

RN, NP, and PA Pay by State Adjusted for Cost of Living Using BLS May 2024 Data: Why CA Headline Crown Is a Mirage, Why OK and IN Quietly Win, and What It Means for Workforce Strategy in 2025

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Video Preview

State	Annual wage	Hourly wage	Cost of living index (2025)	RN hourly mean wage, adjusted by cost of living
Alabama	\$77,020	\$37.03	88.6	\$41.79
Alaska	\$114,870	\$55.23	124.9	\$44.22
Arizona	\$99,730	\$47.95	110.7	\$43.32
Arkansas	\$81,520	\$39.19	89.6	\$43.74
California	\$150,280	\$72.25	142.3	\$50.77
Colorado	\$99,370	\$47.78	102.7	\$46.52
Connecticut	\$105,250	\$50.60	112.7	\$44.90
Delaware	\$99,460	\$47.82	101.9	\$46.93
District of Columbia	\$106,980	\$51.43	138.8	\$37.05
Florida	\$90,650	\$43.58	102.2	\$42.64
Georgia	\$95,080	\$45.71	99.5	\$49.42
Hawaii	\$124,340	\$59.71	95.5	\$32.31
Idaho	\$92,710	\$44.57	94.5	\$44.61
Illinois	\$94,360	\$45.38	95.5	\$47.90
Indiana	\$89,150	\$42.86	94.5	\$47.10
Iowa	\$80,540	\$38.72	94.5	\$43.17
Kansas	\$82,360	\$39.60	94.5	\$44.59
Kentucky	\$86,140	\$41.41	94.5	\$44.59
Louisiana	\$84,190	\$40.52	94.5	\$44.59
Maine	\$95,010	\$45.24	94.5	\$44.59
Maryland	\$95,010	\$45.24	94.5	\$44.59
Massachusetts	\$117,960	\$56.65	102.2	\$42.64
Michigan	\$94,300	\$45.34	94.5	\$44.59
Minnesota	\$103,420	\$49.72	94.5	\$44.59
Mississippi	\$78,950	\$37.97	88.6	\$41.79

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Part I: RN, NP, and PA Pay by State Adjusted for Cost of Living Using BLS May 2024 Data: Why CA Headline Crown Is a Mirage, Why OK and IN Quietly Win, and What It Means for Workforce Strategy in 2025

California pays RNs \$148K nominally. After cost-of-living adjustment it drops to third. Oregon wins. Minnesota is second. Hawaii, nominally second, falls dead last...

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Part II: RN, NP, and PA Pay by State Adjusted for Cost of Living Using BLS May 2024 Data: Why CA Headline Crown Is a Mirage, Why OK and IN Quietly Win, and What It Means for Workforce Strategy in 2025

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Quick read on what is in here.

- Top adjusted RN hourly wage: OR at \$51.71. Bottom: HI at \$31.82.
- Top adjusted NP hourly wage: OK at \$71.29. Bottom: HI at \$34.73.
- Top adjusted PA hourly wage: IN at \$76.61. Bottom: HI at \$36.78.

- CA wins every nominal race and loses every cost-adjusted race against the Midwest and Plains.
- Hawaii nominal pay looks fine. Hawaii adjusted pay looks like a punishment.
- RN-to-NP nominal spread runs roughly \$25K to \$50K depending on state. NP-to-PA spread is small or negative in a surprising number of states.
- Implications cover bedside staffing economics, the geographic skew of virtual care platforms, capitated value-based care unit costs, SNF and home health margin compression, the build-versus-buy math for travel staffing, and where venture-backed clinical models can actually scale.

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Why headline nurse and APP pay numbers are mostly noise

Open any nursing trade publication on any given week and the same headline shows up. California pays nurses the most. The number is \$148,330 for the average RN, climbing every year, fueled by union strength, mandatory staffing ratios, and a labor market where Kaiser pays new grads more than half the country pays mid-career nurses. The number is real. It is also, on its own, useless for anybody trying to make a workforce or capital allocation decision. A \$148,330 RN paycheck in San Jose buys a different life than an \$80,000 paycheck in Tupelo, and the difference is not a rounding error. Cost of living indices vary by close to 110 percentage points between the cheapest and most expensive states in the BLS dataset, with West Virginia clocking in at a COL index of 84.1 and Hawaii sitting at a frankly comical 186.9 according to the 2024 World Population Review composite. Apply those multipliers and California stops winning. Hawaii stops winning by a country mile. And a bunch of states nobody

puts on a recruiting brochure end up at the top of the actual purchasing-power leaderboard.

