COMPTROLLER OF MARYLAND

MARYLAND INDUSTRY ANALYSIS: HEALTHCARE AND THE ECONOMY

APRIL 2026

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LETTER FROM THE COMPTROLLER

This report marks both a milestone and a moment of urgency. The latest report from the Office of the Comptroller is the first one examining a key industry in Maryland – its contributions to our residents, our communities, and our state and local budgets. We begin with health care: Maryland's largest, most complex, and arguably most consequential industry.

The numbers alone are striking. Health care employs more Marylanders than any other sector and has added over 51,000 jobs since 2022 – nearly as many as all other industries combined. More than 30,000 of those jobs represent net new growth beyond pre-pandemic levels. That distinction matters greatly as Maryland absorbs the loss of approximately 25,000 federal government jobs in 2025 alone, a direct consequence of Trump Administration cuts. In an era of federal retrenchment, health care has become one of the few reliable engines of job creation in our state.

Maryland is fortunate to be home to some of the most distinguished health systems in the world. From Meritus Health and Frederick Health in Western Maryland to TidalHealth on the Eastern Shore, and Johns Hopkins Health System, MedStar Health, the University of Maryland Medical System, Adventist HealthCare, and others in Central Maryland, these institutions do more than deliver exceptional care. They function as anchor institutions – stabilizing rural economies, serving low-income communities, and generating broad civic value that no spreadsheet fully captures. In the last year, our 17 health systems injected $23 billion into the state economy and contributed more than $500 million in income tax withholding to state coffers.

Yet size and importance do not insulate an industry from structural vulnerability and a thriving health care sector is not an unambiguous sign of a thriving state. Much of the demand driving job growth is fueled by an aging population and a rising burden of chronic disease; more health care jobs, in other words, can mean more sick people. And, despite its scale, the sector generates comparatively modest multiplier effects, indirect job creation, and productivity gains relative to industries like professional services or manufacturing.

Health care in Maryland also faces serious headwinds. Health care's growth depends heavily on government financing. Nearly one dollar in every four in our state budget is dedicated to federal and state Medicaid spending, and one in four Marylanders relies on Medicaid for coverage. The changes now underway through House Resolution 1 (H.R. 1) and other federal policy shifts could trigger coverage losses in the hundreds of thousands and funding cuts that fall hardest on our hospitals' operating budgets. The likely result: higher costs for consumers and employers, slower job growth or outright cuts, and reduced services for those who need them most.

This report is intended to inform policymakers and stakeholders across the state about the importance of the health care industry to our economy, notable areas of growth in the sector, and the challenges and opportunities that lie ahead. I'd like to thank the many experts from across the state who helped inform this report, including hospital executives, health care practitioners, and policy experts. I would also like to thank partners from the Maryland Department of Health, Maryland Insurance Administration, Maryland Health Care Commission, Maryland Health Services Cost Review Commission, Maryland Hospital Association, and the Hilltop Institute, University of Maryland, Baltimore County (UMBC) for assisting in our research efforts. We hope this report will contribute to making Maryland a more prosperous, equitable, and healthy state.

Brooke E Lierman
Comptroller of Maryland

Introduction

Health care is the dominant sector in Maryland and a cornerstone of the state economy. No other industry employs more people in the state, touches more communities, or shapes more lives than the health care industry. This report - the first in a new series that looks at key industries in Maryland - evaluates the economic impact of Maryland's expansive health care sector.

In recent years, health care has been, by far, the top job creator in the state and the nation. When most industries were shedding jobs last year, health care added 693,000 jobs nationwide. Every other sector of the U.S. economy combined lost more than 500,000 jobs. Since the COVID-19 pandemic, health care hasn't just been a bright spot in the labor market – it has been the only growth area in the U.S. labor market.[1]

The health care workforce itself reflects Maryland's diversity. More than half of the state's health care workers are people of color and roughly 30% are immigrants. In addition, nearly 80% of health care occupations are held by women – making the industry one of the most significant drivers of women's economic empowerment in the state.[2]

The industry's foothold in the private sector is also notable. Maryland's job growth over the last decade has leaned heavily on the public sector, particularly federal government jobs. Maryland has lost more federal jobs than any other state due to Trump administration cuts, more than 25,000 positions.[3] The private sector will have to carry more of the employment load for the foreseeable future, and health care is currently the private sector's biggest jobs engine. No other private sector industry can be credited with doing more for the state's labor force: health care is a sustainable job creator *and* helps keep people healthy, enabling them to work and participate in the economy at large.

However, too much growth in this industry introduces economic vulnerabilities, including the following: (1) reliance on federal government to finance the health care system during a time of federal budget recession and uncertainty, (2) added financial burden on state and local governments, consumers, and employers, which has the effect of crowding out growth in other parts of the economy, and (3) limited productivity gains and relatively small multiplier effect on the overall economy.

This report is intended to give policymakers, industry leaders, and the public an honest accounting of the promise and the drawbacks of Maryland's largest industry.

- **Section 1** analyzes employment growth across Maryland's health care industry and examines the forces propelling that growth, including demographic shifts, morbidity trends, expanded insurance coverage, and technological advancements.
- **Section 2** describes the types of jobs and workers in Maryland's health care industry, and growth trends for specific health care occupations.
- **Section 3** reviews the impact of health care on other aspects of the economy, beyond job creation.
- **Section 4** inventories challenges – such as cuts to federal funding and insurance coverage, along with workforce shortages – and explores what continued health care growth means for the state's economic trajectory.

Key Findings

Section 1 (Industry Employment Data)

- The health care and social assistance sector is the largest industry in Maryland for employment. The industry employs 427,000 people in all corners of the state, supporting 16% of all jobs in Maryland.
- Compared to other industries in Maryland, health care and social assistance has been the leading job generator, adding more jobs than any other industry for seven of the past 10 years. Growth trends in health care vary significantly by subsector – hospitals, ambulatory health care services, nursing and residential care facilities, and social assistance.
- Key drivers of employment growth in health care include demographic shifts, increased access, morbidity trends, state policies and programs, and insurance coverage changes.

Section 2 (Occupation Data)

- There are 274,000 health care workers in Maryland. Registered nurse is the largest health care occupation (50,000 jobs). Home health and personal care aides grew the most among health care occupations in 2024, adding 7,000 jobs from the previous year.
- Wages for health care occupations on average are higher in Maryland than the U.S. and all neighboring states except for Washington, D.C. Most physicians are an exception.
- There is a disproportionately high share of foreign-born, women, and Black residents employed in health care occupations in Maryland compared to their population share and compared to other states and the U.S. overall.

Section 3 (Economic Activity Data)

- Beyond employment, the health care industry has a broader economic impact through wages, GDP, and the purchasing power of hospitals and other health care providers.

Section 4 (Challenges)

- Federal policy changes associated with H.R. 1 (the One Big Beautiful Bill Act) are expected to result in Medicaid coverage losses and funding cuts to Maryland.
- Workforce shortages are a persistent challenge, especially for nurses and home health aides.
- Health care costs continue to rise, increasing spending by governments, employers, and patients.

The health care industry creates clear economic benefits to the state through sustainable jobs, wages, and spending. The industry also helps keep the entire state labor force healthy. However, not all growth is good when it comes to health care, and expansion in health care does not necessarily signal a healthy economy.

Definitions & Methodology

This report uses data from federal sources, primarily the Bureau of Labor Statistics (BLS) and some supporting data from the U.S. Census Bureau, specifically microdata accessed using IPUMS USA. The report also uses data from the Maryland Department of Health, the Maryland Health Benefits Exchange, the Maryland Insurance Administration, the Maryland Health Services Cost Review Commission, the Maryland Health Care Commission, the Hilltop Institute (University of Maryland Baltimore County), and the Comptroller of Maryland.

Industry data

Industry data is based on the North American Industry Classification System (NAICS), the system used by federal data sources to group businesses based on their primary activity. There are 20 main industry sectors (2-digit codes) in the NAICS system. NAICS has a hierarchical structure and industries can be broken down into 2, 3, 4, 5, and 6-digit codes, getting more detailed at each level. This report presents data across all five codes. The industry analysis in this report is based on BLS data from the Quarterly Census of Employment and Wages (QCEW), which classifies establishments and employment by industry sector. Employment by industry includes any job within an industry. For example, employment in the health care and social assistance industry includes anyone who works for a health care establishment in Maryland, from doctors and nurses to administrative, food service, and cleaning staff. The BLS data used in this report is based on the employer location; therefore, the jobs are located in Maryland, but may not necessarily be jobs held by Maryland residents.

Occupation data

Occupation data is based on the Standard Occupational Classification (SOC) system, used by federal data sources to categorize workers based on their job duties, regardless of what type of business or industry they work for. There are 23 “major” occupation groups, and hundreds of “detailed” occupations within those groups. The occupation analysis in this report uses BLS data from the Occupational Employment and Wage Statistics (OEWS). Note that occupation employment data represents filled jobs located in Maryland, not job openings or vacancies.

Demographic data

The health care demographic data analysis in this report is based on U.S. Census microdata available from IPUMS USA (University of Minnesota, www.ipums.org). The analysis examines the demographics of the people in the health care workforce. Because this analysis uses Census data rather than BLS, the data is for Maryland residents rather than jobs based in Maryland. Because of the differences in sources and methodology, there may be slight differences in the jobs data as it measures a different population (residents versus workers in the state).

Section 1: Industry Employment Data

Health care and social assistance is one of the 20 major economic sectors in the North American Industry Classification System (NAICS). It includes employers like hospitals, doctors' offices, home health agencies, as well as services for the elderly or people with disabilities, and counseling centers. Both components of the sector – health care and social assistance – are important to the health and well-being of Marylanders.

(1A) Industry Employment

The health care and social assistance industry plays a critical role in the economy by supporting 427,000 jobs in all corners of the state, which is more than any other industry in Maryland by a wide margin (Figure 1). This represents 16% of all 2.7 million jobs in Maryland.[i]

- The prominence of health care and social assistance jobs across Maryland varies significantly by region, ranging from 26% of all jobs in Wicomico County to 8% in Queen Anne's (see county data in Appendix A: Figure 24, Figure 25, and Table 4).
- Health care is the largest industry (by share/number of jobs) in 10 counties in Maryland and one of the top five industries in every Maryland county.

In Maryland, the vast majority (97%) of jobs in the health care and social assistance sector are in the private sector (including nonprofits), and 3% are government jobs, including those in state or federally owned hospitals.

- Nationally, the health care and social assistance sector is the largest nonprofit sector, representing 67% of all nonprofit employment.[4]
- Nearly all hospitals in Maryland are nonprofit organizations: excluding federal government hospitals and the six psychiatric hospitals run by the state, 96% of Maryland's hospitals are nonprofit organizations, compared to 58% of hospitals nationally.[5] [ii] (See map of hospitals in Maryland in Appendix A: Figure 26.)

After health care and social assistance, the next largest industries in Maryland by number of jobs are educational services (281,000), professional, scientific, and technical services (280,500), public administration (267,000), and retail trade (265,000) (Figure 1).

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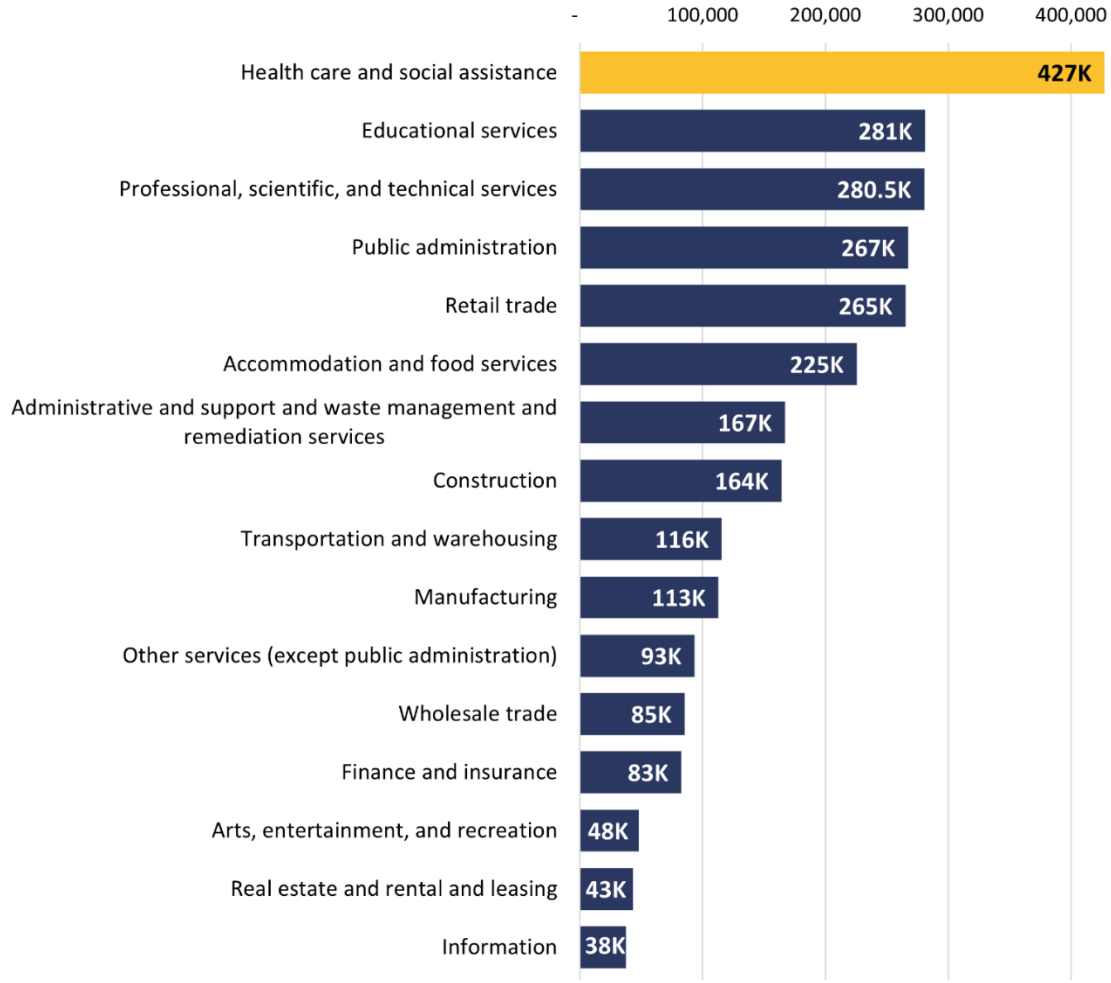
i Like in Maryland, 16% of all jobs in the U.S. are part of the health care and social assistance industry. Some of Maryland's neighboring states with less diverse economies – like Delaware and West Virginia – have a higher share of health care and social assistance jobs (19% and 21%), while others have a lower shares (10% in Washington, D.C.; 14% in Virginia).

ii This data excludes federal hospitals (e.g., National Institute of Health Clinical Center and Veteran's Association medical centers) and state-run specialty hospitals (e.g., psychiatric facilities).

*Figure 1: Average Annual Employment by Industry Sector in Maryland, 2025**



Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
**2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available*
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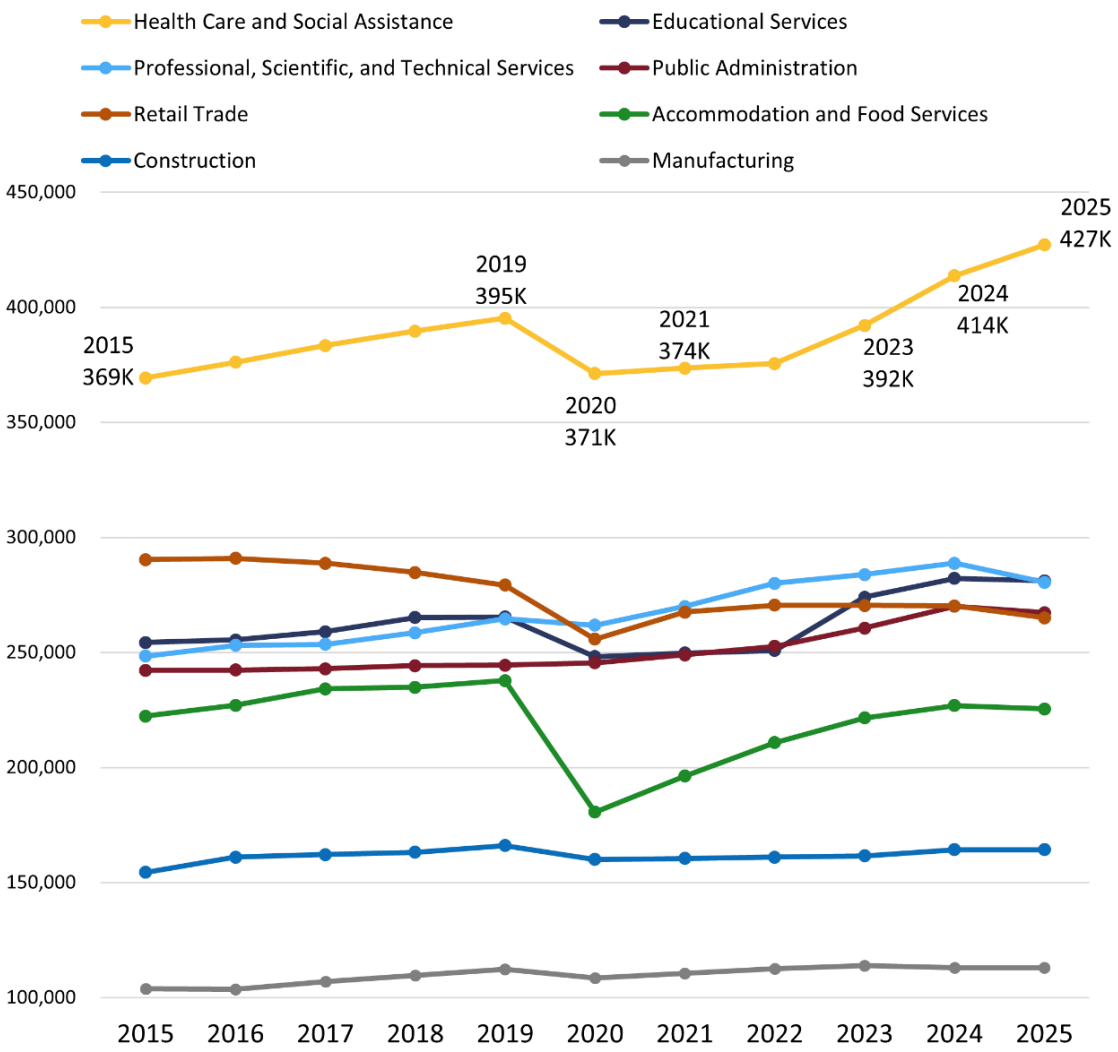
Compared to other industries in Maryland, health care and social assistance has been the leading job generator, adding more jobs than any other industry in seven of the past 10 years. Since 2015, the health care and social assistance industry added 58,000 jobs (a 16% increase) in Maryland (Figure 2). [iii]

- Due to the pandemic, health care and social assistance employment decreased by about 25,000 jobs (6%) from 2019 to 2020 and did not increase until 2022. The slower recovery from the pandemic in this industry compared to others is unsurprising: COVID-19 had a disproportionate impact on health care and social assistance, as burnout among these front-line workers was severe.

iii This growth was driven exclusively by the private sector; state government jobs in the health care and social assistance industry declined over the past decade, while federal government jobs in the industry remained stagnant.

- Strong growth in 2022 and 2023 enabled health care and social assistance employment to surpass pre-pandemic levels in 2024, and strong growth continued in 2025.

*Figure 2: Average Annual Employment by Industry Sector in Maryland, 2015 to 2025**



Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
**2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available*
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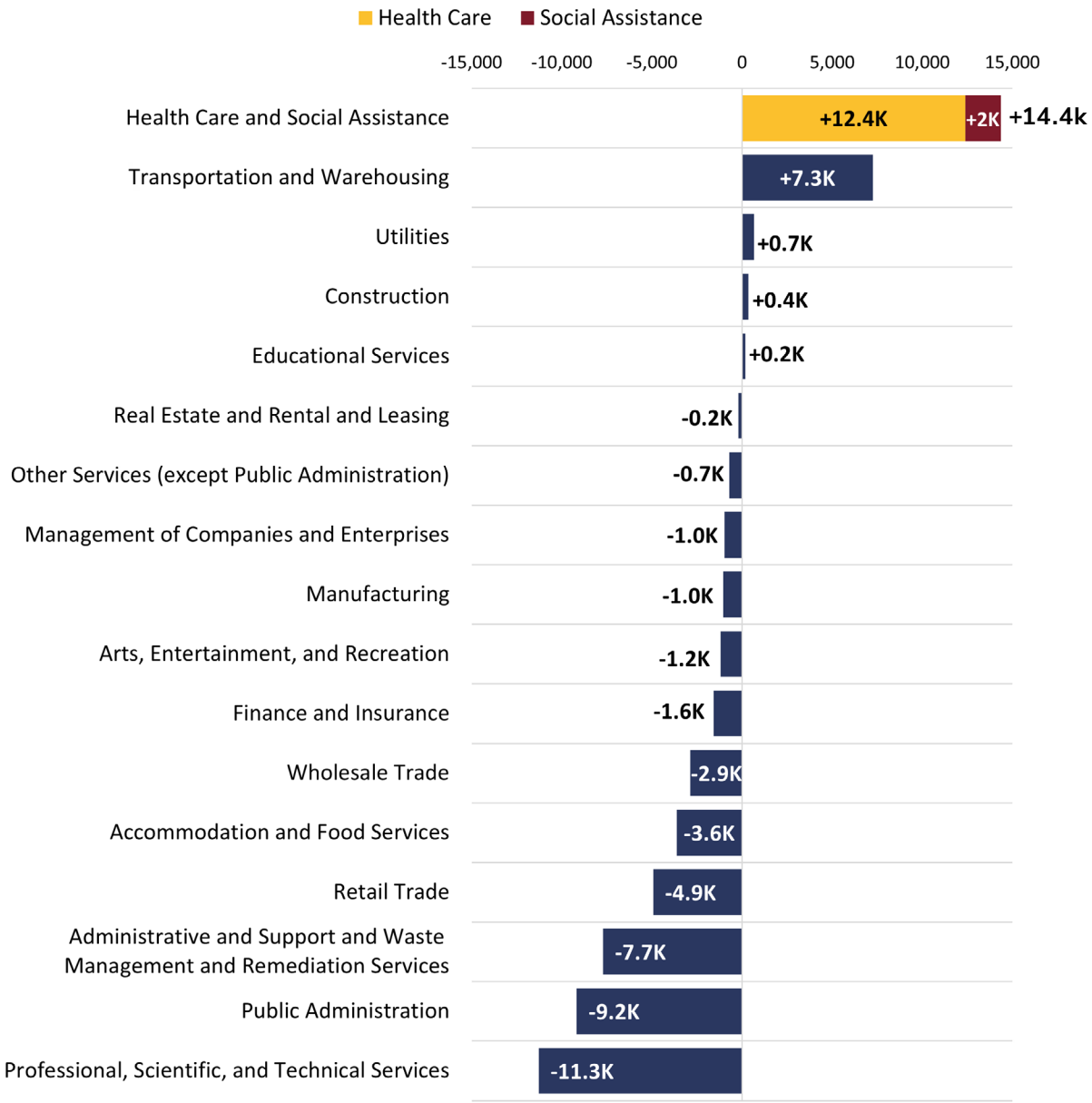
Over a quarter of the industry's growth in the past decade occurred in 2025. Average employment in health care and social assistance increased by 14,400 jobs in Maryland from Q3 2024 to Q3 2025, which was by far **the largest increase in jobs across all industries in the state**. Only four other industries saw job gains over that period; all others had losses (Figure 3).

