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One Curve. Fifty Clocks.

The Demographic Pressure Building Inside America's Fragmented Credentialing System

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A Note From the Author

Draw a map of the United States color coded by how long it takes a physician to start earning a paycheck. You will not see red states and blue states. You will see something stranger: neighbors, sharing a border, sometimes sharing a media market, moving at completely different speeds, for reasons that have nothing to do with the providers crossing that border and everything to do with which side of it they landed on.

I spent this year building that map, state by state, source by source, because I wanted to know whether the pattern this institute has been describing for five reports, that speed is a policy outcome, not a technology outcome, actually held up against the full country, not just a handful of convenient examples. It held up. It also revealed something more unsettling than I expected: even the best available fix, an interstate compact built specifically to solve this problem, only explains part of the story. States that joined it are still, in several cases, among the slowest in the country. The villain here is not a single broken policy. It is the absence of any policy designed to move as one system, at the exact moment the country can least afford that absence.

Every year, more of the country ages into the years when healthcare demand accelerates fastest. That demand does not check which state it landed in before it shows up. The credentialing system that has to absorb it was never built to move at one speed, and no software update changes that.

I wrote this report because an industry cannot fix a problem it has never fully mapped. This is that map.

Marcus J. Frazier

1. Executive Summary

• National health spending is projected to grow from $5.3 trillion in 2024 to nearly $9.0 trillion by 2034, and Medicare enrollment is projected to grow from 63.6 million beneficiaries in 2022 to 76.4 million by 2031, a demand curve already locked in regardless of any operational or technological response.

• This report compiles published physician licensing timelines across all fifty states and the District of Columbia, finding a range from single digit days in the fastest cases to over 150 days in the slowest, a variance of more than tenfold that has nothing to do with any individual organization's technology choices.

• Membership in the Interstate Medical Licensure Compact correlates with meaningfully faster processing on average, 75.4 days versus roughly 90 days for partial or non member states, but the effect is modest, not dramatic, and several full compact member states still rank among the ten slowest in the country.

• Cross referencing this dataset against U.S. Census data on where the senior population is growing fastest in absolute terms reveals a previously unreported collision: California, Florida, and Texas, the three states adding the most seniors in raw numbers nationally, all rank among the ten slowest states for physician credentialing, with the ten fastest growing senior population states averaging 93 days to

credential a physician against a national average near 80.

- A second, compounding collision sits on the supply side: 42 percent of the currently practicing physician workforce is 55 or older, with specialties most needed by an aging population, pulmonology, psychiatry, and orthopedic surgery, showing the highest concentrations of physicians already at or near retirement age, meaning the same slow credentialing system must simultaneously absorb rising demand and replace a retiring workforce.

- This report introduces the Koru Fifty State Exposure Score, an original framework identifying which states currently carry the highest structural risk for any organization expanding its provider footprint.

- Artificial intelligence and automation, the subject of this institute's previous report, cannot resolve this variance, because the variance is a function of state government capacity and policy fragmentation, not application processing speed.

- The report closes with a practical set of questions operators can use to evaluate their own geographic exposure before expanding into a new state, and a set of policy level observations for where the real leverage in this system actually sits.

Abstract

This report compiles and analyzes published physician licensing processing times across all fifty United States and the District of Columbia, a dataset assembled specifically for this report from state medical board publications and current industry sourced guides. The analysis finds a total range exceeding tenfold between the fastest and slowest jurisdictions, and finds that membership in the Interstate Medical Licensure Compact, while correlated with a real and meaningful speed advantage on average, does not fully explain this variance. Several full compact member states remain among the slowest in the country, indicating that state level administrative capacity, not compact membership alone, is the dominant driver of processing speed.

