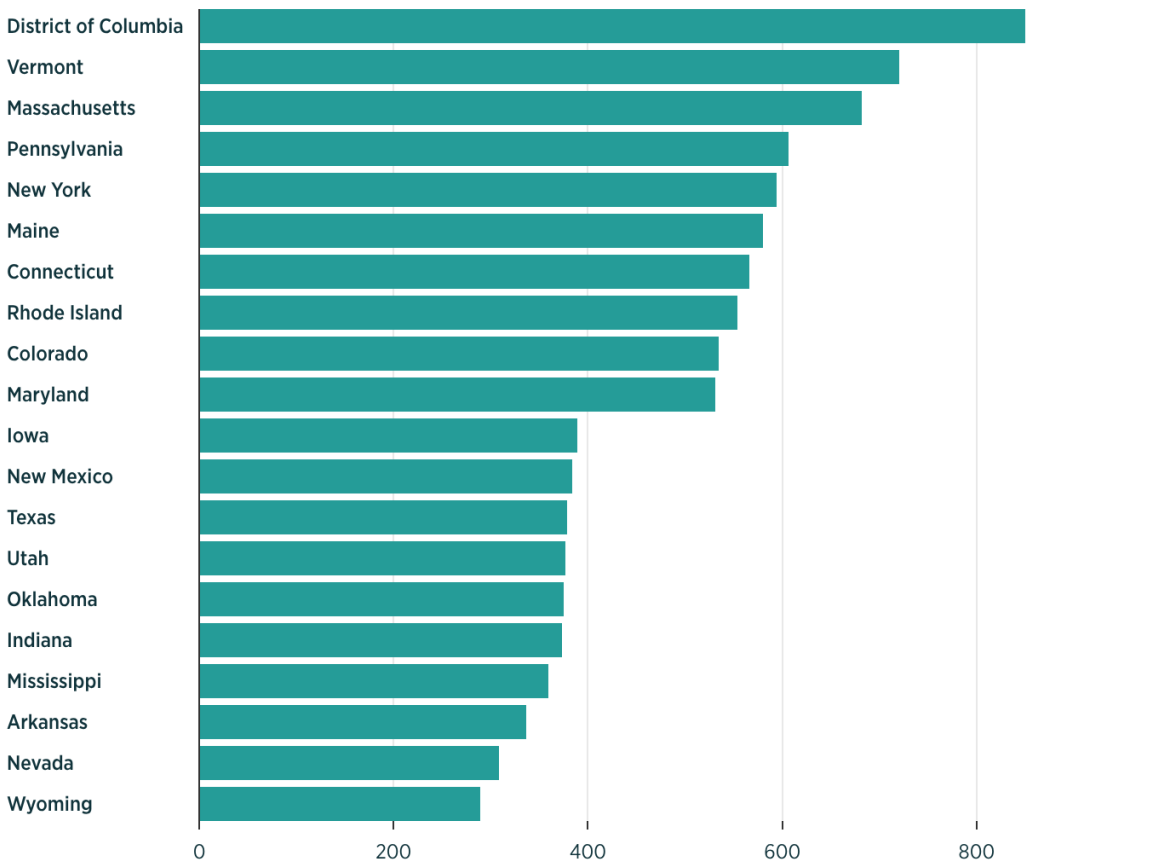
Source: Author's analysis of IPUMS USA, 2020–2024 American Community Survey five-year sample. Values are weighted clinician counts per 100,000 residents by metro status. Covered occupations are physicians and surgeons, physician assistants, nurse practitioners, and nurse anesthetists. Advanced-practice clinicians include physician assistants, nurse practitioners, and nurse anesthetists. Figure excludes mixed or indeterminate metro-status areas.

The same pattern appears across states. Some states have far more covered clinicians per capita than others. In the ACS data, the District of Columbia, Vermont, Massachusetts, Pennsylvania, and New York are among the highest-supply jurisdictions by covered clinicians per 100,000 residents. Wyoming, Nevada, Arkansas, Mississippi, and Indiana are among the lowest-supply states, as shown in figure 5. This variation reinforces that the access problem is not simply a national workforce problem; it is also a geographic mismatch problem.

These findings help explain why temporary staffing arrangements can matter. The access problem is not just national supply, but more importantly, it is a geographic mismatch. Some communities have many clinicians, but others have too few. A national average can hide the actual labor-market problem faced by rural hospitals, community clinics, emergency departments, anesthesia practices, and other facilities in shortage areas.

By reducing classification uncertainty for temporary clinician assignments, H.R. 8347 could make it easier for facilities to access clinicians when permanent hires are not available. The effect would likely be most important in places where provider supply is already thin.

Figure 5. State variation in covered clinician supply, 2020–2024



Source: Author’s analysis of IPUMS USA, 2020–2024 American Community Survey five-year sample. Values are weighted covered clinician counts per 100,000 residents by state. Covered occupations are physicians and surgeons, physician assistants, nurse practitioners, and nurse anesthetists. Figure shows the 10 highest-supply and 10 lowest-supply states by covered clinicians per 100,000 residents.

### Conclusion

Locum tenens is best understood as a flexible labor-supply margin in a shortage-prone healthcare labor market. Healthcare demand can change quickly, but the supply of licensed clinicians adjusts slowly. Temporary independent clinical work can help fill that gap.

The data show five key facts:

1. Independent clinical work is not overtaking or displacing traditional employment.
2. The clinicians covered by H.R. 8347 are highly educated, high-income, licensed professionals, and nearly all self-employed covered clinicians are insured.
3. Self-employed covered clinicians are much older than traditionally employed covered clinicians. For many late-career clinicians, the counterfactual to independent work may be fewer hours, earlier retirement, or exiting practice altogether.
4. Worker-classification laws should be carefully tailored because overly restrictive rules can reduce work opportunities for legitimate independent workers.

5. Access problems in healthcare are geographically uneven. Flexible staffing arrangements can especially help communities where provider supply is already thin.

Classification policy should distinguish between bad-faith misclassification and legitimate independent professional work. If laws restrict the ability of highly skilled clinicians to supply temporary labor, the likely result may not be more permanent W-2 jobs. It may be fewer available clinician hours, earlier retirements, unfilled shifts, and reduced access to care.

Thank you again for the opportunity to testify. I look forward to your questions.