Figure 3: Year-over-year Change in Employment by Industry in Maryland, Q3 2024 to Q3 2025



Source: Analysis of data from Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)

Notes: Industry sectors can include both public and private jobs; public administration includes federal, state, and local government jobs. There was another big drop in federal government jobs in the fourth quarter of 2025, which is not reflected here in third quarter data.

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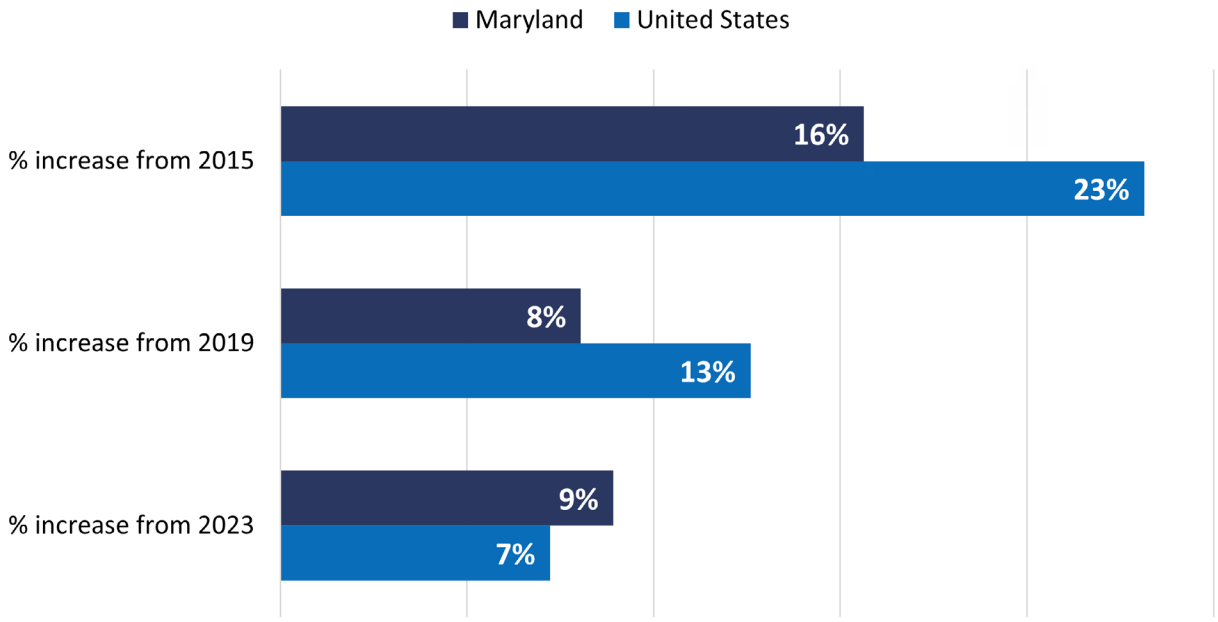
Despite comparatively strong growth, for most of the past decade the employment growth rate in health care and social assistance in Maryland has trailed the nation.[iv] However, since 2023, health care employment growth in Maryland (9%) has exceeded the national growth rate (7%) (Figure 4).

*Figure 4: Percent Change in Average Annual Employment for Health Care and Social Assistance to 2025**



Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
*2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available
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Drivers of Employment Growth

There are three key factors driving employment growth in the health care and social assistance industry in Maryland: (1) more people have access to health care; (2) more people need care; and (3) insurers cover more services and have increased reimbursement rates.

(1) More people have access to health care

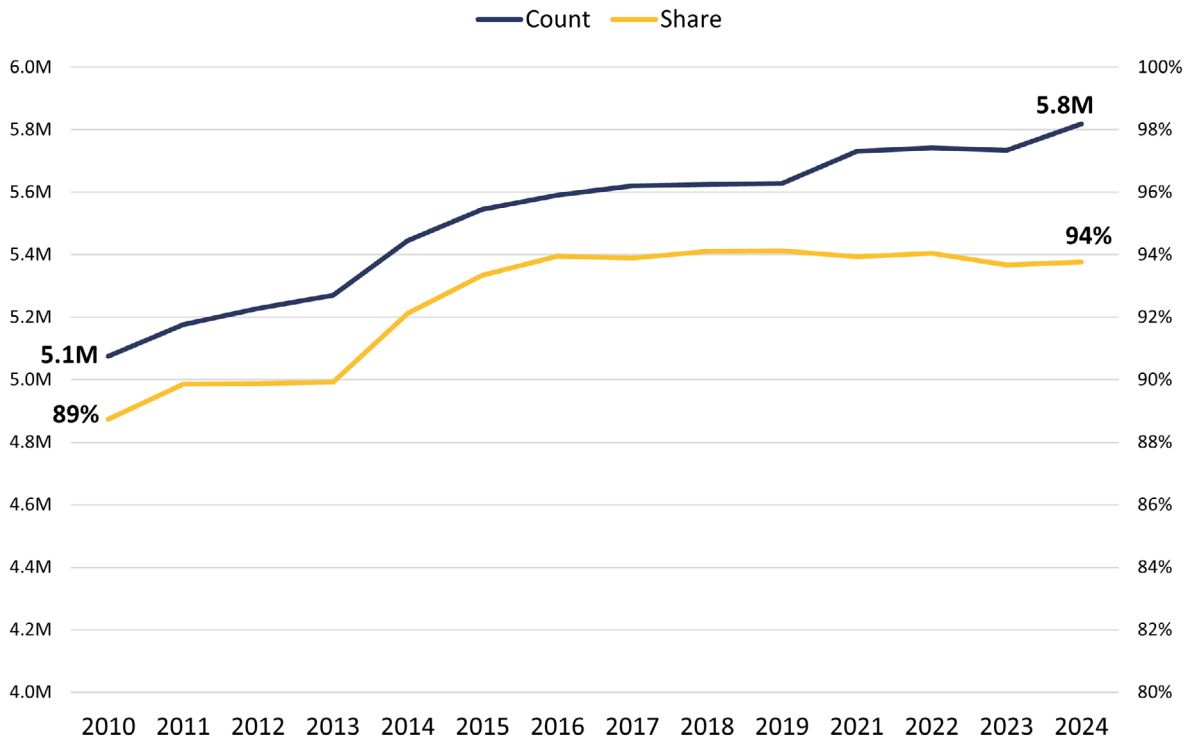
Nationally and in Maryland, the number of residents with health coverage has grown over the past 10 years, in large part due to the Affordable Care Act (ACA).[v] Approximately 94% of

iv Factors responsible for relatively slower growth could include: (1) Maryland's overall economic recovery from the pandemic has been slower than the U.S. (as measured by GDP growth and the state's labor force participation rate), (2) differences in demographic and morbidity trends, and/or (3) to the Maryland Model, discussed below.

v The individual health insurance Marketplace and Medicaid expansion (which both began in 2014 as part of the ACA) cover over half a million (569,000) Maryland residents today (2026).

Marylanders have health insurance coverage, and 6% (390,000 residents) are uninsured (Figure 5).[vi] More covered Marylanders means more residents can afford to obtain health care services. Increased demand for services drives up employment in the industry.

Figure 5: Share and Number of Insured Residents in Maryland, 2010 to 2024



Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 1-year samples
Note: ACS 1-year data is not available for 2020
View Table

(2) More people need care

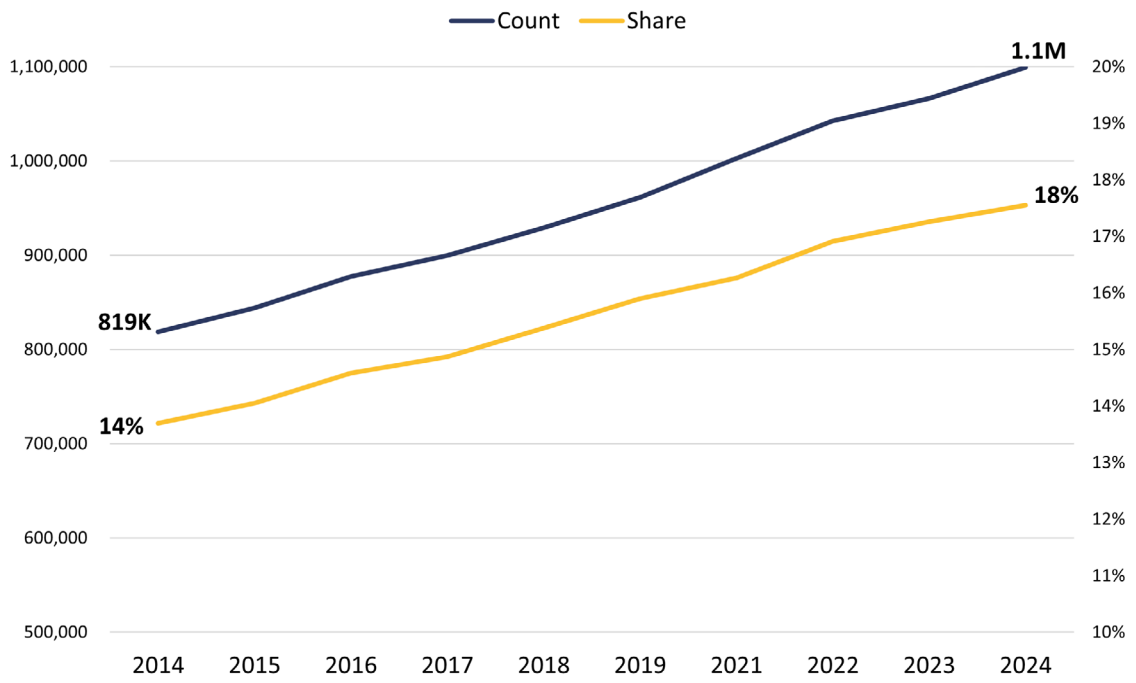
The population in Maryland, and across the country, is aging. As of 2024, 18% of the state's residents are 65 and over, totaling 1.1 million residents (Figure 6). [vii] The share and number of residents 65 and over has been the fastest-growing age group in Maryland over the past decade and is projected to continue to increase.[6, 7]

The implications for health care demand are substantial. A study in the National Library of Medicine found that while the health status of older Americans has improved over the last decade, adults 65 and over have far higher health care utilization than other age groups, and the majority have at least one chronic condition requiring care – commonly hypertension, cancer, or heart disease.[8] As Maryland's population of older adults grows, so will the need for workers to care for them.

vi Though certain populations, like Hispanic or Latino Marylanders, have lower rates of insurance coverage. See the Urban Institute Financial Health and Wealth Dashboard.

vii The share of residents 65+ nationally is also 18%.

Figure 6: Population 65 and over in Maryland, 2014 to 2024



Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 1-year samples
Note: ACS 1-year data is not available for 2020
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Aging is not the sole factor driving rising demand. The incidence of chronic conditions is on the rise across *all* age groups, both nationally and here in Maryland. According to the Maryland Department of Health (MDH), about half (52%) of Marylanders have at least one chronic health condition.[9] Since 2015, rates of obesity, hypertension, high cholesterol, and diabetes have all increased in the state.[10] Rates of mental illness are increasing as well, in part fueled by the COVID-19 pandemic.[11] At the same time, stigma around mental health is decreasing.[12] These factors drive up demand for health care and trigger employment growth.

Finally, climate change is an emerging driver of health care demand. Extreme weather events, such as heat waves,[viii] hurricanes, and floods, are increasing hospital admissions, while warming temperatures are expanding the prevalence of vector-borne diseases like Lyme disease and West Nile Virus.[13] The World Economic Forum estimates an additional $1.1 trillion "treatment burden" due to the climate crisis by 2050.[14]

viii Heat-related deaths among those over 65 have risen by 70% in two decades. Research attributes 37% of heat-related deaths to human-induced climate change. A study from Hong Kong published by the World Economic Forum found that every 1°C of temperature above 29°C equates to a 4.5% rise in hospital admissions.

(3) **Insurers cover more services and have increased reimbursement rates**[ix]

Over the past five years, Medicare and Medicaid have meaningfully expanded the services and devices that they cover – e.g., telehealth for behavioral health and routine checkups, opioid treatment, acupuncture, and more.[15, 16] In addition, Maryland has increased Medicaid reimbursement rates for many of these services. These policy changes drive up both supply and demand for the associated health care services.

- Expanded coverage – through new billing codes that allow practitioners to be reimbursed for previously uncovered services – simultaneously increases opportunities for providers to be paid for their work in the associated fields, and the services that patients can access (e.g., behavioral health services).
- As coverage broadens, the pool of people who can afford care expands and demand rises, driving job creation.
- Higher reimbursement rates make occupations more financially attractive, drawing workers into the field and expanding the workforce (e.g., counselors).

(1B) Employment in Industry Subsectors

Within the health care and social assistance industry, there are four main subsectors: (1) ambulatory health care services,[x] (2) hospitals, (3) nursing and residential care facilities, and (4) social assistance.[xi] This section describes employment growth trends in the state's two largest health care subsectors: ambulatory health care and hospitals.

Ambulatory health care services is the largest subsector, making up 39% of all health care and social assistance employment in Maryland, supporting 166,000 jobs (Table 1). It includes doctors' offices, home health care services, and outpatient care centers. Hospitals are the second largest subsector by employment share, supporting 121,000 jobs. Figure 7 examines employment growth within each of these industry subsectors over the past decade.

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ix A reimbursement rate is the amount that a health insurer (government or commercial) pays a health care practitioner/health care organization for specific health care service rendered.

x Ambulatory health care services are medical, diagnostic, or therapeutic services that are provided in an outpatient setting.

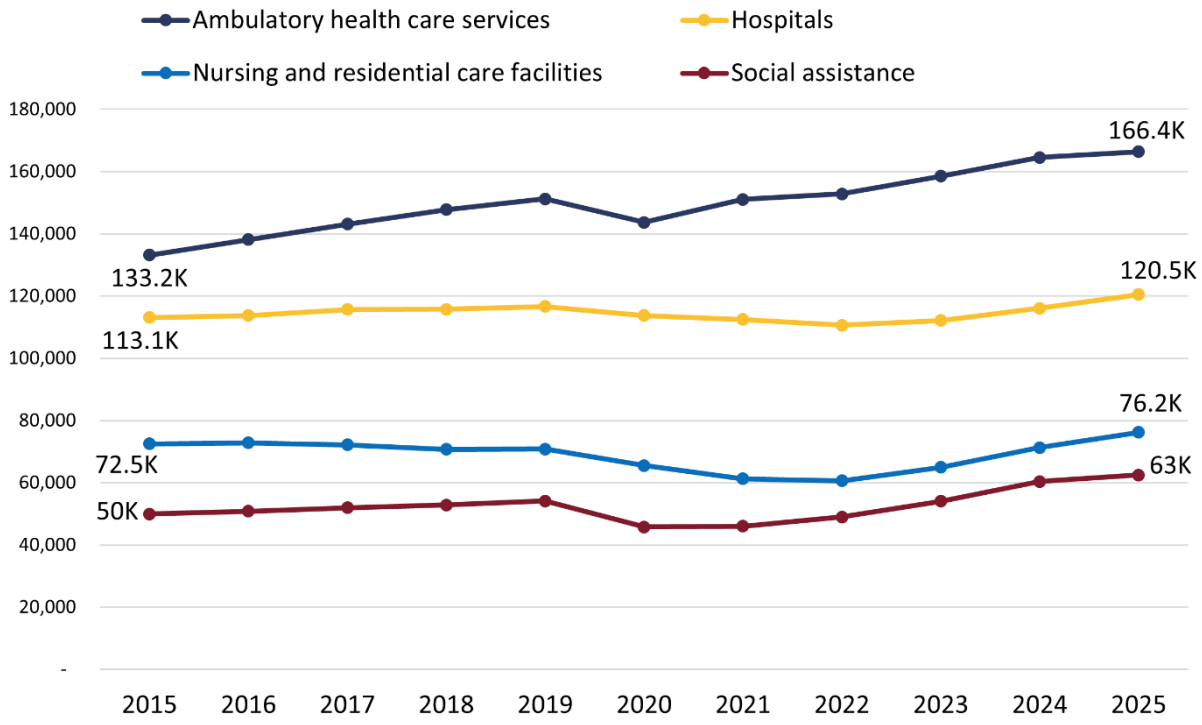
xi For a full breakdown of health care and social assistance employment at more detailed NAICS levels, see Table 5 in Appendix A.

*Table 1: Health Care and Social Assistance Employment by 3-digit Industry Subsectors in Maryland, 2025**

NAICS 3-digit Industry Subsector	Average Annual Employment	Share of Total
Ambulatory health care services	166,426	39%
Hospitals	120,520	28%
Nursing and residential care facilities	76,220	18%
Social assistance	62,506	15%
Health care and social assistance	**427,110**	

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
**2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available Note: Subsectors do not add up exactly to the total for health care and social assistance due to unclassified or suppressed data at the subsector level.*

*Figure 7: Maryland Employment for 3-digit Industry Subsectors of Health Care and Social Assistance, 2015 to 2025**



Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
*2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available
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Ambulatory Health Care Services

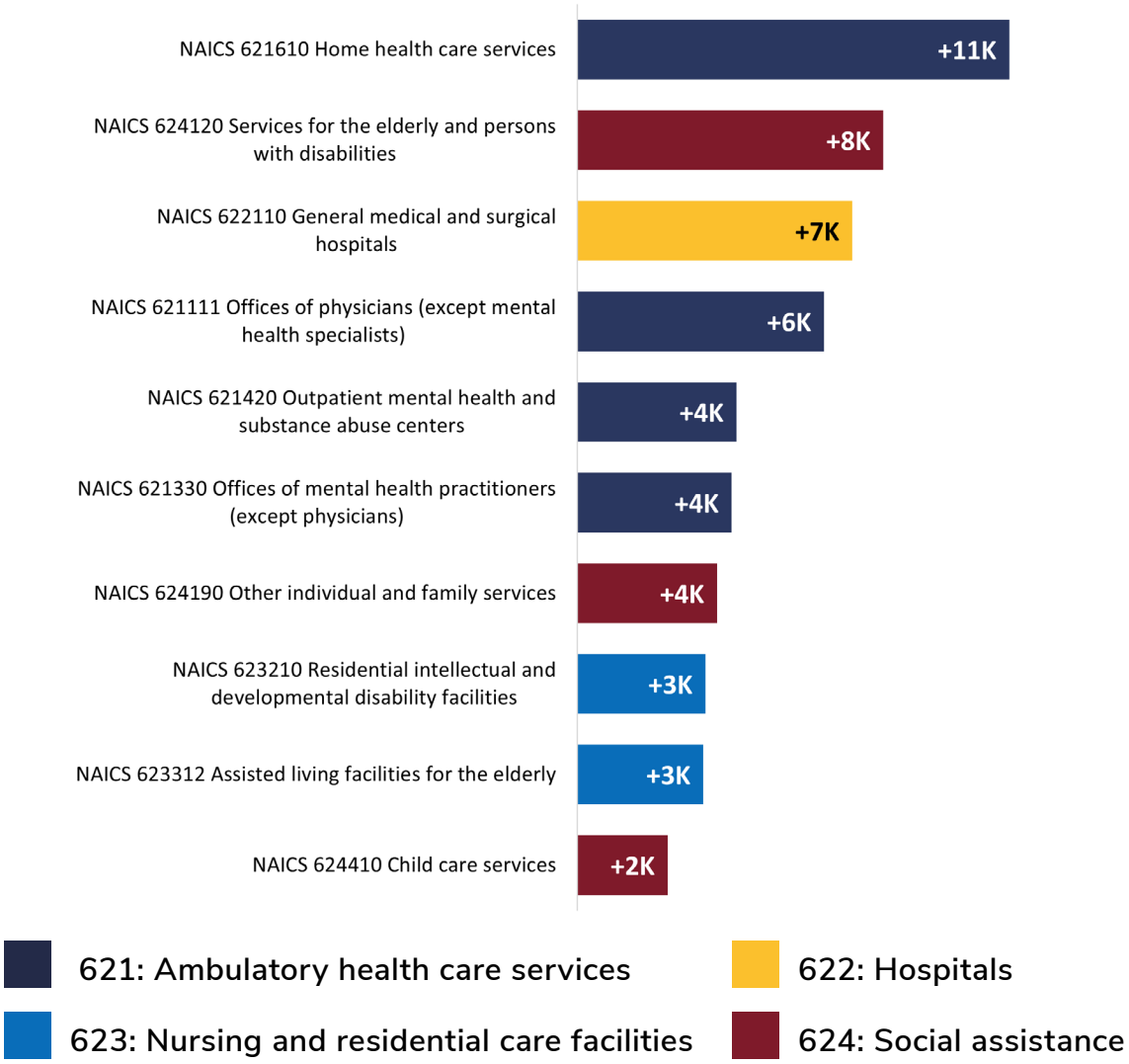
Since 2015, ambulatory health care services grew the most of the four subsectors, adding 33,000 jobs, a 25% increase. Nationally, the ambulatory subsector grew by 31% over the same time period.

Figure 8 examines the more detailed industry segments of the four health care subsectors. Most of the fastest growing segments – as measured by jobs added since 2015 – are under the ambulatory umbrella: (1) home health care services, (2) offices of physicians, and (3) mental health services (outpatient mental health and substance abuse centers; office of mental health practitioners).

- Home health care services added the most jobs of all segments in the health care and social assistance industry in Maryland over the past decade: 11,000 jobs, a 60% increase. (This outpaced national home health care services growth; 36% increase.)
- Offices of physicians added just over 6,000 jobs in Maryland over the past decade, a 13% increase (slightly less than national growth).
- Outpatient mental health and substance abuse centers and office of mental health practitioners added 4,000 jobs each over the past decade, representing a 331% increase and a 100% increase, respectively. (Both outpaced national growth.)

The discussion below explores why these segments – and thereby the ambulatory subsector – have experienced such substantial employment growth over the past decade in Maryland.