This analysis is set against a demographic backdrop that is already locked in regardless of policy response: national health spending is projected to grow from $5.3 trillion in 2024 to nearly $9.0 trillion by 2034, and Medicare enrollment is projected to grow from 63.6 million beneficiaries in 2022 to 76.4 million by 2031, driven by the aging of the largest generational cohort in American history into peak years of healthcare consumption. Cross referencing this dataset against U.S. Census data on senior population growth by state reveals a previously unreported collision: the three states adding the most seniors in absolute numbers nationally, California, Florida, and Texas, all rank among the ten slowest states in this report's credentialing dataset, and the ten fastest growing senior population states average a meaningfully longer credentialing timeline than the national mean. This demand side collision is compounded by a supply side one: 42 percent of the currently practicing physician workforce is 55 or older, with several specialties central to geriatric and chronic care, pulmonology, psychiatry, and orthopedic surgery among them, already carrying physician populations that are 32 to 66 percent aged 65 or older. The same credentialing system shown to be slowest exactly where new patient demand is highest must also process the

replacement of a retiring workforce, a compounding structural pressure this report terms the pincer. The report introduces the Koru Fifty State Exposure Score, an original framework for identifying which states carry the greatest structural risk for organizations expanding their provider footprint, and closes with practical guidance for operators and a set of observations on where genuine policy leverage exists in this system.

Keywords: *physician licensure, healthcare workforce, Interstate Medical Licensure Compact, healthcare demographics, Medicare enrollment, senior population growth, state regulatory policy, healthcare credentialing, artificial intelligence*

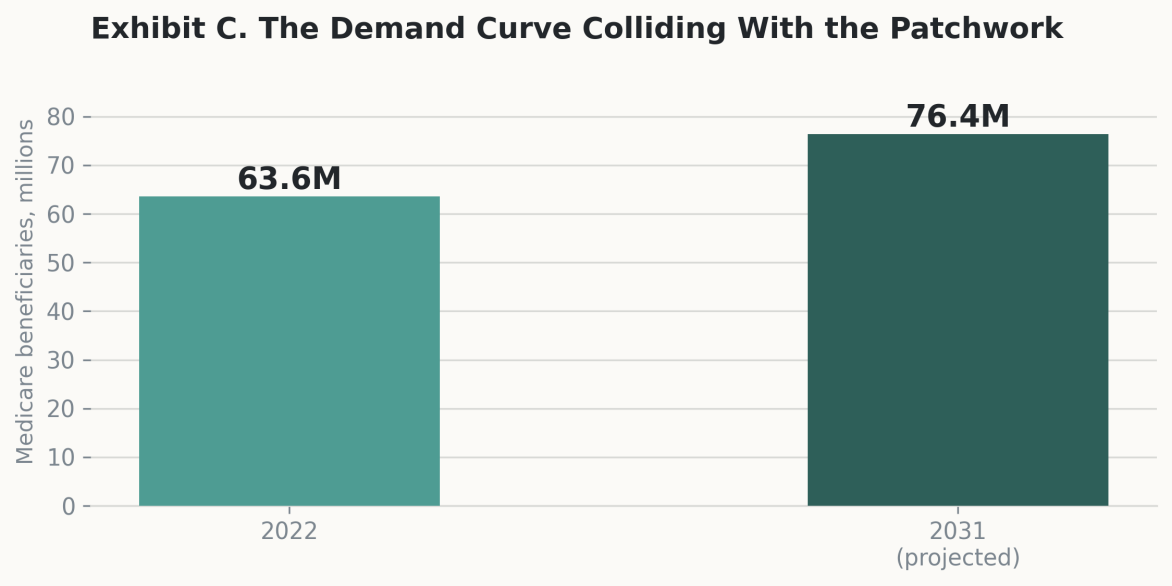
2. Introduction: A Map Nobody Had Drawn

Koru Research Institute's previous report, The Speed Illusion, established a specific claim using eight illustrative state examples: that automated credentialing software cannot meaningfully compress the portion of a licensing timeline controlled by state medical boards, because that portion sits entirely outside any applicant side technology's reach. That report was correct as far as it went. It also left an open question worth answering properly rather than leaving to inference: does the pattern observed in eight states hold across all fifty, or were those eight simply the most convenient examples of a story that does not fully generalize.

This report answers that question directly, with a complete, sourced dataset covering every state and the District of Columbia. The pattern holds. It also reveals something the smaller sample could not: the single policy mechanism built specifically to solve this problem, the Interstate Medical Licensure Compact, only partially solves it, and understanding exactly where it succeeds and where it quietly fails is more useful to an operator than either praising or dismissing it wholesale.