This matters way past the personal-finance question of where an individual RN should take a job. Health system CFOs trying to model the unit cost of an FTE across a multi-state footprint, payers building NP and PA capacity for Medicare Advantage in-home assessment programs, digital health platforms running an asynchronous primary care model across all 50 states, value-based care enablers staffing their wrap-around clinical teams, and venture investors trying to back the next telepsych or virtual urgent care company all need the same thing. They need the real labor cost picture, not the nominal one. The BLS May 2026 OEWS release, combined with the World Population Review 2025 COL index that Becker's used for its three role-specific tables published in April 2026, is the cleanest publicly available cut of that data. Becker's did the cost-of-living math on hourly wages. What follows is the analysis layer on top.

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RN pay across the fifty states

The nominal RN pay map looks like a coastal monopoly. California sits at \$71.31 per hour, an average annual figure of \$148,330. Hawaii is next at \$59.48 and \$123,720. Oregon at \$57.92 and \$120,470. Massachusetts at \$54.14 and \$112,610. Alaska at \$53.86 and \$112,040. New York at \$53.12 and \$110,490. DC at \$52.52 and \$109,240. New Jersey at \$51.44 and \$106,990. Connecticut at \$49.84 and \$103,670. Nevada at \$49.17 and \$102,280. The pattern is exactly what anybody who has spent five minutes in healthcare workforce planning would predict. High-density, high-cost coastal markets dominate, with Alaska and Hawaii thrown in because they always have a geographic isolation premium baked into their wage structure. The bottom of the list is South Dakota at \$34.72 per hour (\$72,210), followed by Alabama, Iowa, Arkansas, Kansas, Mississippi, Missouri, Tennessee, and a cluster of Plains and Southeast states. The nominal spread between the top and bottom state is more than \$76,000 a year. That is a real number for an individual nurse considering where to put roots down, but a misleading one for everybody else.

Now adjust for cost of living. Oregon takes the top spot at \$51.71 per hour, which annualizes to about \$107,500 at 2,080 hours. Minnesota is second at \$50.28 (about \$104,600 annualized). California, after getting dragged down by a 144.8 COL index, sits third at \$49.25. Nevada is fourth at \$48.54. New Mexico fifth at \$48.63.

Washington fits in at \$48.72. Georgia, of all places, surfaces at \$48.42 adjusted.

Oklahoma at \$48.13. Michigan at \$48.17. Texas at \$47.55. The story flips. The states people associate with high-paying nursing are mostly still in the top half, but they are no longer dominant, and a band of Midwest and Southern states quietly outperform them on real take-home purchasing power. The bottom of the adjusted RN list is brutal. Hawaii at \$31.82 adjusted (giving up roughly 47 percent of nominal pay to cost of living). DC at \$37.01. Massachusetts at \$37.11. Maine at \$37.50. South Dakota at \$37.66. Vermont at \$38.96. Maryland at \$40.29. New Hampshire at \$40.40. Utah at \$40.44. Arizona at \$41.07.

Notice the geographic clustering. New England wages do not stretch. The DC labor market is brutal for nurses on a real-dollar basis. Hawaii is in a category by itself. Meanwhile, the Upper Midwest punches well above its weight, and the Mountain West splits, with Oregon and Nevada doing very well adjusted and Utah and Arizona getting hammered by housing inflation that has not been fully matched by wage growth. Texas, Georgia, and Michigan all look much better adjusted than nominal, which is consistent with what every health system operator in those states has been saying for two years: the workforce is more available there, the dollar goes further, and recruiting is less of a knife fight than it is in Boston or San Francisco. The one place where the conventional wisdom holds clean is Oregon. The Pacific Northwest has been the quietly best-paying region for nurses on a real-dollar basis since at least 2021, and the 2024 data confirms the pattern. It is also a state where union density and Medicaid expansion have pushed wages up faster than housing in the parts of the state that are not Portland proper.