*Figure 8: Top 10 6-digit Industry Segments of Health Care and Social Assistance (That Added the Most Jobs) in Maryland, 2015 to 2025**



Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
**2025 data is based on the average of the first three quarters of 2025, as fourth quarter data is not yet available*
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(1) Home health care services

- The vast majority of people want to stay in their homes as they age for reasons that include convenience and affordability. As the population of older Marylanders continues to grow and the costs of care remain high, this trend is expected to continue to impact home health demand.[17] According to the Genworth Cost of Care Study, the median annual cost of care in a Maryland nursing home is $146,000, while the median cost of in-home care (30 hours per week) is $42,000. The cost consideration is particularly relevant as poverty rates for Marylanders 60+ are on the rise (13% increase since 2019).[18]

- Advances in technology have helped make home health care possible. The evolution of telehealth, remote patient monitoring, and devices like smart medication dispensers allow doctors and nurses to track their patients' health status without seeing them in a medical setting (with assistance from home health and personal care aides).[19]
- Reimbursement rates for Medicaid Long Term Services and Supports, Home and Community Based Services (HCBS), and services provided through the Developmental Disabilities Administration all increased in Maryland each year between FY17 and FY25. The vast majority of these services are provided by home health and personal care aides and nursing assistants.[20]
- The state has made deliberate efforts to expand access to HCBS by reducing the waitlist for its waiver programs and redesigning pre-Medicaid long term services and supports programming. According to MDH, the state increased spending on HCBS by 21% between FY24 and FY25.[21]

There are 54 home health agencies in the state as of 2023, according to data from the Maryland Health Care Commission. This number has remained steady over the past decade despite substantial employment growth in home health care and in the home health and personal care aide occupation (discussed in Section 2), indicating that these firms must be getting larger.[22]

(2) Offices of Physicians[xii]

- Technological advances have made many procedures less invasive, which reduces recovery times and makes it possible for more services to be delivered in an outpatient setting.[23]
- The aging population increasingly requires services that are delivered in physicians' offices, such as joint replacements and pacemaker implantation.
- Centers for Medicare and Medicaid Services (CMS) has expanded the list of procedures that are reimbursable when performed in this setting (versus a hospital).[24]
- Most patients (of all ages) prefer to obtain outpatient services in a physician's office rather than in a hospital – it tends to be more convenient and affordable.

Many hospitals are capitalizing on the market trend towards ambulatory care by opening or acquiring off-site physicians' offices. Because hospitals in Maryland operate under a global budget model where revenue is capped (discussed below), they are incentivized to shift patient care, as appropriate, to outpatient settings, which fall outside of their global budgets.[25] This can increase hospital margins and subsidize some of their expenditures. This may help explain why the ambulatory care subsector is growing so much faster than the hospital subsector in the state (Figure 7), and why Maryland has

xii Offices of Physicians (except Mental Health Specialists) – NAICS 621111 – includes private or group practices of doctors in general or specialized medicine such as primary care, surgery, dermatology, gynecology, cardiology, ophthalmology, plastic surgery, etc.

the fifth-highest number of ambulatory surgical centers in the U.S. (344 as of 2023), despite ranking 19th in population size.[26]

Another factor at the national level, as well as here in Maryland, is the growth of private equity firms as owners of physicians' offices, which creates added financial incentives for physicians to open and sell private practices. According to the American Medical Association, 6.5% of physicians characterized their practice as private equity-owned in 2024, an increase from 4.5% in 2020.[27]

(3) Mental health care services

- Utilization of behavioral health services is increasing, and the expansion of telehealth has made these services accessible to more people.[28, 29]
- CMS has expanded access to mental health care, and Maryland's Medicaid program provides optional, additional behavioral health coverage beyond what is required by CMS.[30]
- The state has increased reimbursement rates for behavioral health care providers (between 3.25% and 4% growth each year since FY2019) through Maryland's Medicaid program.[31]

Hospitals and the Maryland Model

Since 2015, hospital employment has grown by 7%, adding 7,000 jobs in Maryland. While meaningful, this represents about half the national hospital employment growth rate (15%) during the same period. However, by many other metrics – including hospitals' financial stability, patient outcomes, and cost control – Maryland has excelled.[32, 33, 34] Both trends are in large part attributed to the "Maryland Model": Maryland's unique system regulating how much (and by whom) hospitals are paid for the services they provide. It is intended to control hospital cost growth, increase the quality of care, and improve population health. **The Maryland Model plays a significant role in shaping employment and revenue growth within hospitals.**

There are two core components to the Maryland model:

1. **Rate setting** (established in the 1970s) ensures that all insurers operating in Maryland – Medicare, Medicaid, and commercial insurers – pay approximately the same reimbursement rates for services rendered in regulated hospitals. To achieve this parity, Medicare and Medicaid pay Maryland hospitals approximately 22% more per unit (per single procedure, test, etc. that a patient receives) than they do in other states, and commercial insurers pay about 25% less per unit. This policy impacts hospitals, patients, and the state in meaningful ways: (1) hospitals receive the same payment regardless of a patient's insurance coverage; (2) all regulated hospitals in Maryland accept Medicare and Medicaid, giving patients broader access to health care; and (3) the state receives more federal revenue for health care relative to other states, because Medicare and Medicaid are paying elevated per-unit rates in Maryland.

(Though changes to the Model are underway that will cap federal revenue for Maryland hospitals, discussed in Section 4A.)

2. **Global budgets** (established in 2014) are akin to annual block grants – hospitals are allocated a predetermined amount of revenue for the year decoupled from the number of patients served. This payment design is intended to encourage hospitals to curb spending and improve patient outcomes. Hospitals are incentivized to (1) invest in public health and preventative care to improve population health and reduce avoidable hospitalizations; and (2) improve the quality and efficiency of care delivered in hospitals. If hospitals achieve these goals, they are "rewarded" with savings. The Maryland Model is an example of a **value-based care model**, designed to link payment to patient outcomes instead of volume.[xiii] Most other states operate under a **fee-for-service model**, so they increase their revenue by increasing volume. Maryland hospitals increase margins by reducing excess utilization and achieving quality of care goals; in Maryland, excess volume reduces rather than increases revenue margins.

The Model helps explain why hospital employment has grown at nearly half the national rate in Maryland. Because hospitals are rewarded for reducing inappropriate patient volume, expansion is structurally discouraged (though it is actively encouraged in lower-cost settings, such as primary care). Post-pandemic, inflation has driven up the costs of drugs, supplies, wages, equipment, etc; demand has increased; patients are sicker; and there is heightened competition for workers. According to hospital administrators engaged for this report, all of this has made the global budget model challenging as it can restrict their ability to raise revenue for things like increased staff, competitive pay raises, capital projects, and investments in technology.[35] A recent study published in Health Affairs details other downsides associated with the Model, including longer emergency room wait times in Maryland compared to most other states due to resource constraints and industry centralization or consolidation. [36]

The Model offers critical upsides:

1. **Stability:** Rural hospitals, which often struggle with low patient volumes, and urban hospitals serving low-income communities benefit from predictable, guaranteed revenue streams. The Model may help explain why there have been no hospital closures in Maryland for at least 20 years, whereas the majority of states (30) have had two or more closures.[37]

2. **Patient outcomes:** Data suggest that the Model is having a positive impact on patient outcomes: (1) a 2019 study found that the Model helped reduce potentially preventable conditions by 51%,[38] and (2) a 2024 progress report on the Maryland Model found a 17% reduction in preventable hospital admissions between 2019 and 2022.[39]

xiii There have been three iterations of value-based care in Maryland: the "All Payer Model" (CY2014-2018), the "Total Cost of Care Model" (CY2019-2025); and the AHEAD Model (CY2026-2034).

3. Cost savings: Everyone benefits from the cost savings achieved when preventable hospitalizations are reduced and when patients receive care in a more cost-effective care setting (e.g., a physician's office instead of a hospital): businesses, individuals, and governments pay lower health care costs. Studies suggest that this shift is well underway in Maryland, and that Maryland is leading the nation. Between 2019 and 2022, the Model is credited with reducing hospital costs by 6.1%, amounting to $1.6 billion in savings. At the same time, there was a 3.1% increase in nonhospital spending, likely reflecting the movement of patients to lower-cost care settings.[40, 41] Figure 27 in the Appendix reveals that many outpatient care settings are growing faster in Maryland than in the U.S., which may be attributable to this shift.

Section 2: Occupation Data

This section describes the types of jobs supported by and people employed in Maryland's health care workforce. The health care workforce is grouped into two broad categories under the Standard Occupational Classification (SOC) system:

1. **Healthcare practitioners and technical occupations** – This group includes physicians, registered nurses, nurse practitioners, pharmacists, dentists, and other licensed professions that diagnose and provide medical care. (174,000 employees in Maryland)

2. **Healthcare support occupations** – This group includes workers who support doctors and nurses and handle direct patient care, such as home health and personal care aides, nursing assistants, medical assistants, and dental assistants. (100,000 employees in Maryland)

Together, these two occupation groups account for 274,000 workers in Maryland. Most are employed within the health care and social assistance industry, though some work elsewhere (a school nurse, for instance, falls under the educational services industry sector). Combined, employment in these occupation groups has grown 21% over the past decade, adding 48,000 jobs in Maryland from 2014 to 2024. Most of that growth (31,000 jobs) has been in the health care support occupations, largely driven by tremendous growth in home health care.

Table 2 details (1) total employment, (2) employment growth – percentage increase or decrease in each occupation since 2019 and 2023, respectively – and (3) median wages for each of the 10 largest health care occupations in Maryland.[xiv]

xiv While not technically categorized under health care in SOC, the substance abuse, behavioral disorder, and mental health counselor occupation is also included in this analysis due to its prevalence in mental and behavioral health related industries, which have been growing in Maryland.

Table 2: Employment Data for Top 10 Healthcare Occupations in Maryland, 2024

Occupation	Total Employment	% Change in employment from 2019	% Change in employment from 2023	Annual Median Wages
Registered Nurses ★	48,980	-8%	-2%	$96,830
Home Health and Personal Care Aides ♥	38,520	21%	24%	$36,970
Nursing Assistants ♥	24,230	-16%	-2%	$40,000
Medical Assistants ♥	14,700	12%	2%	$45,060
Physicians, All Other [xv] ★	9,800	*	33%	$209,370
Licensed Practical/Licensed Vocational Nurses ★	9,510	-2%	24%	$69,870
Pharmacy Technicians ★	8,590	12%	7%	$43,100
Substance Abuse, Behavioral Disorder, and Mental Health Counselors ▲	8,180	67%	6%	$57,820
Clinical Laboratory Technologists/Technicians ★	7,150	-3%	3%	$60,150
Nurse Practitioners ★	6,640	80%	28%	$125,530

**Due to changes in how occupations were categorized, 2019 data is not available for this occupation*
Source: Bureau of Labor Statistic (BLS), Occupational Employment and Wage Statistics (OEWS)

Health Care Occupation Group Legend

★ Healthcare practitioner and technical occupations **♥ Healthcare support occupations**

▲ Community and social service occupations

xv Physicians, All Other (SOC 29-1229) is the largest physician occupation in Maryland and the U.S. in BLS employment data. It accounts for just over half of physician occupations in Maryland (nearly 10,000), but excludes several specialty doctors including anesthesiologists, cardiologists, dermatologists, emergency medicine physicians, family medicine physicians, general internal medicine physicians, neurologists, obstetricians and gynecologists, pathologists, pediatricians, psychiatrists, and radiologists. These speciality doctors have their own SOC occupation codes. When counting *all* physician occupations, including these specialty occupations *and* "physicians, all other," the total employment is 18,400 according to BLS data.

Total Employment

Registered nurse (RN) is the largest health care occupation and the 5th largest occupation across all industries in the state, with nearly 50,000 jobs.[xvi] Home health and personal care aide is the second largest health care occupation in Maryland and the 11th largest out of all occupations in the state, with almost 40,000 jobs.[xvii] Nursing assistants, medical assistants, and physicians round out the five largest health care occupations in Maryland.

Employment Growth

Registered nurses and nursing assistants have been on a steady downward employment trend since 2019, while nurse practitioners and home health and personal care aides have experienced substantial and continued employment growth since 2019. Licensed practical/licensed vocational nurses and physicians have experienced significant employment growth more recently (since 2023).

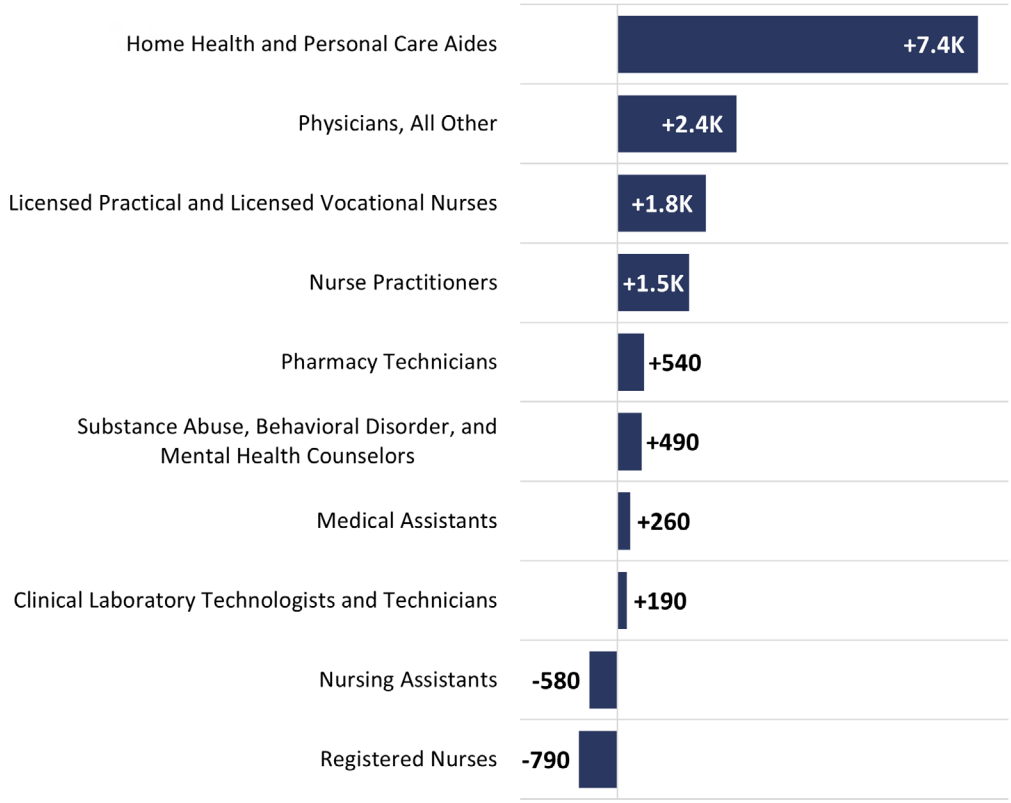
Figure 9 depicts the **number of jobs** added in each of the top 10 health occupations in Maryland between 2023 and 2024. Home health and personal care aides led by a wide margin, followed by physicians, licensed practical/licensed vocational nurses, and nurse practitioners.[xviii]

xvi Top 4 occupations by employment in Maryland are (1) general and operations managers; (2) retail salespersons; (3) secretaries and administrative assistants; and (4) cashiers.

xvii A discussion about how the share of health care workers in each occupation in Maryland compares to the national average – also known as the location quotient – is included in Appendix B.

xviii Other health care occupations that added more than 500 jobs in Maryland between 2023 and 2024 include: speech-language pathologists (1,000), general internal medicine physicians (1,000), therapists (770), surgical assistants (680), emergency medicine physicians (660), and diagnostic medial sonographers (650). These are not included in Table 2/Figure 9 because they are not among the 10 largest health care occupations in Maryland.

Figure 9: Change in Employment for Top Health Occupations, 2023 to 2024



Source: Bureau of Labor Statistic (BLS), Occupational Employment and Wage Statistics (OEWS)
View Table

Income and Wages

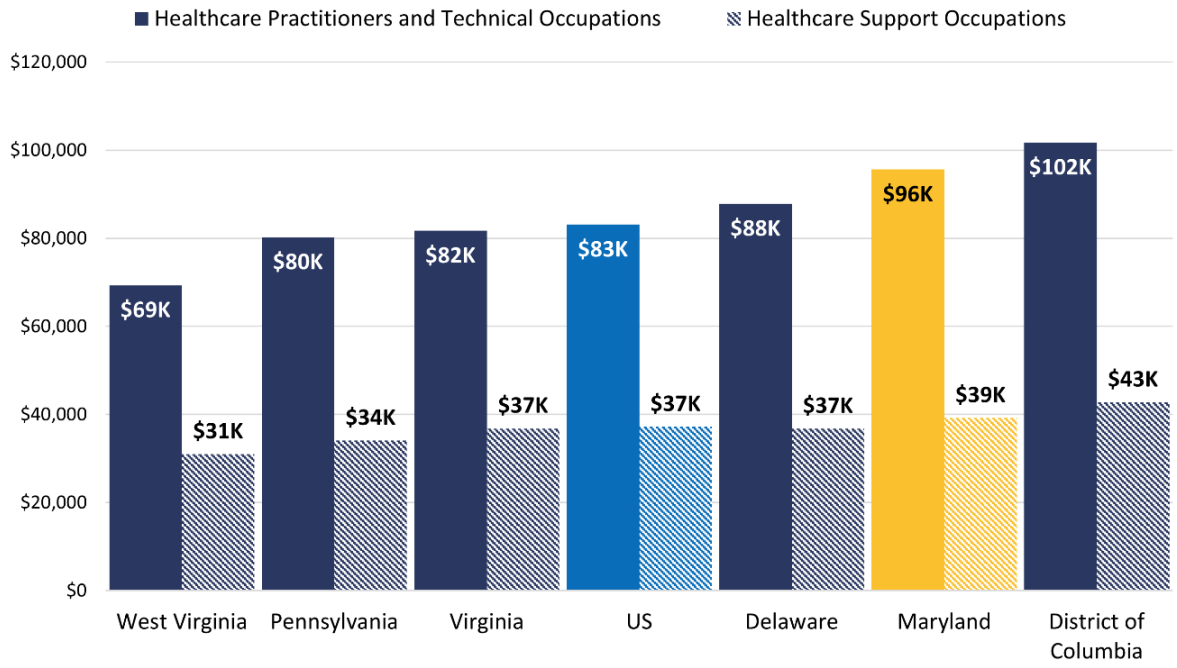
Wages within health care vary meaningfully by occupation. Median wages for practitioner and technical occupations ($96,000) are more than double median wages for support occupations ($39,000). Despite this internal disparity, Maryland's health care wages are generally competitive in the region. Across all health care occupations, Maryland's median wages exceed the national average and those of every neighboring state except Washington, D.C. – a pattern that holds for most major occupations, including RNs (Figure 10).

However, this is not the case for most physicians in Maryland. Though they are among the highest-paid occupations in the health care industry in Maryland (with average annual wages of $217,000[xix]), physician pay in the "Physicians, All Other" occupation in Maryland trails every neighboring state

xix This wage data is for average rather than median because median wage data was not available for all geographies for comparison. Median annual wages for Physicians, All Other in Maryland was $209,370 in 2024 as seen in Table 2.

except D.C., and falls well below the national average (Figure 11).[xx] The **"Physicians, All Other"** occupation is the largest physician occupation in Maryland, the U.S., and neighboring states, according to BLS employment data.[xxi] It accounts for just over half of physicians in Maryland (nearly 10,000). However, it excludes many specialty doctors, some of whom earn higher wages. For example, **general internal medicine physicians** (the next-largest physician occupation in Maryland, with 4,130 jobs) had an average annual wage of $271,000 in Maryland, which is higher than the national average of $263,000 for this occupation. (See Appendix A Table 6 for additional detailed physician wage data.)

Figure 10: Median Annual Wages for Major Healthcare Occupation Groups, 2024

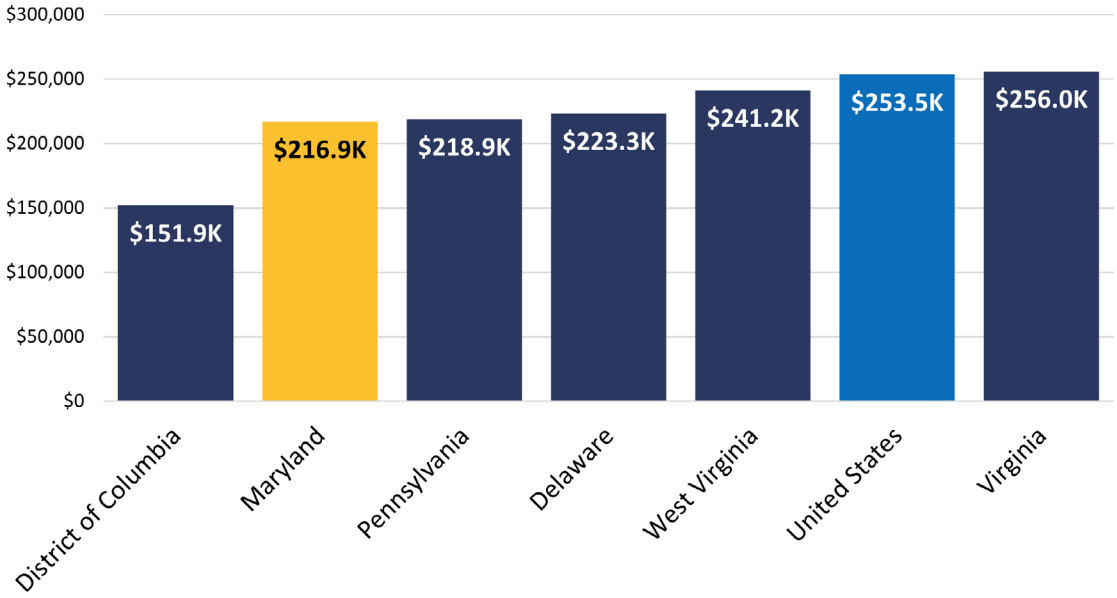


Source: Bureau of Labor Statistics (BLS), Occupational Employment and Wage Statistics (OEWS)
View Table

xx Maryland's cost of living ranks higher than Pennsylvania, Delaware, West Virginia, and Virginia, making this disparity even more significant. (Cost of Living Data Series | Missouri Economic Research and Information Center)

xxi Physicians, All Other (SOC 29-1229) is a residual classification that includes physicians who do not fit in one of the detailed specialty physician codes. It can include hospitalists (primary care doctors who work in a hospital), preventive medicine physicians, or specialty doctors not covered by other codes such as urologists and sports medicine physicians.

Figure 11: Average Annual Wages for Physicians, All Other, 2024



Source: Bureau of Labor Statistic (BLS), Occupational Employment and Wage Statistics (OEWS)
View Table

Composition of the Health Care Workforce

Maryland's health care workforce is disproportionately female, Black, and foreign-born relative to the state's population overall, and higher compared to the U.S. and neighboring states. The data demonstrate a dependence on immigrants and women – in large part Black women – in low-wage health care jobs in particular. (Note: The workforce demographic data is based on *Maryland residents* working in health care occupations, not jobs located in Maryland; see methodology section.)