3. The Scale of the Problem

The demand side of this equation is not speculative. The Centers for Medicare and Medicaid Services project national health spending will grow from $5.3 trillion in 2024 to nearly $9.0 trillion by 2034, rising from 18.0 percent of the American economy to 20.6 percent over the same decade. The driver behind that growth is demographic and already locked in: CMS estimates Medicare enrollment grew from 63.6 million beneficiaries in 2022 toward a projected 76.4 million by 2031, as the baby boomer generation, the largest cohort in American history, moves fully into the years when healthcare consumption accelerates.



Source: Centers for Medicare and Medicaid Services, Office of the Actuary, and CMS National Health Expenditure Projections, 2025 to 2034. See References.

This demand curve does not pause to check whether the states absorbing it have a fast or slow credentialing system. It arrives everywhere, on the same national timeline, into a patchwork of fifty different state level systems, each with its own capacity, its own backlog, and its own administrative culture.

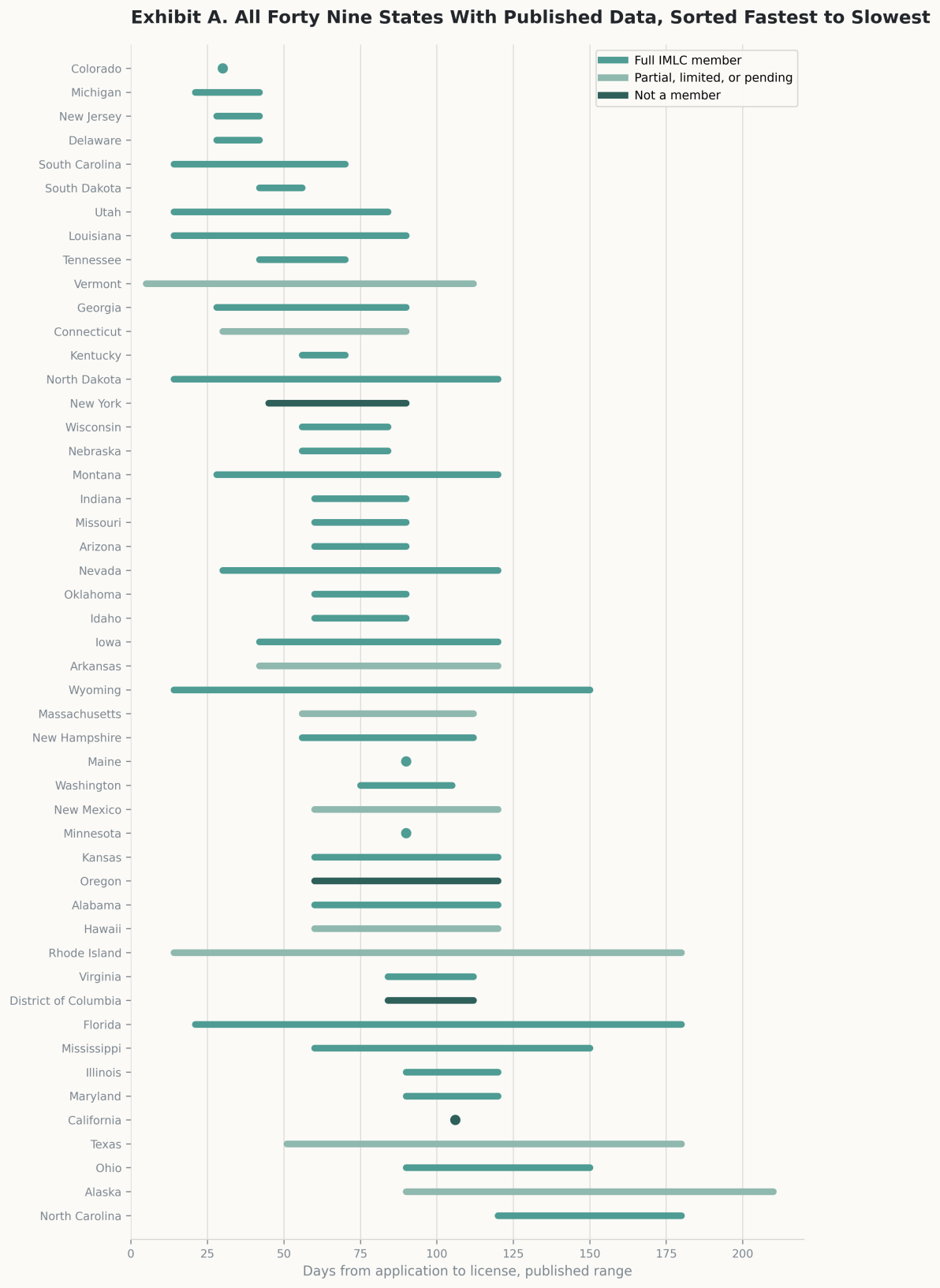
4. Methodology: Building the Fifty State Map