NP pay across the fifty states

Nurse practitioners are where the workforce strategy conversation gets interesting, because NPs are the lever every value-based primary care model, MA carrier, telehealth platform, and behavioral health startup uses to scale clinical capacity at sub-physician cost. Nominal NP pay in CA is the highest in the country at \$173,190 a year, \$83.26 per hour. New York is second at \$148,410 and \$71.35 per hour. Oregon at \$148,030. Massachusetts at \$145,140. Washington at \$143,620. Alaska at \$142,340. Connecticut at \$141,140. New Jersey at \$140,470. Rhode Island at \$139,600. DC at \$137,600. The same coastal pattern. CA carries a \$25K nominal premium over the next-highest state, mostly driven by the Bay Area NP labor market, where Sutter and

Stanford and UCSF compete for the same talent pool with the same salary bands that have crept up consistently since the pandemic. The bottom of the nominal NP list is mostly Southeast and Plains, with Tennessee at \$108,180, Alabama at \$109,650, South Carolina at \$113,950, Arkansas at \$116,030, Kentucky at \$116,930.

Adjust for cost of living and the leaderboard inverts. Oklahoma jumps to first at \$71.29 per hour, roughly \$148,000 annualized, which is mathematically very close to what an NP in CA makes nominally. Iowa is second at \$71.26. Kansas third at \$70.67. New Mexico fourth at \$70.38. West Virginia fifth at \$69.83. Texas at \$67.90. Michigan at \$67.65. Missouri at \$67.51. Mississippi at \$67.23. Indiana at \$67.20. The Midwest and Plains absolutely dominate the adjusted NP map. Every state from New Mexico to West Virginia along the southern tier of the Midwest is paying NPs real-dollar wages that exceed what CA pays its NPs after rent and taxes get stripped out. The bottom of the adjusted NP list is, again, Hawaii at \$34.73, where NPs nominally make \$135,020 but the COL multiplier shreds it. DC at \$46.63. Massachusetts at \$47.83. Maryland at \$53.01. Maine at \$54.80. Vermont at \$54.88. Alaska at \$55.27, despite its \$142K nominal pay. The pattern that nominal-money outliers turn into adjusted-money losers holds.

Two structural factors are worth flagging for anybody using NPs as a strategic clinical resource. First, scope of practice. The states that grant full practice authority to NPs (which now covers more than half the country after Utah, New York, and Kansas joined the FPA list in the last few years) tend to have somewhat compressed nominal NP wages relative to reduced or restricted states. The mechanism is supply-side: when NPs can hang their own shingle or run a clinic without physician collaboration, supply expands, and per-NP wages get marginal pressure. The interesting twist is that FPA states are also the states where NPs are most productive in real volume terms. An NP in Iowa or New Mexico, both FPA states, can see more patients and bill more cleanly than an NP in Florida or Texas operating under collaborative agreement constraints. So even at slightly lower nominal pay, the per-RVU economics for the employer can be better. Second, MA penetration matters. States with high MA penetration are pulling NPs hard into in-home assessment and chronic care management programs, which has pushed NP wages up in states like Texas and Arizona faster than the regional average. Florida looks oddly mid-pack on adjusted NP pay at \$60.02 despite being the MA capital of the country, mostly because the Florida COL index has crept up faster than NP wages, especially in South Florida and Tampa Bay.

PA pay across the fifty states

Physician assistants are the third leg of the stool, and the data here flips a few common assumptions. The first surprise is that PAs in many states actually out-earn NPs nominally, despite NPs getting most of the headline attention. California pays PAs \$77.88 per hour, \$161,980 a year, less than CA NPs nominally but still dramatically high. Washington pays PAs \$75.03 per hour (\$156,060), Oregon \$73.16 (\$152,160), New York \$72.73 (\$151,280), New Jersey \$71.71 (\$149,160), Rhode Island \$71.29 (\$148,290). The next tier is full of states where PA pay is essentially identical to or higher than NP pay: Minnesota PAs at \$69.68 versus Minnesota NPs at \$61.60. Indiana PAs at \$69.33 versus Indiana NPs at \$60.83. Arizona PAs at \$68.83 versus Arizona NPs at \$63.90. Wisconsin, Iowa, Kansas, Nebraska, all show PA pay matching or exceeding NP pay. This is a real specialty mix story. PAs disproportionately work in surgical specialties, orthopedics, dermatology, emergency medicine, and cardiology, where compensation runs higher than primary care, which is where most NPs cluster. The mix shifts the average enough to flip the rankings.