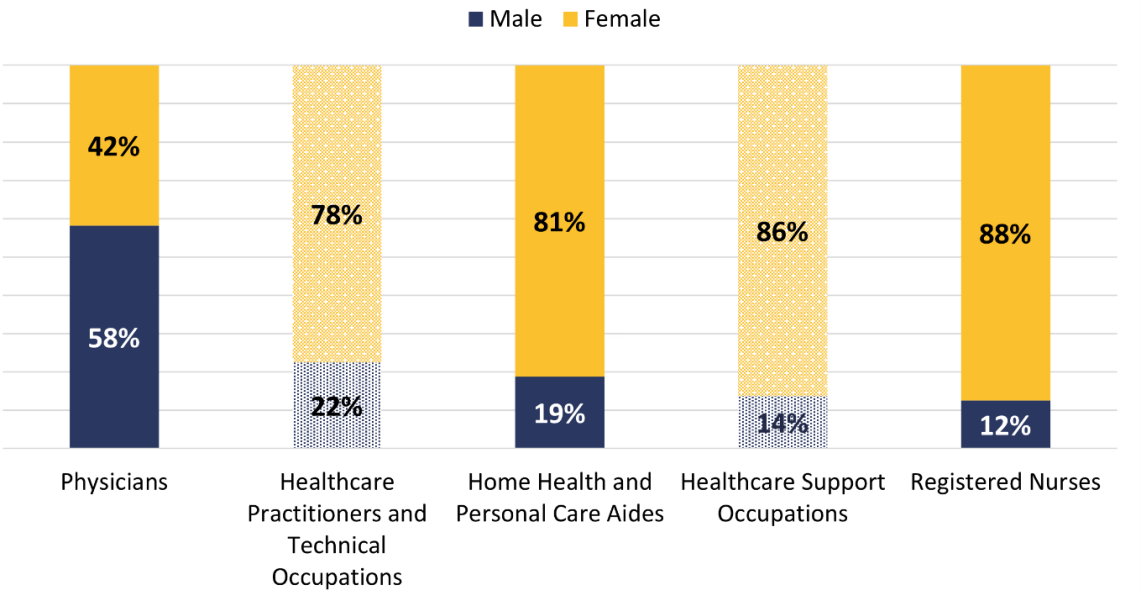
- **Women** make up 78% of workers in healthcare practitioner and technical occupations and 86% of healthcare support workers in Maryland. The one notable outlier: physicians are majority men (58%), consistent with national trends (Figure 12).
- **Black** residents comprise 32% of the workers in healthcare practitioners and technical occupations, and 54% of healthcare support workers in Maryland (Figure 13, Figure 14), shares that are significantly higher than in Virginia, Pennsylvania, and are more than double national shares.
- **Foreign-born residents** make up 28% of workers in healthcare practitioner and technical occupations and 34% of health care support workers in Maryland – higher shares than the U.S. and all neighboring states (Figure 15).[xxii] This indicates that Maryland's health care workforce

xxii The share of immigrant workers in health care support occupations (28%) is the third highest across all occupation groups in Maryland behind (1) building and grounds cleaning and maintenance and (2) construction and extraction; health care practitioners and technical support ranks 6th (Appendix A, Figure 29).

relies more heavily on immigrants, making it disproportionately vulnerable to anti-immigration actions (discussed further in Section 4).

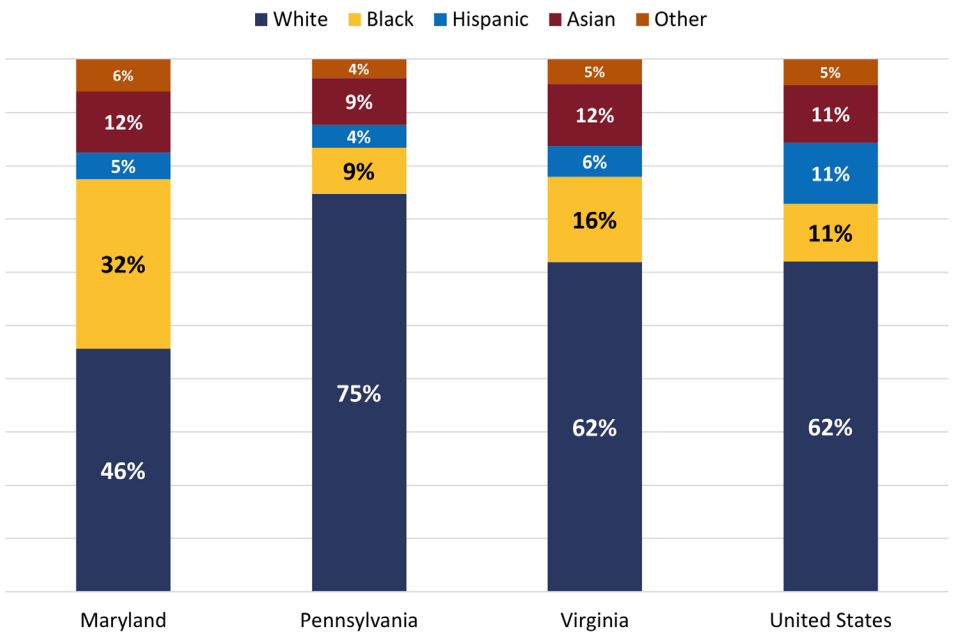
- **Older workers** are a defining feature of Maryland's practitioner workforce. Residents 65-plus comprise 11% of workers in healthcare practitioner and technical occupations in Maryland – nearly double the national share (6%) (Figure 16). The age distribution of a few key occupations helps demonstrate this trend: (1) The median age of RNs in Maryland is 47, which is the second highest of all states in the country, behind only Wyoming. (2) The median age for physicians in Maryland is 53, which is the fourth highest of all states, behind Alaska, Montana, and South Dakota. Almost half of physicians in Maryland are age 55 or older; nationally, only 30% are age 55 or older. Health care support workers in Maryland skew younger and more closely mirror regional and national age patterns.

Figure 12: Share of Health Care Occupations or Occupation Groups by Sex in Maryland, 2024



Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
Note: Physicians from IPUMS data includes a broader group of physician occupations including specialty doctors. The physician occupation here includes SOC codes for Anesthesiologists, Cardiologists, Dermatologists, Emergency Medicine Physicians, Family Medicine Physicians, General Internal Medicine Physicians, Neurologists, Obstetricians and Gynecologists, Pediatricians, Pathologists, Psychiatrists, Radiologists, and Physicians, All Other.
View Table

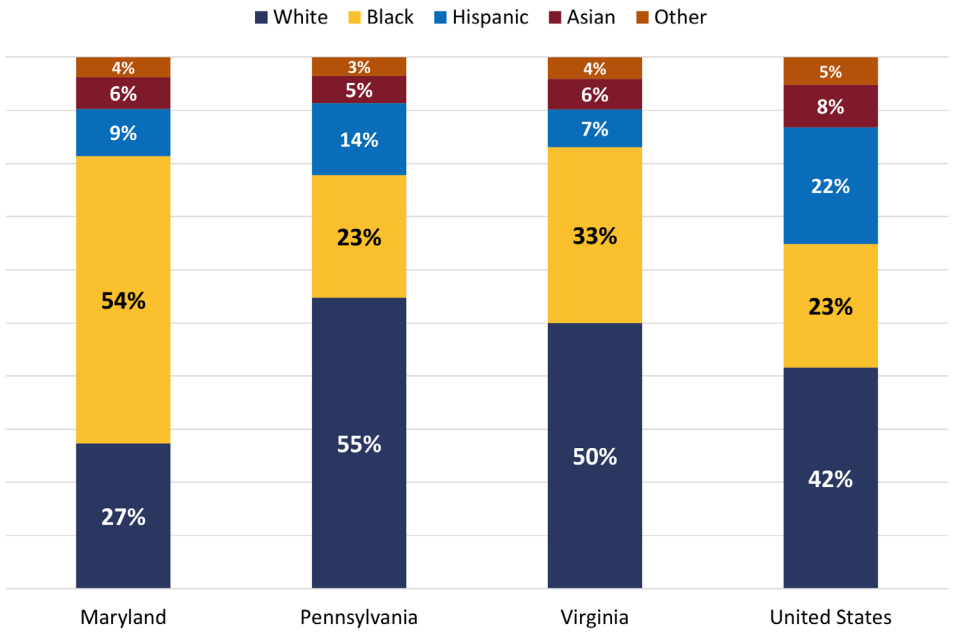
Figure 13: Healthcare Practitioners and Technical Occupations by Race and Ethnicity, 2024



Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
Note: Delaware, the District of Columbia, and West Virginia have too small sample sizes of some racial groups in health care occupation groups to be confident in using those estimates.

View Table

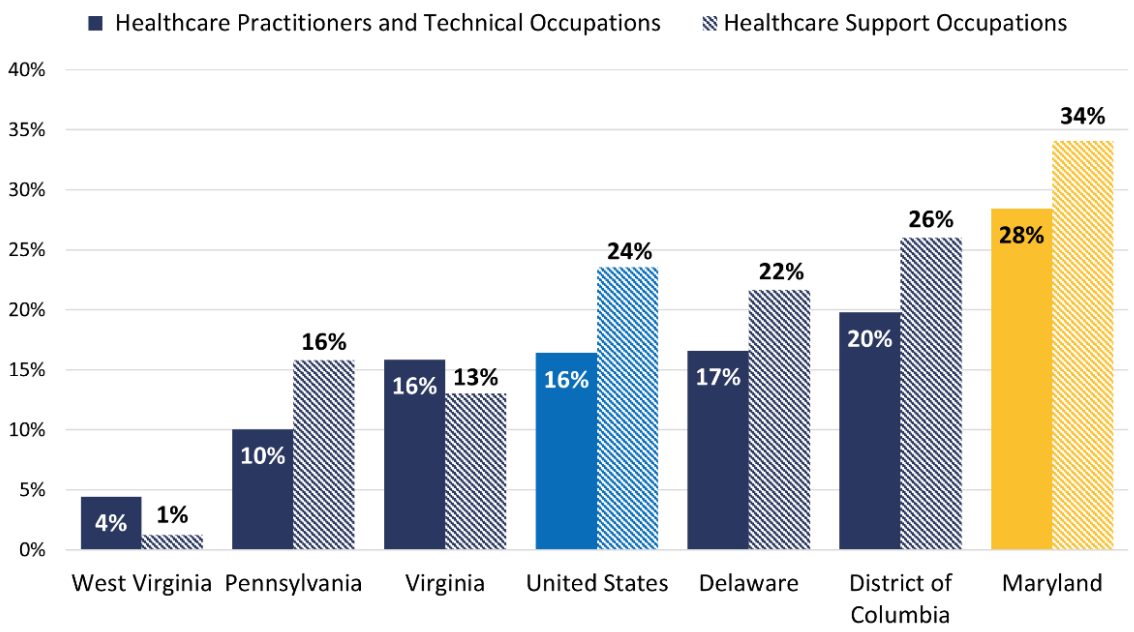
Figure 14: Healthcare Support Occupations by Race and Ethnicity, 2024



Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
Note: Delaware, District of Columbia, and West Virginia have too small sample sizes of some racial groups in health care occupation groups to be confident in using those estimates.

View Table

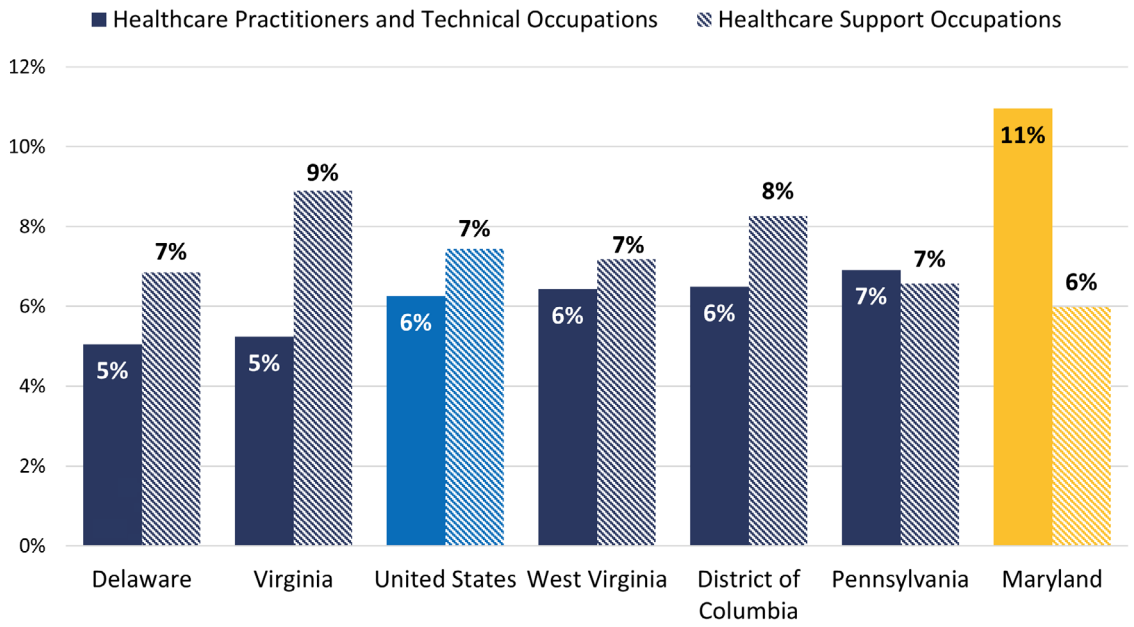
Figure 15: Foreign-born Share of Healthcare Occupation Groups, 2024



Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample

View Table

Figure 16: Share of Health Care Occupation Groups Age 65 and over, 2024



Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample

View Table

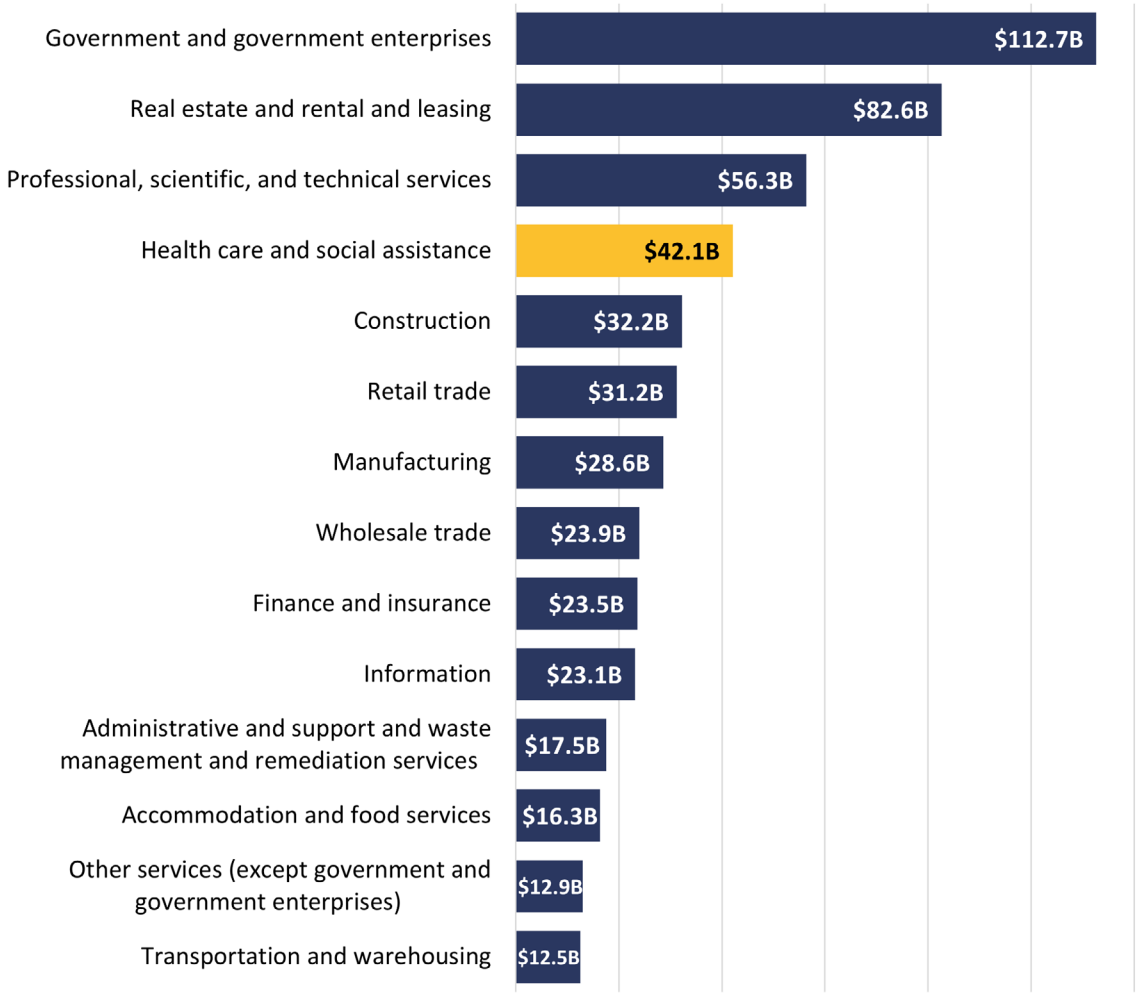
Section 3: Economic Activity Data

Jobs are a large part, but not the only part, of the economic impact analysis. Maryland's health care sector also shapes the state's economy through wages, gross domestic product, hospital spending, tax revenue, and ripple effects across communities.

Gross Domestic Product (GDP)

Health care and social assistance is the state's fourth-largest industry by GDP, contributing $42 billion in 2024, accounting for **8% of Maryland's total GDP** ($546 billion). Government made up the largest share of the state GDP (21%, or $112.7 billion), followed by real estate and rental and leasing, and professional, scientific, and technical services (Figure 17).

Figure 17: Maryland GDP by Industry Sector, 2024

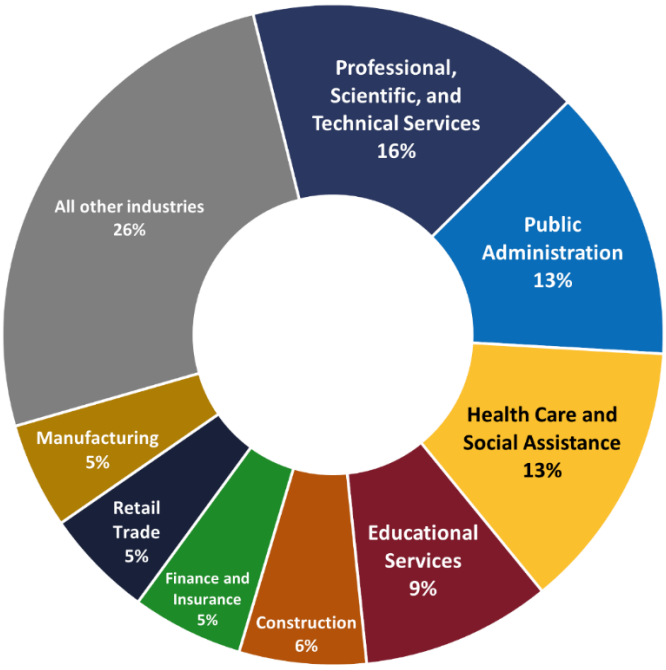


Source: Bureau of Economic Analysis (BEA)
Note: Figure only shows industries that make up more than 1% of Maryland's total GDP
View Table

Total Annual Wages

Health care and social assistance generated $28.7 billion in total wages in Maryland in 2024 – **13% of all wages paid in the state**, ranking the industry third behind the smaller but higher paying professional, scientific, and technical services industry ($36 billion in wages), and behind public administration ($29 billion in wages) (Figure 18).

Figure 18: Share of Total Wages in Maryland by Industry Sector, 2024



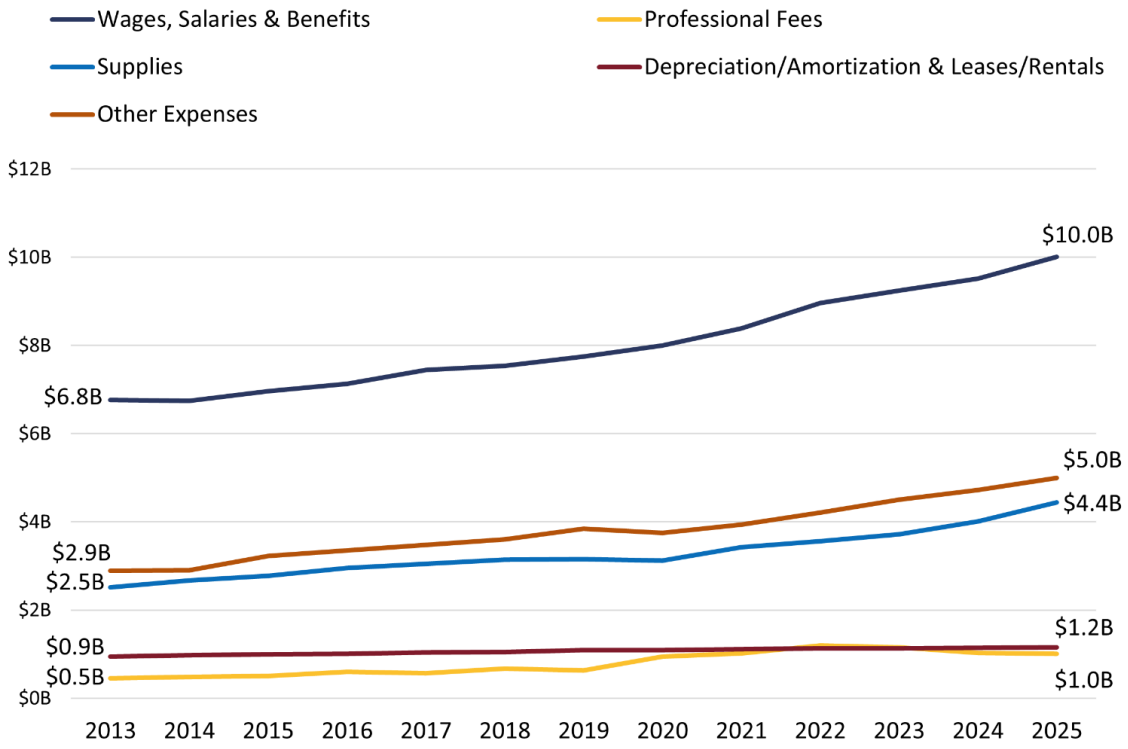
Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
View Table

Health System Spending and Revenue

The Maryland Health Services Cost Review Commission (HSCRC) tracks expenditures by 17 health care systems that operate 52 regulated hospitals in the state.[xxiii] In FY25, they collectively spent $23 billion on (1) wages, salaries, and benefits; (2) supplies; (3) professional fees; (4) depreciation/amortization and leases/rentals; and (5) other expenses [42] (Figure 19).

xxiii Adventist, CalvertHealth, ChristianaCare, Frederick, Greater Baltimore Medical Center (GMBC), Johns Hopkins, Lifebridge, Luminis, MedStar, Mercy, Meritus, St Agnes, TidalHealth, Trinity, University of Maryland Medical System, University of Pittsburgh Medical Center (UPMC), and West Virginia University (WVU). There are about 10 hospitals in the state not regulated by the HSCRC, plus six state-owned hospitals that are not included in this data.

Figure 19: Statewide Total Regulated Entity Expenses by Expense Category, 2013 to 2025



Source: Maryland Health Services Cost Review Commission (HSCRC)
View Table

A portion of these wages is an important source of state revenue. In 2025, the state collected approximately $526 million in income tax withholding from these 17 health systems.[xxiv]

In addition, businesses and economies benefit when health systems purchase goods and services. The Maryland Hospital Association, using HSCRC financial data, estimates that hospitals in Maryland purchased approximately $7 billion in goods and services in 2025.[43] (According to one hospital administrator interviewed for this report, drugs and immunotherapies, as well as medical devices such as implants and pacemakers, are among the top hospital expenditures on goods and services.[44]) Finally, in 2024, hospitals spent $2.3 billion on community benefits programs to support population health and access to care in their communities.[45]

xxiv This figure is based on tax payments from these health systems as tracked in state revenue databases. This is likely an undercount of the actual amount paid because employers tend to file taxes under various names and have subsidiaries or affiliates that makes it difficult to aggregate a complete and accurate amount of total taxes paid by a health system.