This report compiles physician licensing processing time estimates for all fifty states and the District of Columbia, drawn from state medical board publications where available and from current, 2026 dated industry sourced licensing guides where board level publication was unavailable. Each state is presented as a range reflecting the low and high estimates found across sources, rather than a single point figure, since real variation exists based on applicant completeness, verification response time, and seasonal application volume.

Two jurisdictions, Pennsylvania and the West Virginia Board of Osteopathic Medicine, publish no processing time estimate at all, a finding this report treats as data in its own right rather than a gap in the research. Where sources reported meaningfully different figures for the same state, for example Texas, where a statutory review stage target of roughly seven weeks coexists with reported end to end timelines closer to six months, this report presents the fuller range rather than silently selecting the more favorable figure. This disclosure practice is itself a finding: the same inconsistency in public reporting that this institute's prior reports identified inside individual organizations exists at the level of public state government data as well.

5. The Full Spectrum

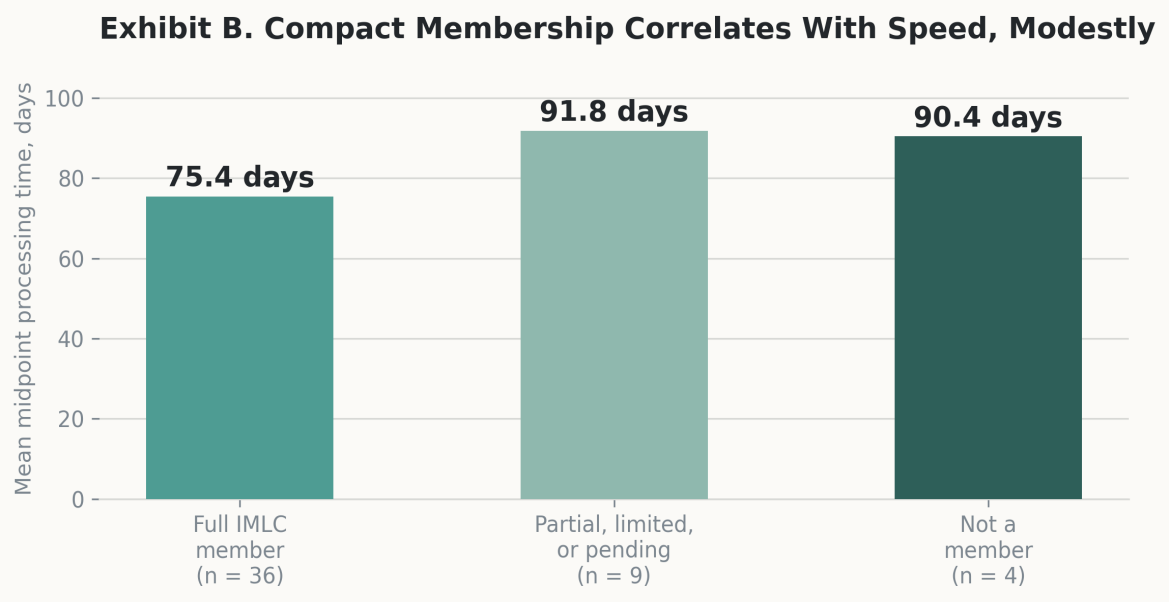
Presented together, all forty nine states with published data span a range from single digit days in the fastest available pathways to over 150 days in the slowest, more than a tenfold difference that exists entirely independent of any credentialing software an organization might purchase.



Illustrative compilation of published state ranges, sorted by midpoint. Compact status reflects documented membership as of 2026 and may shift as state legislation changes. See References for full source list.