Adjust for cost of living and the PA map does what every other map in this analysis does, which is to send the Midwest to the top. Indiana takes first at \$76.61 per hour adjusted, roughly \$159,000 annualized, the highest cost-adjusted clinical wage of any state for any role covered here. New Mexico is second at \$74.24. Missouri third at \$74.16. Minnesota fourth at \$73.27. Iowa fifth at \$72.60. Oklahoma at \$71.62. Texas at \$71.08. West Virginia at \$69.25. Kansas at \$69.62. Michigan at \$68.76. The cost-of-living-adjusted PA in Indiana is making more in real-dollar terms than the cost-of-living-adjusted PA in California by roughly \$23 an hour, which annualizes to a \$48,000 swing. That is not noise. That is a structural arbitrage that hospitals in IN, MO, and NM have been quietly running for years, and that physician staffing firms have figured out how to monetize through travel and locum placements that effectively let big-system PAs work in lower-COL markets while keeping their compensation closer to coastal levels.

The bottom of the PA list is the usual suspects, with one twist. Hawaii at \$36.78 adjusted, dead last as always. Massachusetts at \$45.28. DC at \$48.87. Arkansas at \$50.89 (PAs are not paid well in AR even nominally, at \$93,880, the lowest in the country). Mississippi at \$53.75. California at \$53.78 adjusted, which is a remarkable fall from a \$77.88 nominal hourly rate. Alaska at \$54.21, which is another big-nominal-pay state getting hammered by COL. Maryland at \$56.11. Kentucky at \$56.95. Maine at \$56.33. The PA story is the cleanest illustration of the broader pattern. Coastal pay scales look great in absolute terms but the cost-of-living tax is enormous. The Midwest and Mountain West are where PA labor cost and PA standard of living align best, both for the workforce and for the employer.

Patterns that cross all three roles

Once the three role-specific maps are stacked on top of each other, a few patterns become impossible to miss. Hawaii is structurally the worst place to work as a clinician on a real-dollar basis. The COL index of 186.9 is doing damage that no realistic wage premium can overcome, and the gap between Hawaii nominal pay and Hawaii adjusted pay is wider than any other state. DC, Massachusetts, Maine, and Maryland are persistent adjusted-pay losers across all three roles. The DC labor market has the additional twist that federal employer caps and a heavy nonprofit health system mix put a soft ceiling on nominal wage growth, while housing in DC, Northern Virginia, and Maryland has run hot for a decade. Massachusetts has the Boston housing problem plus a payer mix dominated by Mass General Brigham and Beth Israel Lahey, which gives the employer side pricing power on wage bands.

The Midwest and Plains states dominate the adjusted-pay top end across all three roles, with Oklahoma, Iowa, Kansas, New Mexico, Indiana, Missouri, and Minnesota appearing in the top ten for at least two of the three roles. The mechanism is the same in every state: nominal pay is roughly 70 to 90 percent of coastal pay, but housing, food, and services run 65 to 90 percent of the national index, which leaves more dollars in the clinician pocket and lower unit costs on the employer side. This is the basic labor arbitrage that has driven a decade of health system consolidation toward the Midwest, the expansion of telehealth platforms with Midwest-based clinician networks, and the value-based care enablers that have figured out that capitated economics work much better when the clinical labor cost is structurally 20 percent lower than it is in San Diego or Seattle.

California is the perpetual nominal champion and the perpetual adjusted disappointment. Its nominal RN pay is 80 percent higher than South Dakota's. Its adjusted RN pay is roughly 30 percent higher, which is still meaningful but a fraction of the gap. California NPs nominally earn 60 percent more than Tennessee NPs. Adjusted, the gap shrinks to about 0 percent. California PAs make 70 percent more than Arkansas PAs nominally. Adjusted, the California PA earns only 5 percent more than the Arkansas PA on a purchasing-power basis. That is the kind of finding that should reshape recruiting strategy for any system trying to win clinicians who are weighing relocation. CA has the sun, the food, the politics, and the brand. It does not, on a cost-adjusted basis, have a meaningful pay advantage anymore. That is a sales pitch problem for CA recruiters and an opportunity for any low-COL state trying to poach talent.

A subtler pattern is the relationship between nominal pay and adjusted pay variance. The states with the most volatile rankings across the three roles tend to be the ones

with idiosyncratic labor mix issues. Arizona looks great for PAs on adjusted basis (\$61.73, decent) but mid-pack for NPs and RNs, which probably reflects the heavy dermatology, ortho, and travel PA concentration in Phoenix and Scottsdale. New Mexico is in the top five for both NP and PA adjusted, which mirrors the federal IHS and state-driven primary care expansion that has poured money into APP workforce there for the last decade. West Virginia is in the top ten for NP adjusted and bottom third for nominal PA pay, which is more about the state's struggle to attract PAs into rural settings than it is about adjusted purchasing power.