Indirect Impact and Multiplier Effect

The health care industry adds value to the state, local communities, and economies in several other ways. For example:

- The sector helps people get well: it improves the health of the labor force, which reduces sick days and increases productivity for all workers and across all industries.[46]
- Nonprofit hospitals – nearly all hospitals in Maryland – often have explicit commitments to community engagement and investment and make strategic decisions to spend and hire in a way that thoughtfully enhances the local economy while advancing equity. For example, in Baltimore City, Johns Hopkins University's HopkinsLocal initiative mobilizes the university and health system to promote economic growth and employment opportunities by hiring local residents, contracting with local businesses, and investing in community development projects. Over the past decade, HopkinsLocal has invested over $1 billion in Baltimore businesses and hired more than 2,100 justice-involved individuals.[47, xxv]
- Growth in health care has downstream effects on some adjacent sectors in Maryland's economy. Stakeholders interviewed for this report observed that medical technology companies (which supply equipment and tools that improve care quality and efficiency) benefit directly from hospital purchasing and, thereby, from growth in hospitals and other medical facilities. So do software firms developing AI applications and electronic medical record systems, many of which price their products on a per-employee basis, meaning that health care job growth translates directly into revenue for those companies.

However, health care's economic footprint, while large, has limits. Compared to industries like manufacturing and professional services, health care generates relatively few indirect jobs through its supply chains and has not experienced productivity gains that can amplify economic impact. Every health care job supports 2.1 jobs elsewhere in the economy – a meaningful contribution, but well below manufacturing (7.4 indirect jobs per direct job) and professional services (4.2).[48]

xxv Johns Hopkins is part of a larger, national effort called the Healthcare Anchor Network, which documents the ways that health systems across the country "leverage all of their assets - including their hiring, purchasing, investing, real estate, and voice - in concerted partnership with their peers and the community to address economic and racial inequities, and to create more inclusive, local economies." (Healthcare Anchor Network)

Section 4: Challenges

The health care industry differs from most other private sector industries in important ways:

- In many parts of the industry, demand is not discretionary – it is driven by population health and demographics, largely outside of anyone's control. (There are exceptions, like primary and preventative care, which patients elect to participate in.)
- Unlike most markets, costs are distributed across a collection of third-party payers: The federal government, state government, employers, and patients all share the bill. Many consumers of health care, including those covered by Medicaid, Medicare, or employers that pay a large portion of out-of-pocket costs are less price sensitive, while consumers with high-deductible plans who pay a larger portion of out of pocket costs are highly price sensitive.
- Unlike export-oriented businesses such as manufacturing or professional services that bring in outside revenues by selling goods and services to markets across the world, the health care sector has traditionally operated as a local service provider that is dependent on a narrow and limited market for support and growth. In recent years, however, health care has been increasingly expanding beyond local markets.[xxvi]

As a result of these factors, health care is less responsive to traditional market forces and business cycles that cause other industries to expand or contract. Historically, health care has grown far less than other industries during economic boons, while remaining steady or even growing during downturns. Economists refer to the industry as being recession proof.[49]

Growth in health care is positive because it creates jobs, but increased utilization, especially in more expensive care settings, comes at a cost borne by governments, businesses, and households. This growth in spending cannot be readily controlled because people typically don't have a choice about whether or not to obtain care. Rather than growing the overall economy, increased health care spending creates a crowding-out effect by redirecting resources from more productive investments, ultimately hindering long-term economic growth and lowering overall employment growth.[50, 51] The result is that health care becomes a larger slice of the economic pie. A data point explaining this trend is the increase in health care employment as a percent of overall employment: 25 years ago, health care jobs accounted for 11% of all jobs in both the U.S. and Maryland. Today, they are 16% in both the state and the nation.[52]

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xxvi For example, systems such as Johns Hopkins and Medstar own and operate facilities in multiple regions and states. These and other systems across the country export health care services by bringing patients to the U.S. for medical treatment and procedures and entering into various service agreements with international medical organizations (International Trade Administration). In addition, national private equity firms are buying and consolidating segments of the health care market, notably skilled nursing facilities, nursing homes, and physician practices (American Medical Association). In some cases, these practices create economies of scale and productivity gains, but in other cases, they prioritize volume over quality to generate profit and value for investors.

There are acute headwinds on the horizon. Major changes to federal health care spending are underway, with likely consequences for coverage and affordability, as well as cost-shifting to the state, employers, and residents in Maryland. At the same time, workforce challenges may limit Maryland's capacity to meet rising demand associated with shifts in demographics and morbidity: health care is deeply labor-dependent, and an industry that has historically struggled to achieve productivity gains has few levers to pull when workers are scarce.

(4A) Federal Policy Change

Table 3 outlines the status of current insurance coverage in Maryland by type.

Table 3: Insurance Coverage by Type

Type	Number of Marylanders Covered	Notes
Medicaid (1)	1,565,429	Means-tested, jointly (federal and state) funded, state-designed. The Medicaid expansion population is a subset of this group, with 439,444 enrollees.
Medicare (2)	1,148,648	Federally funded, uniform nationwide.
Affordable Care Act Individual Insurance Market (3)	300,991	This includes individuals enrolled both on the Maryland Health Benefit Exchange and off Exchange.
Group Insured Market (3)	540,532	This includes the small (2-50 employees) and large (50+ employees) group markets.
Self-insured employers (3)	1,782,049	This includes enrollees in the State of Maryland's Health Plan and the Federal Employee Health Benefits Plan.

Sources: (1) The Maryland Medicaid Dataport, Hilltop Institute, 2025. https://hilltopinstitute.org/public-dataport/#pac_dtm_child_3
(2) Kaiser Family Foundation, Total Number of Medicare Beneficiaries by Type of Coverage, 2024. https://www.kff.org/state-category/medicare/medicare-enrollment/.
(3) Maryland Insurance Administration, 2025. Maryland Insurance Administration Covered Lives report, 2025 https://insurance.maryland.gov/Consumer/Appeals%20and%20Grievances%20Reports/Report-required-by-Insurance-Article-15-133-Number-of-Insured-and-Self-Insured-Lives.pdf
Note: It is possible to have both Medicare and Medicaid, and/or both private and public health insurance.

Coverage Losses

Medicaid

In Maryland, approximately 1.6 million residents (or one in four residents) are enrolled in Medicaid, which grants them access to primary care, behavioral health, dental care, hospital care, nursing facilities and more, at no cost.[53] This includes 728,000 children (under 21), 800,000 adults (21+), 240,000 people with disabilities, and 63,000 pregnant women.[54] H.R. 1, or the One Big Beautiful Bill Act (OBBBA), makes significant changes to Medicaid, **which are estimated to cause 130,000 Marylanders to lose health insurance coverage.[55]** Two key changes include:

- Starting October 1, 2026, Medicaid coverage will be eliminated for many lawfully present immigrants, including refugees, asylees, immigrants granted parole for at least one year, and certain victims of abuse and trafficking.[xxvii] MDH estimates that 15,000 Maryland residents may lose coverage under this change.[56]
- Starting January 1, 2027, there will be new work requirements for most of the Medicaid expansion population (adults at the upper end of the Medicaid income eligibility threshold, earning up to 138% of the Federal Poverty Level). This population will also be subject to more frequent redeterminations of their Medicaid eligibility – shifting from once per year to once every six months. Both policy changes are expected to result in coverage losses and coverage lapses that will disrupt care: MDH estimates that 115,000 Marylanders could lose coverage under these changes, which represents about 35% of the 325,000 residents currently covered by Medicaid expansion.[57, 58, 59]

Given the income restrictions for Medicaid eligibility, it is unlikely that residents who lose their Medicaid coverage will be able to afford a high-quality health plan on the Individual ACA Marketplace: the OBBBA restricts eligibility for Marketplace tax credits for individuals who do not meet work requirements.[60] Depending on their health status and ability to work, some of these individuals may be able to access employer-sponsored coverage, provided they can secure employment and coverage is available at rates they can afford.[xxviii]

Marketplace

Approximately 300,000 Marylanders currently obtain coverage through the ACA individual market, with about 244,000 of those individuals purchasing coverage through Maryland's health insurance Marketplace – Maryland Health Connection.[61, 62, 63] These are typically residents who earn too much to qualify for Medicaid, but do not have access to health insurance through work: the self-employed, small business owners, part-time workers, etc.

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xxvii There are a few exceptions, including pregnant women.

xxviii Nationally, McKinsey estimates that 1 million Americans who lose Medicaid coverage due to these eligibility changes will obtain an ACA Marketplace plan, and another 1 million will obtain jobs where they have access to employer-sponsored insurance, leaving 5 to 6 million more people newly uninsured (McKinsey).

For most of them, affordability has depended on federal support. The Advanced Premium Tax Credit – a federal subsidy that provides premium assistance to Marylanders based on income – was utilized by 77% of Maryland Marketplace enrollees in 2025. In 2021, Congress made these subsidies more generous, which reduced premiums by an estimated 44% nationwide for eligible Marketplace consumers. However, the enhanced federal subsidies expired at the end of 2025 and were not renewed by Congress.[64] As a result, premiums in the individual market in Maryland increased by an average of 13.4% this year – more than double the largest annual increase since 2018. Certain groups are feeling the impact even more sharply, such as enrollees earning below 100% and enrollees earning above 400% of the Federal Poverty Level. [65, 66] **According to the Maryland Insurance Administration, reductions in the enhanced federal subsidy are expected to result in coverage losses as people are priced out of this insurance product.**[67]

In 2025, the Maryland General Assembly proactively created a temporary state subsidy in anticipation of the enhanced federal subsidies expiring.[68] This helped keep rates down, moderating premium increases for individuals who had been receiving the enhanced federal subsidies. Currently, 70% of Marketplace enrollees in Maryland receive an average state subsidy of $95 per month. This is a meaningful cushion, but not a full replacement of the federal credit, and it's unclear how long the state will be able to afford to offset federal cuts: the subsidy cost the state nearly $17 million in its first month (January 2026).[69]

In January 2026, the Maryland Health Benefits Exchange estimated that 30,000 ACA Marketplace customers would drop coverage in 2026 due to the loss of the enhanced federal subsidies (90,000 if it were not for the temporary state subsidy). Initial enrollment data for 2026 suggests no drop-off to date, though it is too early in the year to understand the full impact of this federal policy change on consumers.[70]

Impact of coverage losses

Without health insurance, people tend to delay or defer important care, which typically increases morbidity.[71] This harms Marylanders' quality of life and the entire state economy, as people in poor health are less likely to work. (Maryland's Medicaid expansion population is of particular concern: more than half of this population has a chronic health condition, yet 35% are expected to lose coverage due to work requirements.[72])

- In his research for the Brookings Institution, Princeton economist Alan Krueger found that health issues – both physical and mental – are a key factor causing the national decline in labor force participation. For example, he found that (1) half of working-age men who are not in the labor force have a health condition that is a barrier to employment, and (2) people who are not in the labor force (not working and not searching for work) report health barriers at significantly higher rates than do those who are unemployed but actively searching for a job.[73]

Coverage losses are expected to increase uncompensated care. Though uninsured residents typically defer care, most will eventually need health care services. Unfortunately, many end up in emergency rooms – the costliest place to receive care. Some will be forced to pay out of pocket, and may incur medical debt, or the state and federal government will have to cover the cost.[74] Both have a negative impact on individuals, state revenues, and the state economy.

- A U.S. Census study found that uninsured individuals are more likely to have preventable visits to the emergency room than insured individuals.[75]
- A 2022 study in the Journal of the American Medical Association found decreased emergency room utilization in states that expanded Medicaid, which is at risk of reverting now that Medicaid is contracting.[76]

Further, coverage losses typically increase health insurance costs for the remaining enrollees. When premiums rise, healthier residents typically opt out/elect to leave the insurance market. This yields a relatively sicker insurance pool with greater and more expensive medical needs, leading to higher premiums.[77]

Finally, Medicaid cuts will threaten the financial sustainability of small businesses – like group homes and independent practices – that serve low income residents and rely on Medicaid dollars as their primary source of reimbursement.

Funding Cuts

Medicaid

Medicaid is typically the largest single source of federal funds for states – a major revenue source – and at the same time a substantial spending item by states.[78] In Maryland, 58% of total Medicaid program costs are federally funded.[79] In FY26, combined state and federal Medicaid spending in Maryland totaled $15.4 billion.[xxix] [80] This represents about 23% of the total state FY26 operating budget ($66.9 billion).[81]

It is estimated that in total, the OBBBA **will reduce Maryland's federal Medicaid funding by up to $2.7 billion annually, representing nearly 20% of Maryland's current Medicaid budget, beginning FY27.** [82, 83] In addition, there will be new costs to the state associated with implementing and administering OBBBA requirements, especially eligibility changes such as work requirements.[84]

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xxix The $15.4 billion figure includes Medicaid services for somatic services and behavioral health, as well as Maryland Children's Health Program (MCHP) services. The amount does not include the costs included to operate the state Medicaid program, including personnel and Major Information Technology Projects, nor does it include the budget for operating the state's programs for those with developmental disabilities, which operate under Medicaid waivers and generate the Medical Assistance federal match, nor does it include the budget in other state agencies that offer Medicaid services (MDH).

In response, Maryland can (1) fill in gaps with its own revenue; (2) cut Medicaid benefits; (3) reduce eligibility; (4) lower reimbursement rates to providers; or (5) implement a combination of these actions.[85] Governor Moore recently announced $13 million in new investments related to implementing H.R. 1-related Medicaid changes in his FY27 budget.[86] This will help, but given the state's revenue outlook, it is unlikely that Maryland can fill the entire gap created by the federal Medicaid funding cuts. In any scenario, these federal Medicaid cuts present a challenge for Maryland's budget/economy and for the health of its residents.

Medicare

The federal government also plans to pull back some Medicare dollars to Maryland, by way of reconfiguring the Maryland Model – the State's unique rate setting and global budget agreement with CMS (discussed in Section 1B).

Currently, global budgets are funded by Medicaid, Medicare, and commercial payments. They are developed/approved annually by the HSCRC.[xxx] As per new federal policies, the HSCRC will lose rate-setting authority for the Medicare portion of global hospital budgets in 2028. Instead, CMS will negotiate directly with hospitals to determine the share of their global budget that will come from Medicare, and **Medicare payments to hospitals will be reduced.** (The HSCRC will retain rate-setting authority for commercial payers and Medicaid; however, under Maryland's revised agreement with the federal government, as Medicare payments to hospitals are reduced, Medicaid payments must have a corresponding decrease.) **It is estimated that, under this new arrangement, federal funding flowing into Maryland will be reduced by nearly $1 billion ($870 million) by 2032.**[87]

Hospitals will need to make up for lost federal funding, so the state is considering cost-shifting to commercial insurers. The current proposal is to gradually increase hospital reimbursement rates for commercial providers by a cumulative $435 million by CY2032 ($87 million each year).[xxxi] Cost shifting would raise premiums for employers and individuals. It is still to be determined where the other half of the cost savings will come from.[88]

(4B) Workforce Challenges

The health care industry has largely recovered from the COVID-19 pandemic but still faces persistent worker burnout and is navigating increased demand for services. Workforce shortages are a significant challenge.

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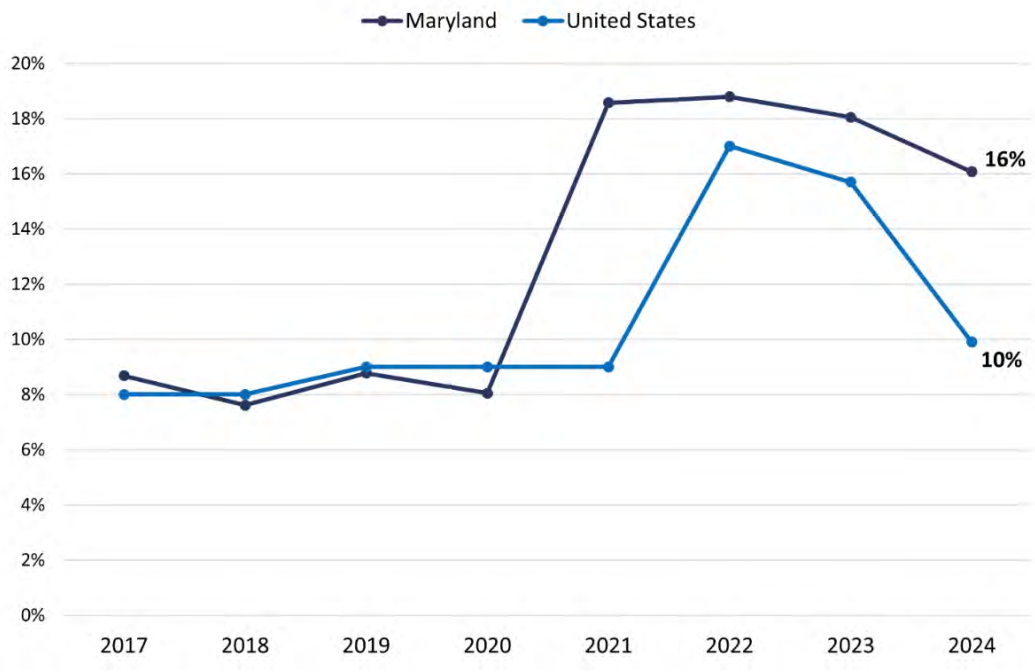
xxx Changes to global budgets year over year are informed by population growth/decline in zip codes around hospitals, demographic changes, and annual inflation compared to a 2013 baseline.

xxxi The state has created a Regulatory Working group to address concerns related to the implementation of H.R. 1 and the AHEAD model (which includes representatives from MDH, the HSCRC, the Maryland Health Benefits Exchange, the Maryland Health Care Commission, and the Maryland Insurance Administration). They will recommend policy and regulatory actions that prioritize population health, access to care, and the stability of Mayland's health care market.

In Maryland, the shortage is particularly severe in nursing and home health aide occupations. For example, **hospital vacancy rates for RNs in Maryland are 16%, significantly above pre-pandemic levels, and much higher than national rates (10%).**[89]

Figure 20: Registered Nurse (RN) Vacancy Rates in Hospitals, 2017 to 2024



Source: Maryland Health Services Cost Review Commission (HSCRC)

View Table

Another metric to examine workforce challenges is job posting data, which reflects job openings and helps illuminate high-demand occupations.

In 2025, the health care occupation with the most job openings in Maryland was RN.

- There were more than 50,000 unique job postings for RNs in Maryland in all of 2025, and on average, there were about 9,000 unique postings active each month.[xxxii] There were an average of 1,800 RNs hired per month in 2025, so demand substantially exceeds supply (Figure 21).

Home health and personal care aides ranked second for health care job openings in 2025.

- There were around 2,000 unique job postings per month for home health aides. However, hiring data suggests that this is an underrepresentation of vacancies in the occupation: On average in 2025, there were 3,500 home health and personal care aids hired each month, almost twice the number of unique job postings (Figure 21). This indicates (1) high turnover,

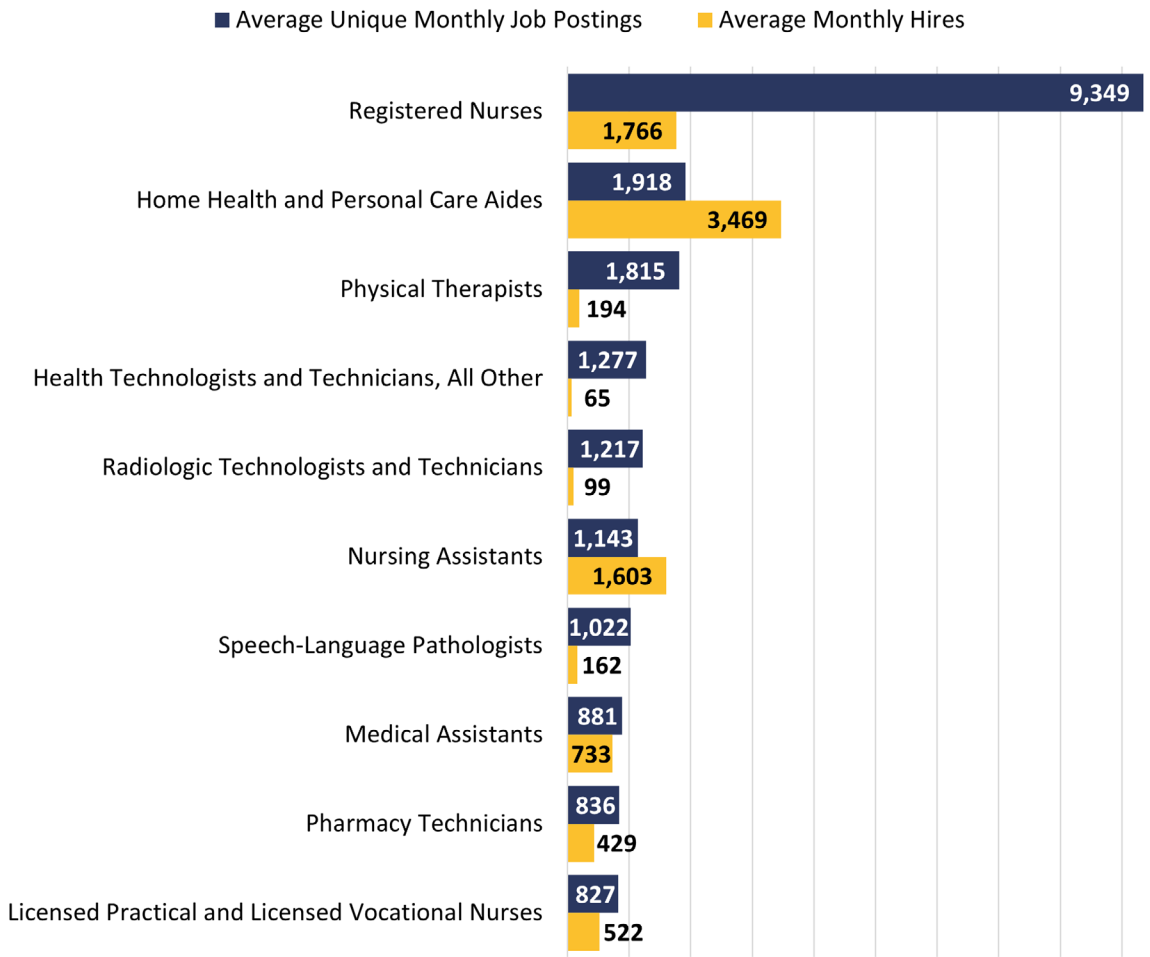
xxxii This does not necessarily reflect 9,000 new job postings each month; one job posting can be active for several months if not filled.

and (2) that employers are likely hiring multiple home health aides from one job posting, which makes it difficult to get a complete picture of demand.