6. Where the Compact Helps, and Where It Doesn't

Grouping every state by compact status produces a real, honest finding, one worth stating precisely rather than rounding up for effect. Full Interstate Medical Licensure Compact members average 75.4 days to license. States with partial, limited, or pending compact status average 91.8 days. States outside the compact entirely average 90.4 days. That is a genuine advantage for full membership, roughly fifteen to sixteen days on average, but it is a meaningful improvement, not a transformation.



Illustrative group comparison based on the fifty state dataset compiled for this report. Midpoint of published low and high estimates per state, averaged within each compact status group.

The more consequential finding sits inside the exceptions. Ohio, Texas, and Illinois are all full or limited Interstate Medical Licensure Compact members, and all three still rank among the ten slowest jurisdictions in the country by published processing time. Compact membership changes the odds. It does not guarantee the outcome, because the underlying driver of speed is not compact status itself. It is the individual state board's actual administrative capacity, staffing, and application volume, factors compact membership can support but cannot fully override.

7. The Collision Nobody Named

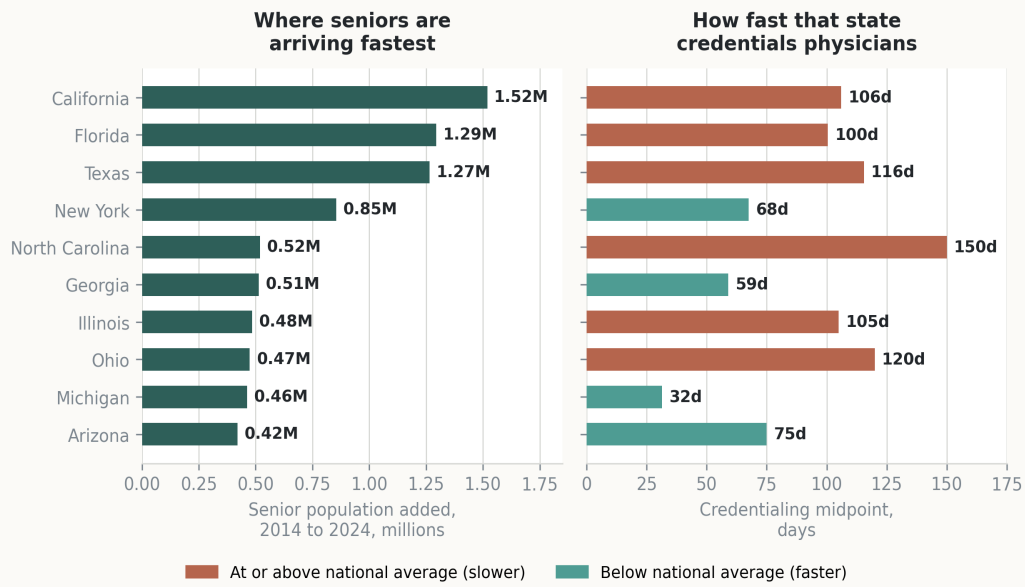
Two datasets exist, published by different agencies, for different purposes, and as far as this institute's research could determine, nobody had ever placed them side by side. The first is the fifty state processing time dataset this report has already presented. The second is real, public Census Bureau data on where the country's senior population is actually growing, not by percentage, which favors small states with dramatic relative swings, but by raw, absolute numbers, which reveals where the real weight of new demand is landing.

Between 2014 and 2024, California added 1.52 million residents aged sixty five and older. Florida added 1.29 million. Texas added 1.27 million. These are, by a wide margin, the three largest absolute increases in

senior population of any state in the country. This is where the aging of America is landing hardest, in raw human terms, not percentage terms.

All three of those states also appear among this report's ten slowest states for physician credentialing. California averages 106 days. Texas averages 116 days. Florida, despite full compact membership, still averages 100 days. Across the ten states adding the most seniors in absolute numbers nationally, the average credentialing timeline runs 93 days, meaningfully worse than the fifty state average of roughly 80 days established earlier in this report. Excluding the two fastest outliers in that group, the remaining eight average 105 days.