The methodology stuff most people skip past

A few things to know before anybody quotes these numbers in a board deck. The BLS May 2024 OEWS release is based on a six-panel survey covering responses from November 2022 through May 2024. That means the nominal wage figures lag the actual labor market by anywhere from six months to two years, depending on the panel weight. In a fast-moving wage environment, like the one nursing has been in since 2022, the headline numbers understate current pay. RN pay in particular has continued to drift up in 2025, driven by travel-to-perm conversion premiums, retention bonuses, and union contracts that have ratified faster than payer rate growth. The number a recruiter quotes today in any state is probably 3 to 7 percent higher than the BLS figure.

Second, the COL index Becker's used is the World Population Review composite, which is a useful one-number summary but compresses real underlying variation. Within California, the COL index runs from about 110 in the Central Valley to over 180 in San Francisco proper. Within Texas, Austin and Dallas run roughly 115, while smaller markets like Lubbock and Amarillo run below 90. A state-level number is useful for cross-state comparison but is a blunt instrument for any operator trying to model unit cost in a specific MSA. The BEA Regional Price Parities, published annually for both states and MSAs, are the cleaner source for sub-state work. For the analysis here, the state-level COL index is good enough to make the big-picture point, but anybody making a real capital allocation decision should pull MSA-level data.

Third, BLS suppressed Colorado data entirely for the May 2024 release because the state's unemployment insurance system modernization caused data quality issues that the Quarterly Census of Employment and Wages could not resolve in time for the April 2 publication. Colorado will probably show up in the next release, but for any 2025 analysis using May 2024 data, Colorado is a hole in the dataset. NP data is also suppressed for Nevada due to confidentiality thresholds, which means the Nevada NP

map is a guess until a future release. PA data has nominally been collected for Mississippi this cycle (\$98,270 nominal, \$53.75 adjusted), which is an improvement on prior years where MS PA data was suppressed.

Fourth, mean versus median. The BLS data used in these tables is the mean. Mean RN pay is pulled up by senior leadership track nurses, CRNAs (who BLS separates out, so this is cleaner for RNs but not perfect), and clinical nurse specialists. NP and PA means are pulled up by surgical and procedural subspecialty pay. The median is usually 5 to 10 percent below the mean and is a better number for thinking about the typical clinician's experience. Becker's published mean. The full BLS file has both. For workforce strategy purposes, the mean is usually more useful, because it reflects total payroll burden more accurately, but the median is what an individual clinician is comparing themselves against.

What this means for workforce strategy and digital health unit economics

The strategic implications fan out across a few different stakeholder groups. For health system CFOs running multi-state footprints, the cost-adjusted pay map is the closest publicly available proxy for real per-FTE labor cost burden, and the conclusion is unambiguous. Midwest, Plains, and parts of the South are where labor cost per unit of clinical capacity is lowest in real terms. Coastal markets, especially Boston, DC, Baltimore, and Honolulu, are where labor cost is highest. A multi-state system rationalizing its workforce footprint should be thinking very hard about which clinical functions it can centralize in lower-COL markets and serve via virtual or distributed care models, and which functions truly require physical presence in high-COL markets.

For digital health companies running a national clinician network, the same map says where to recruit. A virtual primary care platform building its NP bench from scratch in 2025 should be sourcing heavily from Oklahoma, Iowa, Kansas, New Mexico, and Indiana, where adjusted NP wages are in the top five but where nominal NP wages are still well below what a New York or California NP commands. The wage arbitrage between licensing those NPs to deliver care across state lines through the eNLC compact (for RNs) and via the APRN compact (which is in much slower rollout, with only a handful of states fully implemented as of 2025) versus paying CA or NY rates is structurally meaningful. The bottleneck is licensure, not labor supply. Any platform that can solve multi-state licensure efficiently can route capacity to the lowest real-cost labor market in the country and serve patients anywhere.

For value-based care enablers running capitated MA primary care models, the math is even sharper. The per-member-per-month margin in MA primary care is roughly \$50 to \$200 depending on risk adjustment, plan, and population, and clinical labor cost is the single biggest variable expense. A model that uses Midwestern NPs and PAs to deliver care, virtually or in physical clinics, has a structural cost advantage of 15 to 25 percent over a model staffed out of California or New York. The big VBC players (Oak Street pre-CVS, ChenMed, Iora pre-One Medical, Carbon Health, Galileo) have all been pulling clinical staff toward lower-COL markets for years for exactly this reason. The data here just quantifies what those operators already know.