- National projections suggest that this occupation will continue to expand substantially due to the aging population. The Bureau of Labor Statistics (BLS) estimates that nationally, the home health and personal care aides occupation will grow by 17% from 2024 to 2034, a much faster rate than the average for all occupations.[90]
- Barriers to entry into this field are low relative to other health care jobs, and there are opportunities for mobility in the field (e.g., medical assistant, nurse assistant) – a tailwind for hiring. However, wages are relatively low ($37,000), which serves as a barrier to sustainable full employment in this field.[91]

Several stakeholders interviewed for this report also expressed concern about the limited supply of health care workers that commonly serve the aging population, including geriatricians, physical and occupational therapists, and nursing assistants.

Figure 21: Average Unique Monthly Job Postings and Average Monthly Hires for Top Health Care Occupations in Maryland, 2025



Source: Lightcast
Note: Figure shows the top ten occupations with the highest number of unique monthly job postings in 2025
View Table

Health care workforce challenges are greater in some regions of the state than in others, based on demographic composition and geography. Rural areas typically face additional challenges in recruiting and hiring health care workers *and* tend to have older populations on average.

- On average statewide, 18% of the population is 65+, but counties on the Eastern Shore and in Western Maryland have higher shares of seniors: 30% of the population in Talbot County is 65+; 29% in Worcester; 27% in Kent, and 24% in Garrett (see Figure 28 in Appendix A).
- There are currently 60% fewer physicians per 1,000 residents in rural areas nationally, and nonmetro/rural areas are projected to have disproportionately higher shortages of nurses over the next decade compared to metro areas.[92, 93] Talbot, Worcester, Kent, Dorchester, and St. Mary's counties are on the Health Resources & Services Administration's (HRSA) list of "health professional shortage areas."[94] The Rural Health Care Transformation program (discussed further below) could help address this disparity.

Workforce shortages in health care are driven by several factors: (1) low wages and turnover in many health care support occupations; (2) federal immigration policy (restricting supply); (3) the aging population (driving up demand) combined with the aging health care workforce (restricting supply); and (4) pipeline challenges, including impending federal student loan caps.

Burnout & Turnover

Most health care occupations are labor-intensive, and many require irregular work hours and limited flexibility in terms of hybrid/remote work. On top of that, staff have to work in an environment with tremendous administrative complexity created by the federal, state, and local health insurance/care systems in the U.S. This high-stress, challenging environment contributes to burnout and high turnover in health care occupations, especially in the lower wage occupations.

According to the Maryland Health Care Commission, the turnover rate for RNs in hospitals in Maryland in FY24 was 22%.[95] This means that, for every 100 RNs in Maryland hospitals, 22 left their jobs in 2024.

- Pre-pandemic – on average between 2017 and 2019 – turnover rates for RNs in hospitals were about the same in Maryland and the U.S. (16.5%). Since the pandemic, vacancy rates have come down to 17% nationally but remain elevated in Maryland.[96]
- A 2024 survey from the National Council of State Boards of Nursing found that 40% of nurses plan to leave the workforce or retire within the next five years due to burnout, stress, and increasing workloads. A majority of nurses reported feeling emotionally drained at least weekly and "used up" at the end of the workday.[97]

According to PHI National, the national turnover rate in the home health industry in 2024 was 75%.[98]

- A person working in a health care support occupation (e.g., home health and personal care aides, nursing assistants, medical assistants, and dental assistants) in Maryland in 2024 earned a median annual salary of $39,000, which is $20,000 a year less than the median wage across all occupations in Maryland of $58,000.

Certain emergencies that disrupt health care delivery, including extreme weather events and cybersecurity attacks, are becoming more common and may worsen worker burnout and turnover.[99, 100]

Immigration Policy

Maryland's labor force overall is more reliant on immigrants compared to neighboring states and the U.S.: Foreign-born residents represent a larger share of Maryland's total labor force (22%) than the U.S. (18%), D.C. (19%), Virginia (17%), Delaware (15%), Pennsylvania (10%), and West Virginia (3%). The same is true for Maryland's health care workforce (Figure 15).

Increasingly restrictive immigration policy and heightened enforcement activity under the Trump Administration are resulting in fewer immigrants coming to the U.S. and Maryland, and more foreign-born residents already in the U.S. leaving voluntarily or being forcibly removed.[101] Between July 2024 and July 2025, net international immigration dropped from 2.7 million to 1.3 million nationwide.[102] The trend line looks similar in Maryland. For three years in a row (2022, 2023, 2024), net international migration exceeded 43,000 annually. Last year (2025), it dropped to 20,500.[103]

The loss of international immigrants will make it harder for the health care industry to fill vacancies, given that foreign-born residents make up about 31% of Maryland's health care workforce. Some of the specific Trump Administration immigration policy changes that could impact the health care workforce include:

- Over the past two years, **Temporary Protected Status (TPS) designation has been terminated for immigrants from Afghanistan, Burma, Cameroon, Ethiopia, Haiti, and South Sudan**, and the administration is actively attempting to terminate TPS for immigrants from Honduras, Nepal, Nicaragua, and Venezuela (litigation ongoing).[xxxiii]
- **The termination of parole programs for Cubans, Haitians, Nicaraguans, and Venezuelans** (CHNV) and suspension of Afghan Parole Programs.[104, 105]

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xxxiii Before the Trump Administration assumed office, immigrants from 17 countries were eligible for Temporary Protected Status (TPS). As of March 2025, there were 33,700 Maryland residents with TPS.

- **Weakening the U.S. refugee resettlement program** by suspending the U.S. Refugee Admission Program, lowering the annual refugee cap (to its lowest point in history), and conducting additional eligibility reviews of previously vetted refugees.[106, 107, 108]
- All immigrants covered by these programs receive work authorizations tied to their immigration status. Many work in health care occupations.

An April 2025 study published in the Journal of the American Medical Association found that nationally, about 2.3 million naturalized foreign-born residents and 1.1 million noncitizens (698,000 documented; 367,000 undocumented) work in health care settings. The noncitizen residents, including those with TPS or CHNV, account for approximately 4% of personnel in hospitals and outpatient settings, 7% of nursing home workers, and at least 10% of personnel in home care agencies and nonformal settings.[109] This is the group most at risk of deportation.

Finally, additional screening and revoked student visas has led to significantly decreased international student enrollment – an estimated 17% decrease between fall 2024 and 2025 – reducing the pool of future health care employees with advanced training.[110, 111]

This drop in international migration coincides with continued net domestic outmigration in Maryland (in 2025, Maryland lost more residents to other states than it gained from other states for the 14th year in a row).[112] Both of these trends reduce the available labor pool in health care and other industries.

Aging Workforce

While the population is aging and needs more health care, the health care workers employed and trained to care for them are also aging; many in Maryland are nearing retirement. As discussed in Section 2, Maryland has an older healthcare workforce on average than the U.S. and neighboring states (Figure 16). Research suggests that turnover from retirement – and the resulting loss of institutional knowledge – may impact patient outcomes. A study by Stanford and Columbia researchers found that longer nurse tenure leads to higher-quality and more cost-efficient care in hospitals, chiefly by reducing patients' length of stay.[113]

At the same time, post-pandemic, Maryland has been losing a greater share of younger residents to domestic outmigration, which negatively impacts the pipeline to replace these aging health care workers.[114]

Student Loan Caps

Another concern regarding the pipeline of future health care workers is new caps on federal student loans created by the OBBBA for certain professional degrees, including medicine. The new caps

are $50,000 annually or $200,000 over four years. Medical school typically costs $300,000, so these caps will result in more debt for many prospective medical students and will deter some from pursuing a degree in the field. Lower-income, minority populations are likely to be the most affected, which could impact the profession's demographics moving forward. Research suggests that medical students without medical debt are more likely to practice in underserved areas, so this policy change could have a disproportionate impact on rural areas and urban areas of concentrated poverty, which already struggle most with staff recruitment and retention.[115]

Additionally, the OBBBA capped loans for degrees deemed "non-professional," including advanced graduate nursing degrees such as nurse practitioners. These degrees are capped at $20,500 a year or $100,000 total.[116] These caps could lead to additional workforce shortages, including nursing faculty shortages, which restricts the pipeline of nurses being trained.[117] Nurse practitioners and similar advanced degrees are especially important in providing primary care in rural areas.

Various state actions could help address workforce shortages:

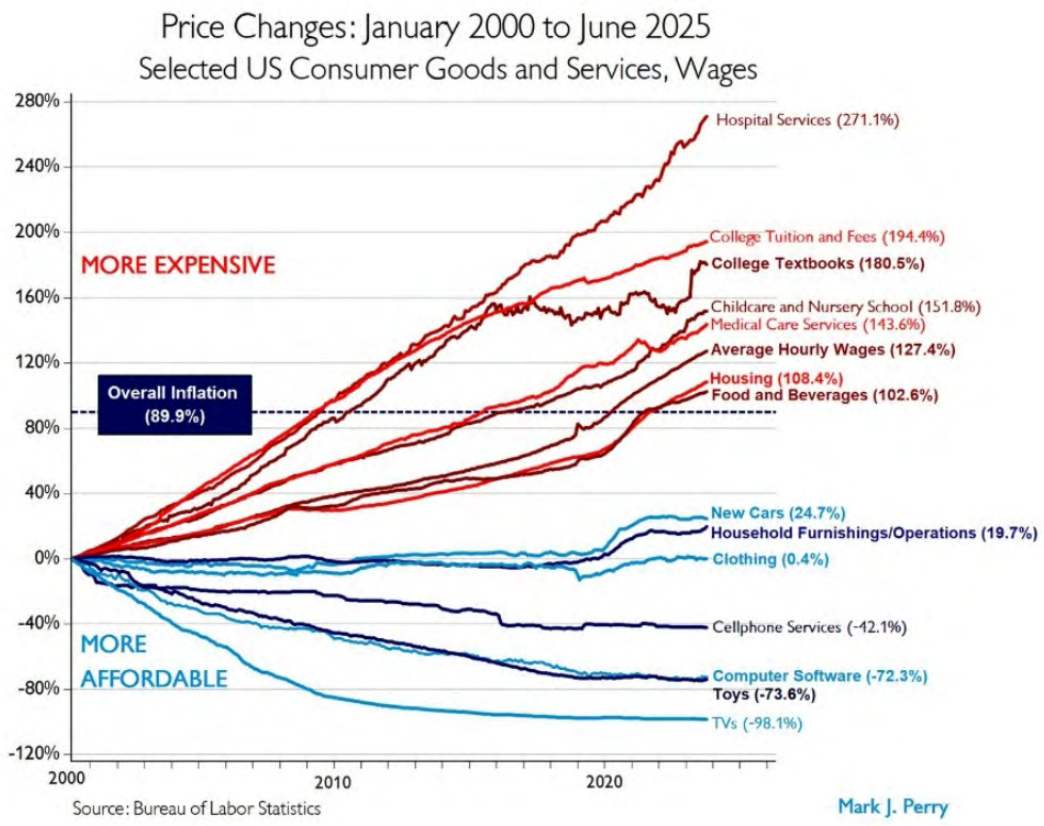
- In 2025, the Governor announced nearly $600,000 in grant awards to help build career pathways for and increase retention of health care workers in Maryland, which are being administered by the Maryland Department of Labor. Funding will (1) support training opportunities focused on upskilling, so that existing health care workers can obtain additional credentials and therefore boost their wages; and (2) cover licensing costs and wraparound services (e.g., transportation) for prospective direct care workers.[118]
- The Maryland Department of Health is working to expand the state's behavioral health workforce through several programs: the Workforce Expansion Initiatives at colleges and universities and the Behavioral Health Workforce Investment Fund to address workforce needs. The Department is examining policy and regulatory barriers to workforce expansion through the Workgroup on Social Worker Requirements for Licensure and the Commission on Behavioral Health Care Treatment and Access.[119]
- The state was recently awarded $168 million in Rural Health Transformation grant funds from the federal government. One of the three pillars of this program is to help grow Maryland's health care workforce in rural parts of the state. This will be achieved through investments in apprenticeship and training programs, area health education centers, and recruitment and retention programs for rural physicians.[120]
- Maryland offers loan repayment programs for health professionals including physicians, physician assistants, medical residents, nurses, and nursing support staff pursuing higher education. To qualify for assistance, they have to practice in areas of health care professional shortages.[121]

(4C) Health Care Costs

Over time, the cost of caring for patients has steadily increased, meaning that health care providers (e.g., hospitals), governments, businesses, and individual consumers are spending more on health care (through premiums, out-of-pocket costs, deductibles, etc.). The cost of "hospital services" has increased considerably more than other common consumer goods and services in the U.S. since January 2000 (Figure 22). There are a few reasons for this:

- Over the past 30 years, productivity has not improved in health care delivery. The number of hours that it takes a health care practitioner to treat a patient, perform a procedure, administer a blood test, etc., is about the same as it was three decades ago.[122] A BLS study found that hospital labor productivity grew an average of just 0.1% per year between 1993 and 2022, with extended periods of outright decline.[123]
    - Meanwhile, wages have risen steadily. Industries like health care, child care, and education – which have been unable to use less labor to produce the same outputs/provide the same services – are experiencing the greatest price growth.
- On the other hand, industries like manufacturing have been able to use less labor to produce the same output over time, which helps control cost growth and has resulted in cheaper cars, furniture, phones, computers, and TVs.[124]
    - These goods are also subject to foreign competition and globalization, which helps curb inflation (while hospitals are "non-tradables").[125]
- It will be hard for labor-intensive industries like health care to break this cost trend. However, there are opportunities for efficiency gains on the margins (e.g., administrative cost bloat); AI has the potential to improve productivity (discussed further in the conclusion); and structural shifts in health care financing – such as directing much more investment into public health, primary care, and population health programs – could yield significant savings.

Figure 22: Price Changes – January 2000 to June 2025, Selected U.S. Consumer Goods and Services, Wages

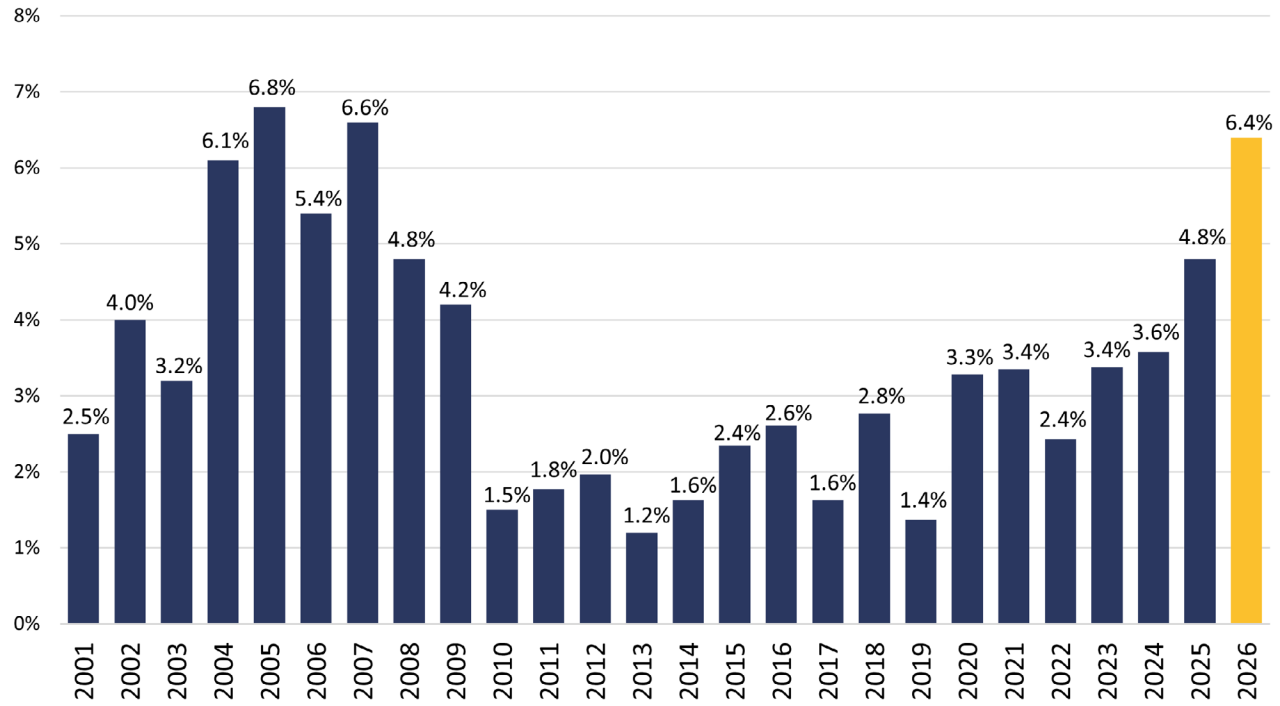


Source: Bureau of Labor Statistics shared by Mark J. Perry at view.

Nationally, since 2008, per-enrollee spending has grown by over 75% for the privately insured, 50% for Medicare, and 30% for Medicaid.[126] According to the Maryland Insurance Administration, health care costs for those covered by the ACA individual Market are expected to continue to rise. The Maryland Insurance Administration estimates a 6.5% increase in 2026 on average. Specifically, they anticipate a 4.8% cost increase for hospital services, 6.1% for professional physician services, and 10.4% for pharmaceuticals.[127]

HSCRC data on approved all-payer rates demonstrate the cost trends in hospitals: as Figure 23 illustrates, the rates that insurers (Medicaid, Medicare, and commercial plans) pay for hospital services have increased each of the past 25 years (though these rates are lower than national averages).

Figure 23: All-Payer Hospital Rate Increases, Maryland, FY2001 to FY 2026



Source: HSCRC via MDH presentation 1/29/26
View Table

The Maryland Insurance Administration, the HSCRC, and MDH all publish information on the drivers of increased health care costs/rates.[128, 129, 130] The most commonly cited factors include:

- Pharmacy spending on high-cost drugs
- Increased utilization (associated in large part with demographic changes)
- Increased complexity of patients/higher-acuity needs post-pandemic
- The worsening behavioral health crisis
- Rising provider rates (driven in part by inflation and workforce shortages, which have increased the costs of goods, services, and labor)
- New benefits/new covered services (for Medicaid specifically)

Due to the rising cost of service delivery – associated with all of these factors – the state and federal government, businesses, and individuals are all paying more for care each year. **However, various state actions are helping to control costs and improve patient outcomes:**

- The Maryland Model helps contain hospital cost growth in Maryland compared to other states by reducing preventable hospitalizations and moving people into more cost-efficient care settings, which helps alleviate pressure on premiums across the board. Between 2013 and 2019, hospital spending growth in Maryland averaged 2.6% compared to 4% nationwide. This has a positive impact on total health care spending growth rates (3.7% in Maryland versus 4.1% in the U.S. over the same period), as hospitals constitute 38% of spending.[131]
- The Maryland Primary Care Program (MDPCP) provides advanced payments to select primary care providers, which enables them to better manage and coordinate their patients' care, with the goal of preventing unnecessary hospitalizations among their patient population.[132] A new "Primary Care AHEAD" program will expand this funding approach to more practices. Investments like these in primary and preventative care and public health interventions (e.g., improving individuals' access to green spaces, healthy food, smoking cessation programs, etc.) can keep people healthier, which reduces costs associated with hospital utilization and saves lives. Research suggests that every dollar invested in public health saves about $14.[133]

Conclusion

Maryland's health care sector has become the state's most reliable source of job growth – but growth in health care is fundamentally different from growth in other private-sector industries. Policymakers should resist the temptation to treat industry growth as an unqualified economic win.

There is cause for optimism: Health care creates jobs across every corner of the state, and growth in ambulatory care, primary care, and home health signals a shift toward more efficient, higher-quality, community-based care – exactly the direction that the Maryland Model is designed to encourage. For many communities, particularly rural ones, a growing health care sector is among the few sources of stable employment available.

But the costs are substantial and often obscured. Health care growth drives up spending and crowds out budgets, investments, and spending in other areas by governments, employers, and individuals alike. About half of health care spending is publicly financed.[134] Maryland's dependence on federal health care dollars adds another layer of vulnerability for the state's hospitals, workforce, and coverage markets to federal policy and funding decisions. There is only so much the state can do to compensate for federal health care cuts. Further, its multiplier effect on the broader economy is limited compared to industries like manufacturing or professional services.

Finally, expansion in health care does not necessarily signal a healthy economy.[135] In fact, historically, health care employment tends to be very stable during economic downturns - increasing in some cases -, when the rest of the economy contracts. [136] Much of what looks like sector vitality is actually a reflection of an aging population, rising chronic disease, and growing behavioral health needs – demand driven by hardship, not prosperity.

Not all growth in health care is good, but the state and the industry are thinking about how to grow it smarter. Several promising opportunities may be key to addressing the challenges discussed in this report:

Workforce Development: The Maryland Departments of Labor, Aging, and Health are collaborating on workforce programs designed to grow the pipeline of health care workers and better align training with where demand is heading. And the **Rural Health Transformation Program** directly addresses one of the report's most persistent findings: that workforce shortages are most acute – and most consequential – in rural Maryland, where access to care is already limited. Two potential opportunities that health care and labor leaders are considering: (1) improve practitioner retention and reduce burnout by expanding telehealth (which would allow practitioners to practice remotely); (2) encourage more men to enter the female-dominated health care industry, similar to efforts that

have been made to encourage more women to enter male-dominated fields like STEM.[137] Other than physicians, men represent about 20% of health care employment, and of all jobs created this year, about 75% were filled by women, driven by growth in health care which is majority female.[138]

- **Cost Savings:** The Maryland Model, Maryland's Primary Care Program, and the Episode Quality Improvement Program (EQIP) represent a deliberate bet on prevention over treatment – investing upstream in community-based care to reduce costly hospitalizations and improve long-term health outcomes. The state has the opportunity to improve value-based care models by enhancing incentives and extending them to other care settings (i.e., other subsectors). If successful, these programs could bend the cost curve while improving care quality, a rare combination in health policy. Drugs that help improve patients' health status, like GLP-1s, could also deliver cost savings to the health care system.
- **Productivity:** One of the most consequential opportunities, albeit the least certain, is AI. For decades, health care has been stubbornly resistant to the productivity gains that have transformed other industries. AI may finally change that.