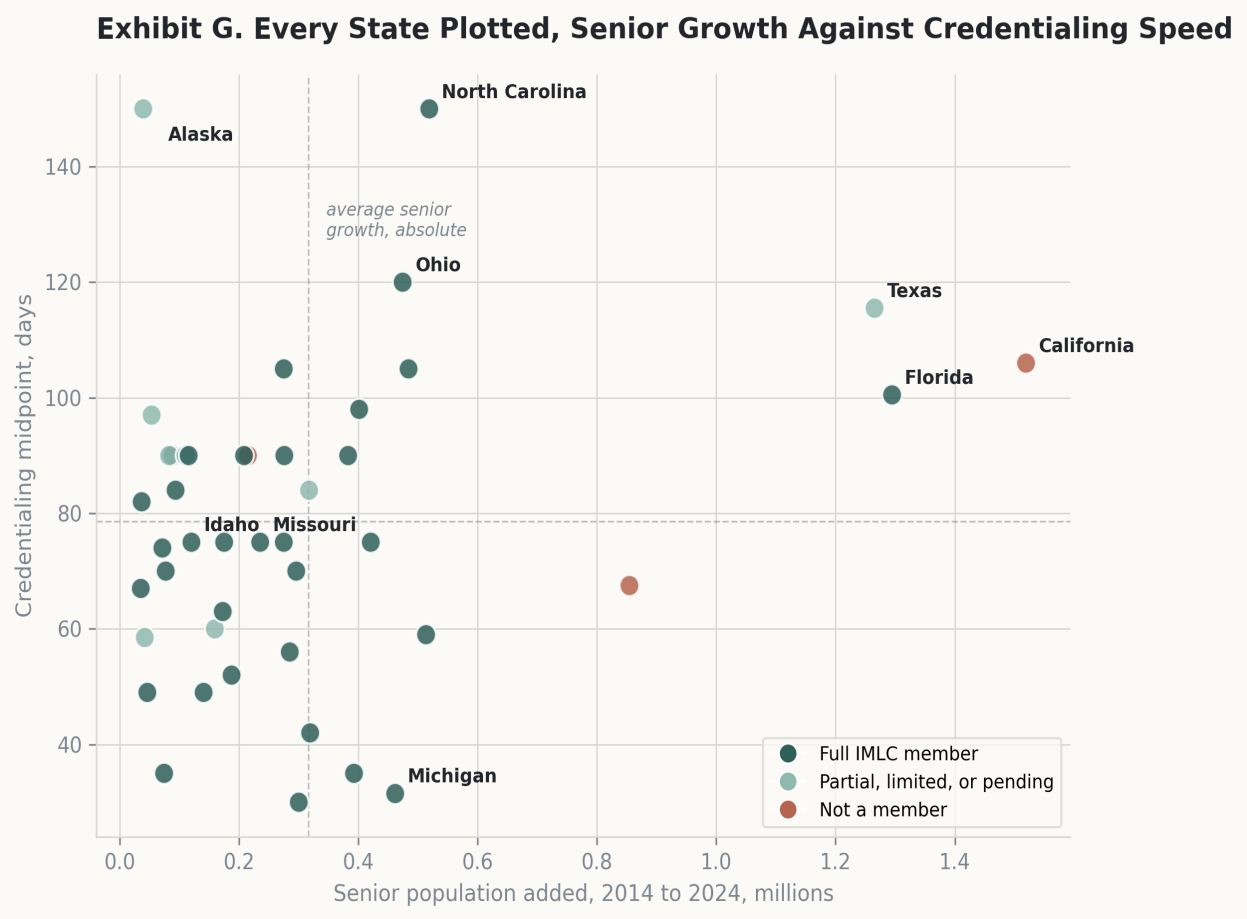
Exhibit E. The Collision, Where Demand Is Growing Fastest Against How Slowly the System Responds



Illustrative cross reference of two independently published datasets: senior population growth by state, 2014 to 2024, U.S. Census Bureau data compiled by USAFacts and Visual Capitalist, and the fifty state credentialing dataset compiled for this report. See References.