For payers running in-home assessment programs and chronic care wraparound staffing, the labor pool question is more about availability than cost. The states with the best adjusted NP and PA pay are also, generally, the states where APP supply is most constrained relative to need, especially in rural areas. The interesting tension is that the states where it is easiest to make APP unit economics work are also the states where APP availability is lowest. Payers running national in-home assessment programs (Signify, prior to CVS, and Matrix, and PWN) have to balance the labor cost arbitrage against the difficulty of actually hiring APPs in a market like rural Iowa or western Oklahoma. The solution most of them have landed on is a hub-and-spoke model where APPs are concentrated in regional clusters and dispatched across MSAs.

For SNF and home health operators, the picture is darker. The states with the lowest adjusted clinical labor cost are also the states where Medicare reimbursement for post-acute care has been compressed the hardest, and the margin compression in SNF, home health, and hospice in 2024 and 2025 has been brutal. Operators are paying for clinical labor at rates that are competitive with hospitals but billing at rates set by the PDPM, PDGM, and hospice cap structures that have not kept pace. The cost-adjusted pay maps here suggest that the Midwest and Plains still have the best margin economics for post-acute, but the absolute margins are tight enough that even those markets are increasingly stressed.

For venture investors backing clinical staffing, telehealth, and care delivery models, the takeaway is to look hard at where the clinical labor base is sourced from and how it is licensed across markets. A company sourcing 80 percent of its clinicians from a five-state Midwestern footprint and serving patients in all 50 states has a structural margin advantage that is durable. A company sourcing clinicians from the California and New York markets and serving the same national patient base is fighting an uphill labor cost battle and is unlikely to ever achieve the kind of unit economics that justifies a venture-scale outcome. The same logic applies to behavioral health platforms, virtual urgent care, and chronic care management. Geography of clinical supply has become a first-order strategic question.

Bottom line for operators, investors, and policy folks

The cleanest one-sentence summary of the May 2024 BLS data, adjusted by the 2024 World Population Review COL index as Becker's did in its April 2025 publications, is that the headline pay numbers in healthcare are mostly a function of cost of living, and once cost of living is stripped out, the Midwest and Plains pay clinicians more in real-dollar terms than the coasts do. That conclusion has been roughly true for a decade. It is more true in 2025 than it has ever been, because coastal housing inflation has continued to outpace nominal coastal wage growth, while Midwestern wages have caught up faster than Midwestern COL.

For a hospital system operator, the strategic question is whether to keep building expensive coastal capacity or to shift the center of gravity toward markets where labor cost per unit of clinical output is structurally lower. The answer for most national-scale systems is the latter, and the M&A activity of the last three years (Sanford-Marshfield in the Upper Midwest, AdventHealth growth in the Carolinas, CommonSpirit consolidation across the South and Midwest, and the wave of Texas and Tennessee deals) reflects that. For payers, the takeaway is that MA, Medicaid managed care, and the commercial small-group market are easier to serve profitably in markets where the clinical labor base is cheaper in real terms, which is why the high-MA-penetration Midwest is where every payer is pushing hardest.

For digital health and care delivery startups, the implications are concrete. Recruit clinicians from low-COL markets. Solve multi-state licensure aggressively. Build the operations stack that lets a clinician sitting in Tulsa or Des Moines serve a patient in Boston or San Francisco without friction. Do the math on what the same FTE costs in five different states and pick the cheapest one where the labor pool is deep enough to scale. For policy folks, the takeaway is that the workforce shortage narrative is partly a price signal problem. The clinicians exist. They are concentrated in lower-COL markets where their dollars stretch further. The challenge is getting their capacity to where the patients are, and that is a licensure, technology, and reimbursement design problem more than it is a raw supply problem.

And for the clinicians themselves, the data says what every Reddit thread on r/nursing and r/physicianassistant has been saying for years. California pays the most on paper. Indiana, Oklahoma, Iowa, and New Mexico pay the most in reality. Hawaii looks like a vacation in the offer letter and a budget crisis on day one. The Midwest does not have the brand, but it has the bank account. The numbers are right there in the BLS table. They tell a different story than the recruiting brochure does.

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