  The information overload/cognitive burden that health care practitioners face today is real: medical knowledge that once took 50 years to double now doubles in an estimated 73 days.[139] Research suggests that it would take a primary care physician 628 hours per month (21 hours a day) to review all the new literature published in high-quality primary care journals each month. AI offers a way to manage the volume and complexity of new medical research at scale.[140]

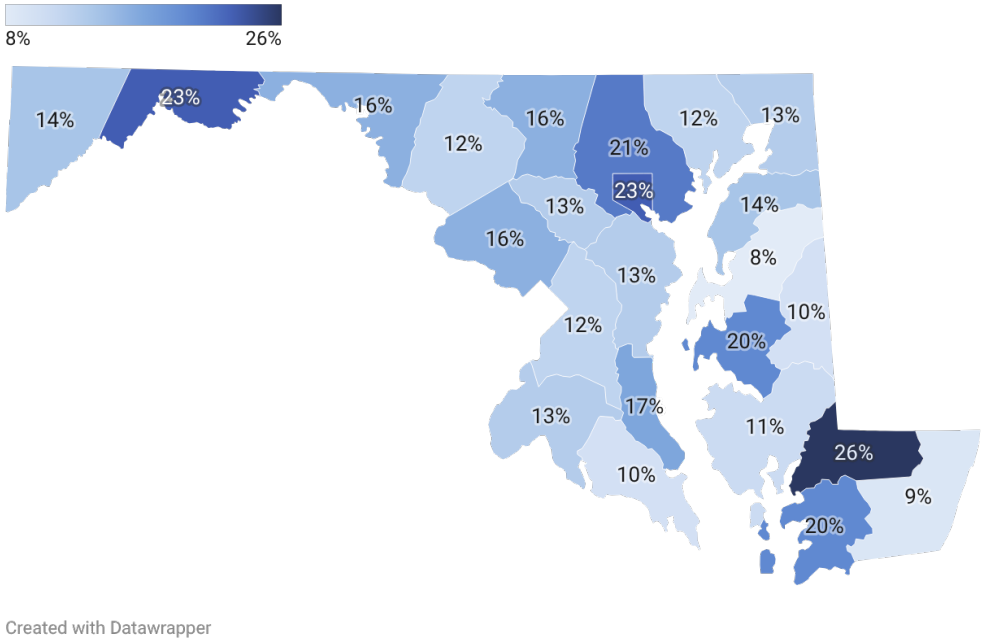
  The applications are broad: AI is being used for clinical notetaking, scheduling, insurance claims and appeals, and predictive diagnostics. For example, at Kaiser Permanente's 21 Northern California hospitals, an AI system analyzes every patient's vitals and charts hourly to identify those at highest risk – a system a *New England Journal of Medicine study found saves more than 500 lives per year.* [141]

  Unlike for prior technological innovations, like computers, health care organizations are showing great interest in AI. The industry is already adopting AI at more than twice the rate of the broader economy. The industry went from 3% adoption to among the highest of any sector in just two years – 27% of health systems now pay for commercial AI licenses.[142]

Maryland enters this moment with genuine structural advantages: a unique payment model that has kept hospitals stable and is helping shift care to more cost-efficient settings, a highly educated and diverse workforce, and institutions of national caliber anchoring its major metro areas. The challenges – an aging workforce, federal funding uncertainty, coverage losses, and persistent inequities in the workforce – are real and require active policy responses. Health care will continue to grow. The work of the state government is to ensure that growth translates into a stronger, more equitable Maryland not a larger health care bill.

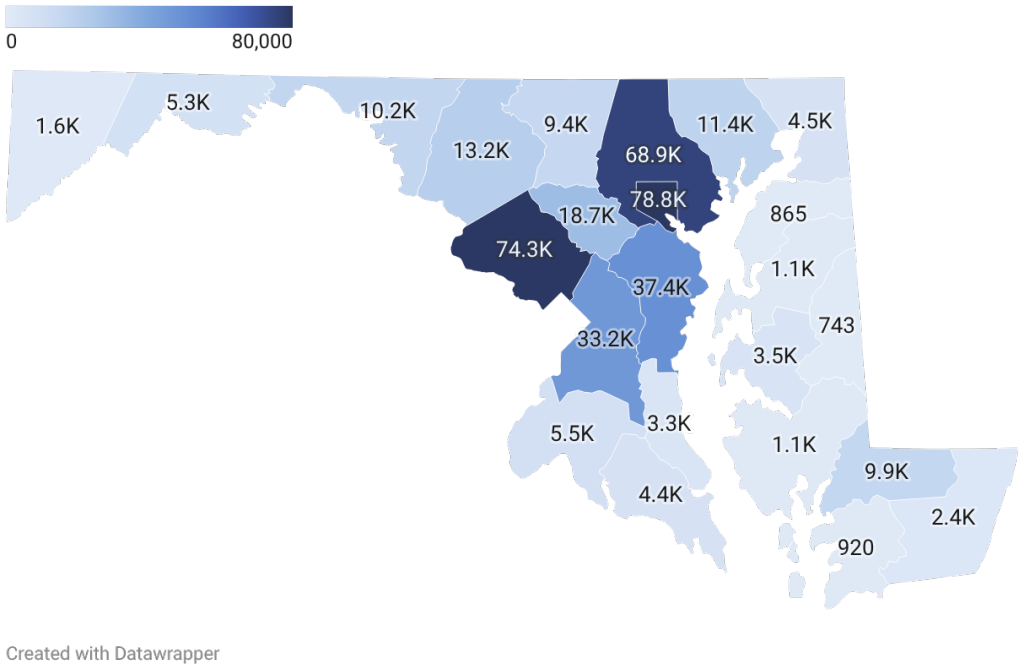
Appendix A: Additional Figures and Tables

Figure 24: Share of Employment in Health Care and Social Assistance Industry by County, 2024



Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)

Figure 25: Number of Jobs in Health Care and Social Assistance Industry by County, 2024



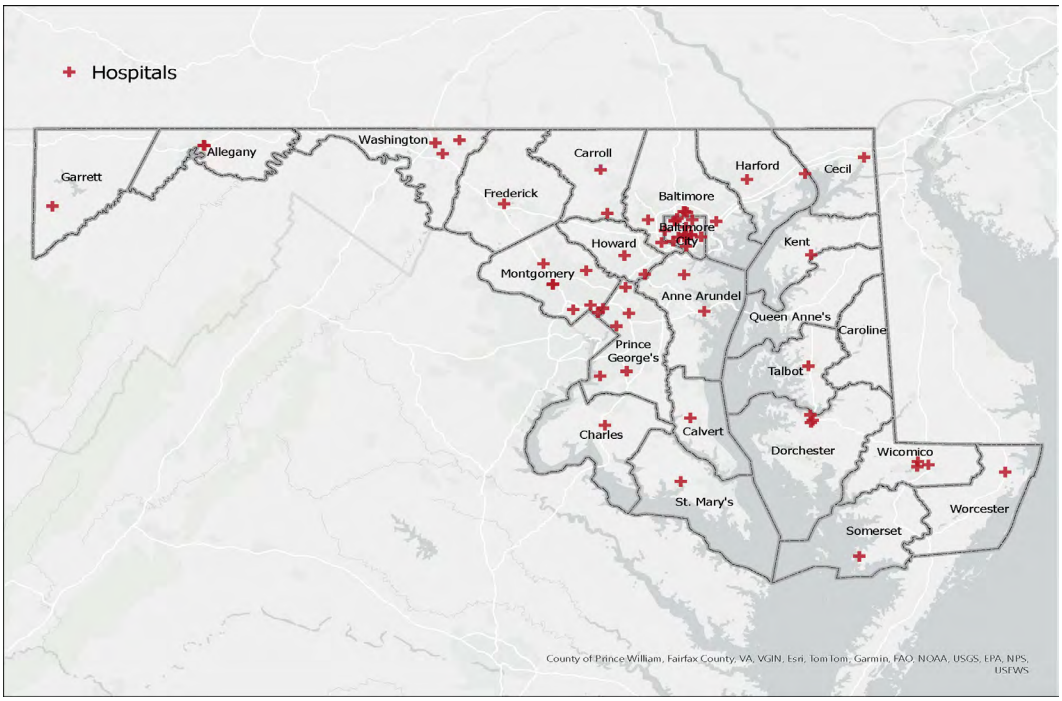
Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)

Table 4: Health Care and Social Assistance Industry Employment by County in Maryland, 2024

County	As share of total employment	Average Annual Employment
Allegany	23%	5,315
Anne Arundel	13%	37,401
Baltimore City	23%	78,815
Baltimore County	21%	68,919
Calvert	17%	3,312
Carroll	16%	743
Cecil	13%	9,441
Charles	13%	4,465
Dorchester	11%	5,462
Frederick	12%	1,094
Garrett	14%	13,197
Harford	12%	1,571
Howard	13%	11,390
Kent	14%	18,693
Maryland	15%	865
Montgomery	16%	74,344
Prince George's	12%	33,210
Queen Anne's	8%	1,107
Somerset	20%	920
St. Mary's	10%	4,426
Talbot	20%	3,545
Washington	16%	10,226
Wicomico	26%	9,930
Worcester	9%	2,398

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)

Figure 26: Hospitals in Maryland



Source: ArcGIS Online for Maryland

*Table 5: Employment for Health Care and Social Assistance Industry in Maryland with Subsector Detail, 2025**

NAICS Industry	Employment
62: Health care and social assistance	**427,110**
621 Ambulatory health care services	***166,426***
6211 Offices of physicians	57,054
621111 Offices of physicians (except mental health specialists)	54,716
621112 Offices of physicians, mental health specialists	2,338
6212 Offices of dentists	17,969
6213 Offices of other health practitioners	22,107

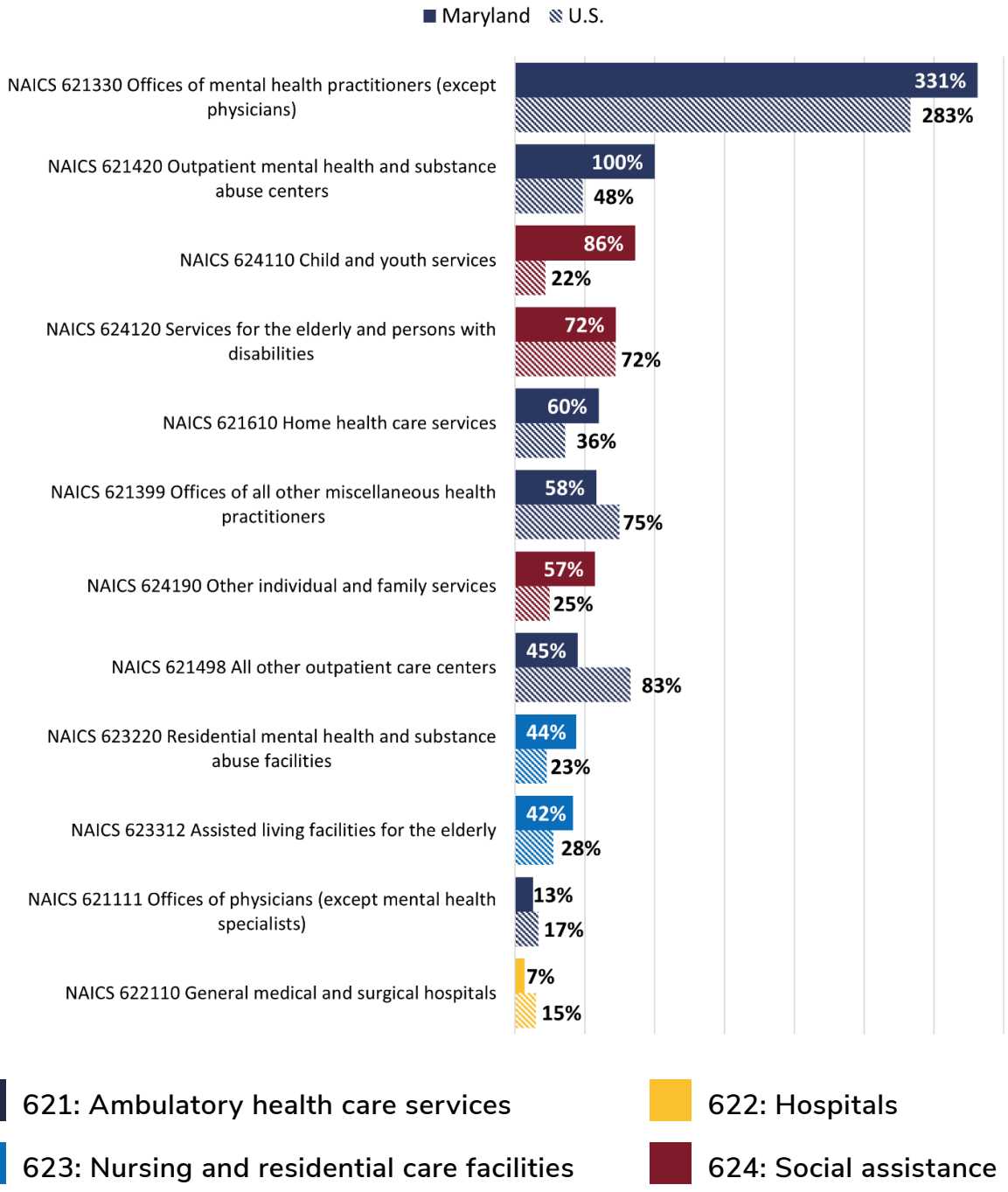
NAICS Industry	Employment
621310 Offices of chiropractors	1,542
621320 Offices of optometrists	2,119
621330 Offices of mental health practitioners (except physicians)	5,112
621340 Offices of physical, occupational and speech therapists, and audiologists	9,670
621391 Offices of podiatrists	792
621399 Offices of all other miscellaneous health practitioners	2,872
6214 Outpatient care centers	27,301
621410 Family planning centers	380
621420 Outpatient mental health and substance abuse centers	8,104
621491 Hmo medical centers	6,029
621492 Kidney dialysis centers	3,121
621493 Freestanding ambulatory surgical and emergency centers	3,696
621498 All other outpatient care centers	5,970
6215 Medical and diagnostic laboratories	6,107
621511 Medical laboratories	3,853
621512 Diagnostic imaging centers	2,254
6216 Home health care services	29,319

NAICS Industry	Employment
6219 Other ambulatory health care services	6,569
621910 Ambulance services	2,235
621991 Blood and organ banks	1,142
621999 All other miscellaneous ambulatory health care services	3,193
622 Hospitals	***120,520***
6221 General medical and surgical hospitals	110,002
6222 Psychiatric and substance abuse hospitals	2,917
6223 Specialty (except psychiatric and substance abuse) hospitals	4,718
623 Nursing and residential care facilities	***76,220***
6231 Nursing care facilities (skilled nursing facilities)	27,934
6232 Residential intellectual and developmental disability, mental health, and substance abuse facilities	19,410
623210 Residential intellectual and developmental disability facilities	12,519
623220 Residential mental health and substance abuse facilities	6,892
6233 Continuing care retirement communities and assisted living facilities for the elderly	24,515
623311 Continuing care retirement communities	13,575
623312 Assisted living facilities for the elderly	10,940
6239 Other residential care facilities	4,361

NAICS Industry	Employment
624 Social assistance	**62,506**
6241 Individual and family services	31,507
624110 Child and youth services	3,197
624120 Services for the elderly and persons with disabilities	18,556
624190 Other individual and family services	9,754
6242 Community food and housing, and emergency and other relief services	4,291
624210 Community food services	655
624221 Temporary shelters	1,557
624229 Other community housing services	775
624230 Emergency and other relief services	1,304
6243 Vocational rehabilitation services	6,690
6244 Child care services	20,070

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
**2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available*
Note: Includes 2-, 3-, 4-, 6-digit NAICS codes

*Figure 27: Percent Change in Employment for the Top 10 Industry Segments of Health Care and Social Assistance with Highest Growth Rates in Maryland, 2015 to 2025**



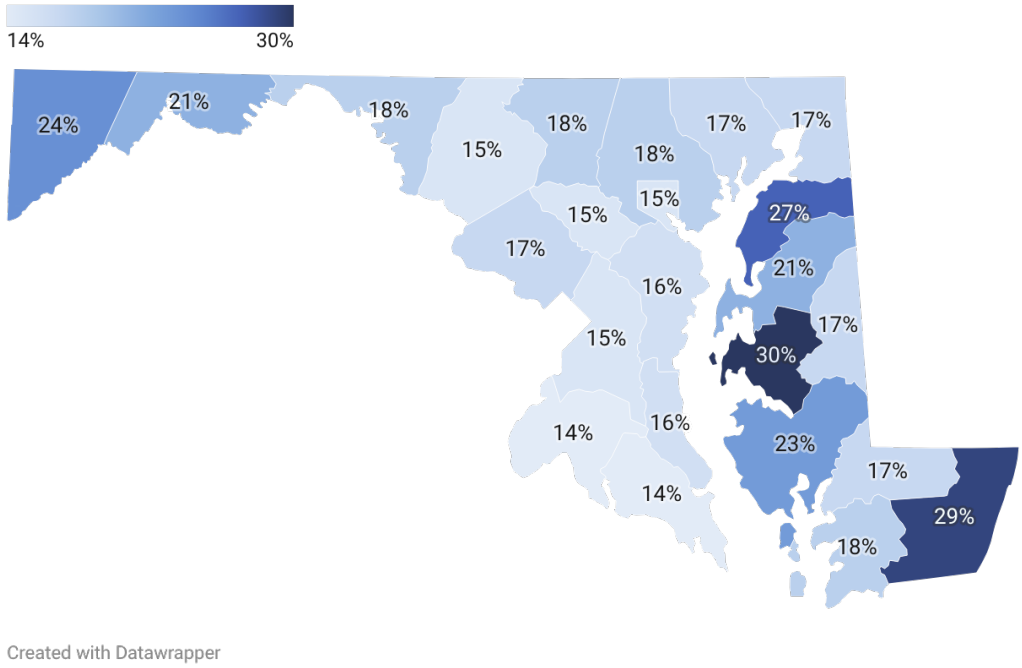
Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
*2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available
Notes: Top ten excludes industry segments with fewer than 1,000 employees as of 2025. The figure also includes the 6-digit industry segments for general medical and surgical hospitals and offices of physicians (except mental health specialists) even though they are not in the top 10 growth rates. Those are the top two with the highest employment of all 6-digit industry subsectors and are important to include.
View Table

Table 6: Average Annual Wages for Detailed Physician Occupations, 2024

Occupation	Maryland	United States	Delaware	District of Columbia	Pennsylvania	Virginia	West Virginia
Emergency Medicine Physicians	$344,370	$320,700	-	$279,760	$377,110	$332,430	$345,480
Family Medicine Physicians	$269,020	$256,830	$238,210	$236,820	$283,590	$220,010	$249,170
General Internal Medicine Physicians	$270,880	$262,710	$205,520	$194,440	-	-	$254,790
Pediatricians, General	$242,470	$222,340	$205,530	$143,880	$243,450	$200,990	$182,710
Physicians, All Other	$216,910	$253,470	$223,310	$151,890	$218,880	$255,970	$241,220
Psychiatrists	$260,100	$269,120	$238,660	$162,360	$272,960	$268,420	$138,350
Radiologists	$287,830	$359,820	-	$308,460	$376,520	-	-

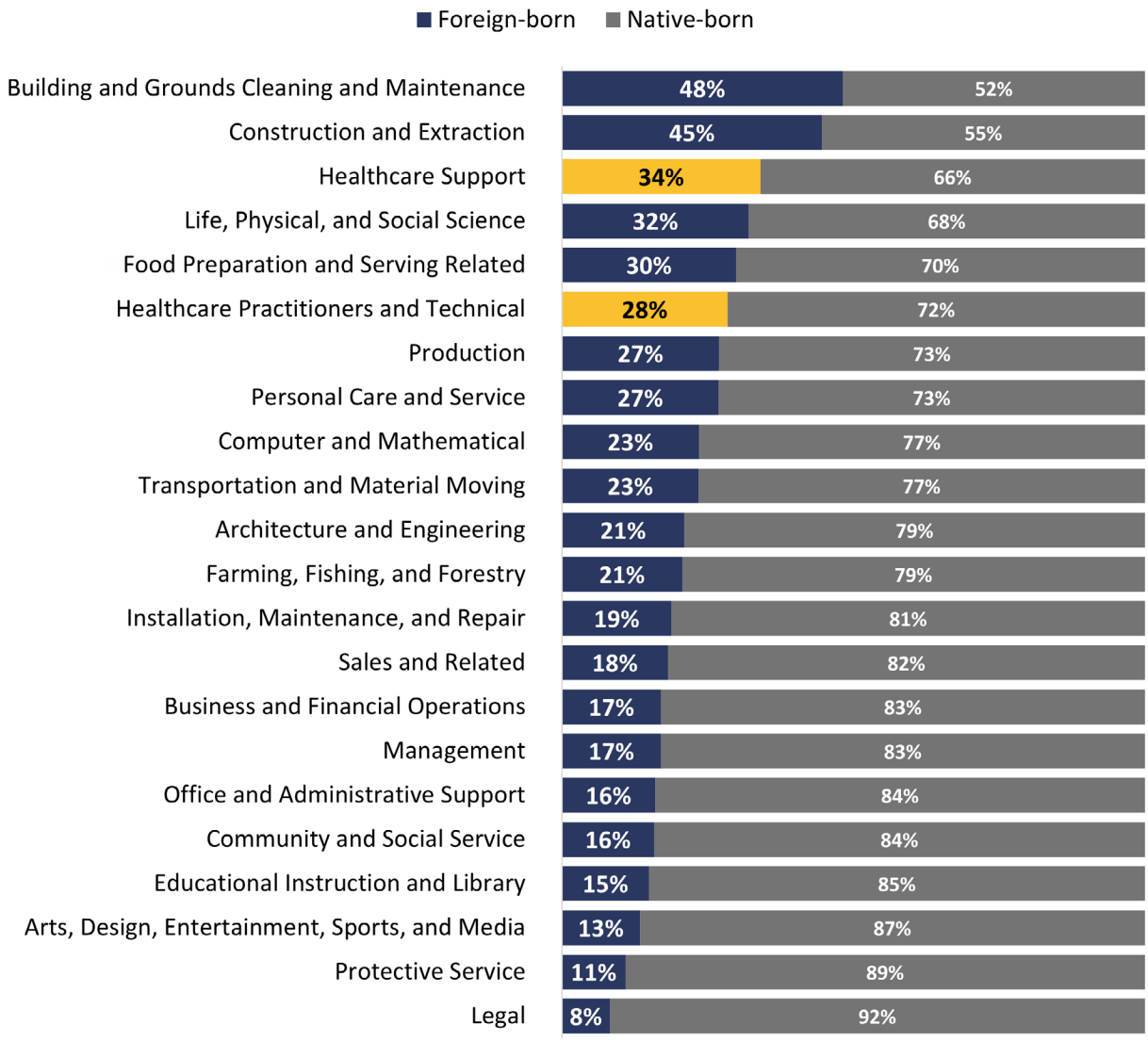
Source: Bureau of Labor Statistic (BLS), Occupational Employment and Wage Statistics (OEWS)
Note: Some data is missing because average wage data is not available for all occupations in every state

Figure 28: Map with Share of Population Age 65 and over by County, 2024



Source: IPUMS USA, U.S. Census, American Community Survey (ACS)
View Table

Figure 29: Foreign-born Share of Major Occupation Groups in Maryland, 2024



Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
View Table

Appendix B: Location Quotient

Table 8: Location Quotient for Top 10 Health Care Occupations in Maryland, 2024

Occupation	Location Quotient
Registered Nurses	0.84
Home Health and Personal Care Aides	0.54
Nursing Assistants	0.98
Medical Assistants	1.04
Physicians, All Other	1.74
Licensed Practical/Licensed Vocational Nurses	0.84
Pharmacy Technicians	0.99
Substance abuse, behavioral disorder, and mental health counselors	1.04
Clinical Laboratory Technologists/Technicians	1.17
Nurse Practitioners	1.21

Table 8 provides the location quotient (LQ) for each occupation. The LQ indicates whether a region (in this case the state of Maryland) has more, about the same, or a lower share of employment in an occupation group compared to the U.S. It is calculated by comparing an industry or an occupation's **share of regional employment with its share of national employment.**[xxxiv]

A value greater than 1 means that a region has a **higher concentration of employment in this occupation than the national average. For Maryland, physicians** and nurse practitioners fall into this category.

Physicians are more highly concentrated in wealthier, urban and suburban areas as opposed to rural areas, which could explain why Maryland has a higher concentration than the national average.[143] States in the Northeast and Mid-Atlantic have some of the highest physicians per capital while the South and Great Plains states have some of the lowest. [144] [145] Rural areas in general have lower concentrations of doctors.[146] Maryland has less rural areas than most states.[147] Nurse Practitioners are more prevalent in states that allow them to practice independently, which includes Maryland.

xxxiv For example, if registered nurses in a region account for 10% of all jobs, while nationally they account for 9% of all jobs, the LQ for the region will be 1.11 (.1 / .09). This means that the region's concentration of nurses is just slightly higher than the national average.

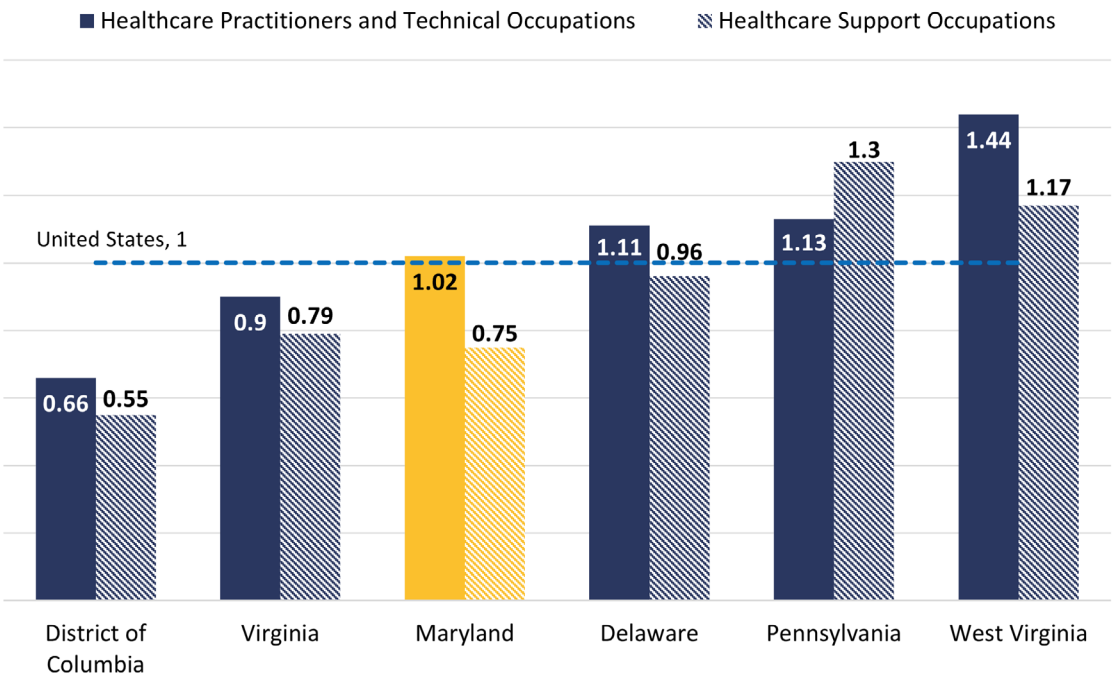
Maryland ranks in the top three states for nurse practitioners based on salary, job outlook, and practicing authority.[148]

A location quotient of less than 1 means that a region has a lower concentration of this type of health care worker than the U.S. average. For Maryland, home health and personal care aides and Licensed Practical/Licensed Vocational Nurses fall into this category. Though home health and personal care aides have added the most jobs of any health care occupation in Maryland since 2023, the low LQ indicates that Maryland is still behind other states and may not be adequately staffed to meet demand. This is likely due to the low wages for these occupations in high cost of living areas like in Maryland. Nationally, 36% of the direct care workforce (home health aides and nursing assistants) live in poverty.[149]

Demand for these occupations will only increase as the population continues to age and people want to age in place at home. Wages will need to be higher to attract enough workers to meet the demand in Maryland, but wages are highly dependent on Medicaid.[150]

Across the whole group of healthcare practitioners and technical occupations, Maryland is squarely average in terms of share of employment in health care and social assistance. The LQ for healthcare practitioners and technical occupations, in Maryland is 1.02, meaning it is average and the same as national employment levels (LQ of 1) (Figure 30). For healthcare support occupations, Maryland is 25% below the national average with a LQ of 0.75.

Figure 30: Location Quotient for Healthcare Occupation Groups in Maryland, 2024



Source: Bureau of Labor Statistic (BLS), Occupational Employment and Wage Statistics (OEWS)
View Table

Appendix C: Tables for Report Figures

*Table for Figure 1: Average Annual Employment by Industry Sector in Maryland, 2025**

Industry	Employment
Health care and social assistance	427,110
Educational services	281,185
Professional, scientific, and technical services	280,542
Public administration	267,284
Retail trade	265,122
Accommodation and food services	225,444
Administrative and support and waste management and remediation services	166,903
Construction	164,304
Transportation and warehousing	115,626
Manufacturing	112,939
Other services (except public administration)	93,395
Wholesale trade	85,362
Finance and insurance	82,635
Arts, entertainment, and recreation	48,164
Real estate and rental and leasing	43,407
Information	37,533

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)

**2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available*

View Figure

*Table for Figure 2: Average Annual Employment by Industry Sector in Maryland, 2015 to 2025**

Year	Health Care and Social Assistance	Educational Services	Professional, Scientific, and Technical Services	Public Administration	Retail Trade	Accommodation and Food Services	Construction	Manufacturing
2015	369,368	254,356	248,453	242,243	290,380	222,286	154,424	103,757
2016	376,111	255,494	253,134	242,340	290,919	227,067	161,014	103,586
2017	383,460	259,032	253,563	242,884	288,809	234,236	162,140	106,864

Year	Health Care and Social Assistance	Educational Services	Professional, Scientific, and Technical Services	Public Administration	Retail Trade	Accommodation and Food Services	Construction	Manufacturing
2018	389,686	265,164	258,599	244,279	284,749	234,809	163,210	109,683
2019	395,292	265,403	264,571	244,525	279,300	237,729	166,132	112,273
2020	371,164	248,150	261,840	245,463	255,751	180,606	160,039	108,500
2021	373,612	249,789	269,946	249,009	267,487	196,251	160,439	110,636
2022	375,584	250,879	280,000	252,679	270,537	210,785	161,023	112,656
2023	392,152	274,043	283,831	260,547	270,454	221,541	161,589	113,907
2024	413,723	282,184	288,830	270,109	270,262	226,891	164,323	113,023
2025	427,110	281,185	280,542	267,284	265,122	225,444	164,304	112,939

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)

**2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available*

View Figure

Table for Figure 3: Year-over-year Change in Employment by Industry in Maryland, Q3 2024 to Q3 2025

Industry	Change in Employment
Health Care and Social Assistance	14,361
Health Care	*12,383*
Social Assistance	*1,978*
Transportation and Warehousing	7,271
Utilities	670
Construction	355
Educational Services	183
Agriculture, Forestry, Fishing and Hunting	87
Information	(11)
Mining, Quarrying, and Oil and Gas Extraction	(125)
Real Estate and Rental and Leasing	(208)
Other Services (except Public Administration)	(718)

Industry	Change in Employment
Management of Companies and Enterprises	(965)
Manufacturing	(1,034)
Arts, Entertainment, and Recreation	(1,195)
Finance and Insurance	(1,576)
Wholesale Trade	(2,865)
Accommodation and Food Services	(3,610)
Retail Trade	(4,930)
Administrative and Support and Waste Management and Remediation Services	(7,708)
Public Administration	(9,171)
Professional, Scientific, and Technical Services	(11,282)

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
View Figure

*Table for Figure 4: Percent Change in Average Annual Employment for Health Care and Social Assistance to 2025**

Percent increase	Maryland	United States
% increase from 2015	16%	23%
% increase from 2019	8%	13%
% increase from 2023	9%	7%

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
**2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available*
View Figure

Table for Figure 5: Share and Number of Insured Residents in Maryland, 2010 to 2024

Year	Count	Share
2010	5,075,000	89%

Year	Count	Share
2011	5,176,908	90%
2012	5,227,650	90%
2013	5,270,790	90%
2014	5,444,571	92%
2015	5,544,858	93%
2016	5,590,731	94%
2017	5,620,641	94%
2018	5,624,736	94%
2019	5,628,235	94%
2021	5,731,652	94%
2022	5,742,454	94%
2023	5,734,386	94%
2024	5,818,102	94%

Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 1-year samples
Note: ACS 1-year data is not available for 2020
View Figure

Table for Figure 6: Population 65 and over in Maryland, 2014 to 2024

Year	Count	Share
2014	818,716	14%
2015	844,230	14%
2016	877,477	15%
2017	900,128	15%
2018	929,234	15%
2019	961,504	16%
2021	1,002,955	16%

Year	Count	Share
2022	1,042,939	17%
2023	1,066,777	17%
2024	1,099,590	18%

Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 1-year samples
Note: ACS 1-year data is not available for 2020
View Figure

*Table for Figure 7 Maryland Employment for 3-digit Industry Subsectors of Health Care and Social Assistance, 2015 to 2025**

Year	Ambulatory health care services	Hospitals	Nursing and residential care facilities	Social assistance
2015	133,218	113,138	72,519	49,959
2016	138,158	113,723	72,822	50,875
2017	143,124	115,658	72,191	51,994
2018	147,749	115,799	70,789	52,840
2019	151,232	116,649	70,858	54,112
2020	143,729	113,732	65,498	45,806
2021	151,042	112,484	61,255	46,054
2022	152,802	110,618	60,677	49,031
2023	158,496	112,147	64,999	54,031
2024	164,536	116,075	71,301	60,389
2025	166,426	120,520	76,220	62,506

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
**2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available*
View Figure

*Table for Figure 8: Top 10 6-digit Industry Subsectors of Health Care and Social Assistance (That Added the Most Jobs) in Maryland, 2015 to 2025**

NAICS 6-digit Industry	Change from 2015
NAICS 621610 Home health care services	10,994
NAICS 624120 Services for the elderly and persons with disabilities	7,787
NAICS 622110 General medical and surgical hospitals	6,996
NAICS 621111 Offices of physicians (except mental health specialists)	6,281
NAICS 621420 Outpatient mental health and substance abuse centers	4,053
NAICS 621330 Offices of mental health practitioners (except physicians)	3,927
NAICS 624190 Other individual and family services	3,559
NAICS 623210 Residential intellectual and developmental disability facilities	3,262
NAICS 623312 Assisted living facilities for the elderly	3,211
NAICS 624410 Child care services	2,301

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
**2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available*
View Figure

Table for Figure 9: Change in Employment for Top 10 Health Occupations, 2023 to 2024

Occupation	Change from 2023 to 2024
Home Health and Personal Care Aides	7,380
Physicians, All Other	2,430
Licensed Practical and Licensed Vocational Nurses	1,810
Nurse Practitioners	1,460
Pharmacy Technicians	540
Substance Abuse, Behavioral Disorder, and Mental Health Counselors	490
Medical Assistants	260

Occupation	Change from 2023 to 2024
Clinical Laboratory Technologists and Technicians	190
Nursing Assistants	-580
Registered Nurses	-790

Source: Bureau of Labor Statistic (BLS), Occupational Employment and Wage Statistics (OEWS)
View Figure

Table for Figure 10: Median Annual Wages for Major Healthcare Occupation Groups, 2024

Geography	Healthcare Practitioners and Technical Occupations	Healthcare Support Occupations
District of Columbia	$101,750	$42,760
Maryland	$95,620	$39,190
Delaware	$87,840	$36,760
United States	$83,090	$37,180
Virginia	$81,700	$36,800
Pennsylvania	$80,250	$34,050
West Virginia	$69,340	$30,980

Source: Bureau of Labor Statistic (BLS), Occupational Employment and Wage Statistics (OEWS)
View Figure

Table for Figure 11: Average Annual Wages for Physicians, All Other 2024

Geography	Average Annual Wages
Virginia	$255,970
United States	$253,470
West Virginia	$241,220
Delaware	$223,310

Geography	Average Annual Wages
Pennsylvania	$218,880
Maryland	$216,910
District of Columbia	$151,890

Source: Bureau of Labor Statistic (BLS), Occupational Employment and Wage Statistics (OEWS)
Note: For the SOC occupation "Physicians, All Other" and does not include specialty doctors.
View Figure

Table for Figure 12: Share of Health Care Occupations or Occupation Groups by Sex in Maryland, 2024

Occupation or Occupation Group	Male	Female
Physicians	58%	42%
Healthcare Practitioners and Technical Occupations	22%	78%
Home Health and Personal Care Aides	19%	81%
Healthcare Support Occupations	14%	86%
Registered Nurses	12%	88%

Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
View Figure

Table for Figure 13: Healthcare Support Occupations by Race and Ethnicity, 2024

Race or Ethnicity	Maryland	Pennsylvania	Virginia	United States
White	27%	55%	50%	42%
Black	54%	23%	33%	23%
Hispanic	9%	14%	7%	22%
Asian	6%	5%	6%	8%

Race or Ethnicity	Maryland	Pennsylvania	Virginia	United States
Other	4%	3%	4%	5%

Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
Note: Delaware, District of Columbia, and West Virginia have too small sample sizes of some racial groups in health care occupation groups to be confident in using those estimates.
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Table for Figure 14: Healthcare Practitioners and Technical Occupations by Race and Ethnicity, 2024

Race or Ethnicity	Maryland	Pennsylvania	Virginia	United States
White	46%	75%	62%	62%
Black	32%	9%	16%	11%
Hispanic	5%	4%	6%	11%
Asian	12%	9%	12%	11%
Other	6%	4%	5%	5%

Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
Note: Delaware, District of Columbia, and West Virginia have too small sample sizes of some racial groups in health care occupation groups to be confident in using those estimates.
View Figure

Table for Figure 15: Share of Foreign-born Residents in Healthcare Occupation Groups, 2024

Geography	Healthcare Practitioners and Technical Occupations	Healthcare Support Occupations
Maryland	28%	34%
District of Columbia	20%	26%
United States	16%	24%
Delaware	17%	22%
Pennsylvania	10%	16%

Geography	Healthcare Practitioners and Technical Occupations	Healthcare Support Occupations
Virginia	16%	13%
West Virginia	4%	1%

Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
View Figure

Table for Figure 16: Share of Workers Age 65 and over in Health Care Occupation Groups, 2024

Geography	Healthcare Practitioners and Technical Occupations	Healthcare Support Occupations
Maryland	11%	6%
Pennsylvania	7%	7%
District of Columbia	6%	8%
West Virginia	6%	7%
United States	6%	7%
Virginia	5%	9%
Delaware	5%	7%

Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
View Figure

Table for Figure 17: Maryland Gross Domestic Product (GDP) by Industry Sector, 2024

Industry	GDP
Government and government enterprises	$112,684,100,000
Real estate and rental and leasing	$82,638,100,000
Professional, scientific, and technical services	$56,340,100,000
Health care and social assistance	$42,094,600,000

Industry	GDP
Construction	$32,234,100,000
Retail trade	$31,197,100,000
Manufacturing	$28,579,800,000
Wholesale trade	$23,929,100,000
Finance and insurance	$23,549,200,000
Information	$23,143,800,000
Administrative and support and waste management and remediation services	$17,543,600,000
Accommodation and food services	$16,299,100,000
Other services (except government and government enterprises)	$12,931,300,000
Transportation and warehousing	$12,535,200,000

Source: Bureau of Economic Analysis (BEA)
Note: Only shows industries that make up more than 1% of Maryland's total GDP
View Figure

Table for Figure 18: Share of Total Wages in Maryland by Industry Sector, 2024

Industry	Share
Professional, Scientific, and Technical Services	16%
Public Administration	13%
Health Care and Social Assistance	13%
Educational Services	9%
Construction	6%
Finance and Insurance	5%
Retail Trade	5%

Industry	Share
Manufacturing	5%
All other industries	26%

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
View Figure

Table for Figure 19: Statewide Total Regulated Entity Expenses by Expense Category, 2013 to 2025

Year	Wages, Salaries & Benefits	Professional Fees	Supplies	Depreciation/ Amortization & Leases/Rentals	Other Expenses
2013	$6,761,081,057	$454,739,355	$2,512,403,562	$945,827,079	$2,887,071,901
2014	$6,743,667,913	$480,826,824	$2,669,514,233	$975,552,869	$2,896,857,013
2015	$6,963,175,468	$507,614,631	$2,778,547,772	$992,337,421	$3,229,512,120
2016	$7,130,585,605	$598,002,173	$2,949,656,298	$1,010,462,393	$3,346,249,163
2017	$7,440,376,362	$562,292,787	$3,048,994,012	$1,034,145,284	$3,476,521,138
2018	$7,533,151,767	$670,426,581	$3,137,109,380	$1,048,842,853	$3,606,555,228
2019	$7,742,909,493	$631,128,278	$3,156,177,302	$1,089,772,663	$3,840,158,354
2020	$7,997,351,278	$945,178,419	$3,121,575,368	$1,089,248,487	$3,752,055,486
2021	$8,389,825,505	$1,021,262,369	$3,420,040,380	$1,113,285,807	$3,941,373,110
2022	$8,959,312,806	$1,194,991,286	$3,555,562,358	$1,135,579,761	$4,207,112,896
2023	$9,242,862,661	$1,150,759,984	$3,714,079,232	$1,134,724,769	$4,505,668,716
2024	$9,521,360,512	$1,024,161,958	$4,014,606,689	$1,138,784,058	$4,717,267,865
2025	$10,007,632,203	$1,004,273,537	$4,441,295,955	$1,150,439,375	$4,999,368,623

Source: Maryland Health Services Cost Review Commission (HSCRC)
View Figure

Table for Figure 20: Registered Nurse (RN) Vacancy Rates in Hospitals, 2017 to 2024

Year	Maryland	United States
2017	9%	8%
2018	8%	8%
2019	9%	9%
2020	8%	9%
2021	19%	9%
2022	19%	17%
2023	18%	16%
2024	16%	10%

Source: Maryland Health Services Cost Review Commission (HSCRC)
View Figure

Table for Figure 21: Average Unique Monthly Job Postings and Average Monthly Hires for Top Health Care Occupations in Maryland, 2025

Occupation	Average Unique Monthly Job Postings	Average Monthly Hires
Registered Nurses	9,349	1,766
Home Health and Personal Care Aides	1,918	3,469
Physical Therapists	1,815	194
Health Technologists and Technicians, All Other	1,277	65
Radiologic Technologists and Technicians	1,217	99
Nursing Assistants	1,143	1,603

Occupation	Average Unique Monthly Job Postings	Average Monthly Hires
Speech-Language Pathologists	1,022	162
Medical Assistants	881	733
Pharmacy Technicians	836	429
Licensed Practical and Licensed Vocational Nurses	827	522

Source: Lightcast

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Table for Figure 23: HSCRC Update Factors, FY2001 to FY 2026

Year	Update Factor
2001	2.5%
2002	4.0%
2003	3.2%
2004	6.1%
2005	6.8%
2006	5.4%
2007	6.6%
2008	4.8%
2009	4.2%
2010	1.5%
2011	1.8%
2012	2.0%
2013	1.2%
2014	1.6%

Year	Update Factor
2015	2.4%
2016	2.6%
2017	1.6%
2018	2.8%
2019	1.4%
2020	3.3%
2021	3.4%
2022	2.4%
2023	3.4%
2024	3.6%
2025	4.8%
2026	6.4%

Source: Maryland Health Services Cost Review Commission (HSCRC)

View Figure

*Table for Figure 27: Percent Change in Employment for the Top 10 Industry Subsectors of Health Care and Social Assistance with Highest Growth Rates in Maryland, 2015 to 2025**

	Maryland	United States
NAICS 621330 Offices of mental health practitioners (except physicians)	331%	283%
NAICS 621420 Outpatient mental health and substance abuse centers	100%	48%
NAICS 624110 Child and youth services	86%	22%
NAICS 624120 Services for the elderly and persons with disabilities	72%	72%

	Maryland	United States
NAICS 621610 Home health care services	60%	36%
NAICS 621399 Offices of all other miscellaneous health practitioners	58%	75%
NAICS 624190 Other individual and family services	57%	25%
NAICS 621498 All other outpatient care centers	45%	83%
NAICS 623220 Residential mental health and substance abuse facilities	44%	23%
NAICS 623312 Assisted living facilities for the elderly	42%	28%
NAICS 621111 Offices of physicians (except mental health specialists)	13%	17%
NAICS 622110 General medical and surgical hospitals	7%	15%

Source: Bureau of Labor Statistics (BLS), Quarterly Census of Employment and Wages (QCEW)
**2025 data is based on the average of the first three quarters of 2025 as fourth quarter data is not yet available*

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Table for Figure 28: Map with Share of Population Age 65 and over by County, 2024

County	Share
Charles	14%
St. Mary's	14%
Prince George's	15%
Howard	15%
Baltimore city	15%
Frederick	15%
Anne Arundel	16%

County	Share
Calvert	16%
Wicomico	17%
Montgomery	17%
Cecil	17%
Caroline	17%
Harford	17%
Somerset	18%
Carroll	18%
Washington	18%
Baltimore County	18%
Queen Anne's	21%
Allegany	21%
Dorchester	23%
Garrett	24%
Kent	27%
Worcester	29%
Talbot	30%

Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
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Table for Figure 29: Foreign-born Share of Major Occupation Groups in Maryland, 2024

Major Occupation Group	Foreign-born	Native-born
Building and Grounds Cleaning and Maintenance	48%	52%
Construction and Extraction	45%	55%
Healthcare Support	34%	66%

Major Occupation Group	Foreign-born	Native-born
Life, Physical, and Social Science	32%	68%
Food Preparation and Serving Related	30%	70%
Healthcare Practitioners and Technical	28%	72%
Production	27%	73%
Personal Care and Service	27%	73%
Computer and Mathematical	23%	77%
Transportation and Material Moving	23%	77%
Architecture and Engineering	21%	79%
Farming, Fishing, and Forestry	21%	79%
Installation, Maintenance, and Repair	19%	81%
Sales and Related	18%	82%
Business and Financial Operations	17%	83%
Management	17%	83%
Office and Administrative Support	16%	84%
Community and Social Service	16%	84%
Educational Instruction and Library	15%	85%
Arts, Design, Entertainment, Sports, and Media	13%	87%
Protective Service	11%	89%
Legal	8%	92%

Source: IPUMS USA, U.S. Census, American Community Survey (ACS) 2024 1-year sample
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Table for Figure 30: Location Quotient for Healthcare Occupation Groups in Maryland, 2024

State	Healthcare Practitioners and Technical Occupations	Healthcare Support Occupations
District of Columbia	0.66	0.55
Virginia	0.9	0.79
Maryland	1.02	0.75
Delaware	1.11	0.96
Pennsylvania	1.13	1.3
West Virginia	1.44	1.17

Source: Bureau of Labor Statistic (BLS), Occupational Employment and Wage Statistics (OEWS)

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