> *This is not a coincidence buried in a footnote. It is a structural pattern hiding in plain sight, because the two datasets that reveal it are published by different agencies, tracked for different purposes, and read by different audiences, none of whom had reason to compare them until now.*

The mechanism is not mysterious once named. States drawing the largest number of new retirees and aging residents are, disproportionately, large, high volume states, exactly the states where medical boards already carry the heaviest application load, the longest backlogs, and the least spare capacity to absorb a demographic surge on top of an existing one. The system's slowest processors and the country's fastest growing demand centers are, in most cases, the same places.



Illustrative plot of all forty four states with both published credentialing data and published senior population growth data, absolute numbers, 2014 to 2024. Included to verify that the pattern highlighted above holds across the full dataset, not only the ten states featured in Exhibit E. California, Florida, and Texas cluster together at the intersection of the highest absolute senior growth and among the slowest credentialing times in the country. Alaska represents a separate pattern entirely, an extreme outlier on credentialing speed despite comparatively modest absolute population growth, a small state carrying a severely broken system rather than a large state overwhelmed by scale. See References.

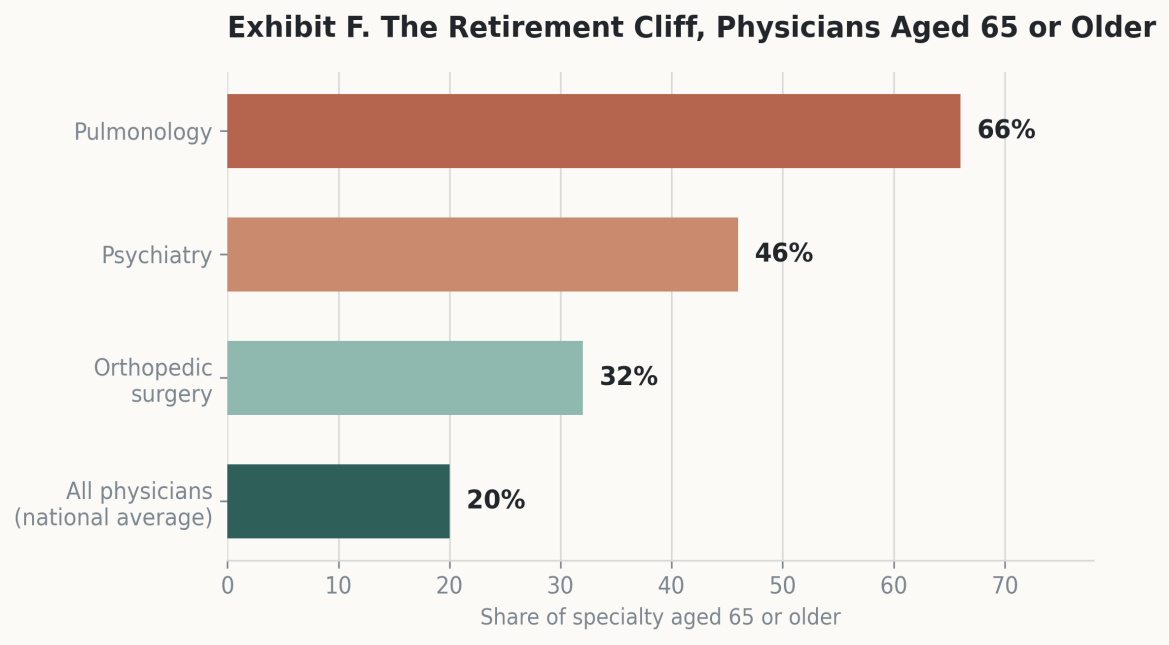
An intelligence analyst is trained to treat this kind of overlap as a signal, not an anecdote. Two independently sourced datasets pointing at the same six or seven states is not noise. It is a pattern that should already be shaping workforce and expansion strategy for any organization operating in, or considering, California, Florida, Texas, North Carolina, Illinois, or Ohio, and it is not currently being discussed anywhere in this industry's public conversation about credentialing or artificial intelligence.

8. The Second Collision: A Workforce Retiring Into the Storm

Section 7 documented a collision on the demand side. There is a second collision sitting directly behind it, on the supply side, and it involves the same generation.

The Association of American Medical Colleges, the most authoritative source on the American physician workforce, reports that 20 percent of the currently practicing clinical physician workforce is already 65 or older, and another 22 percent is between 55 and 64. Put together, 42 percent of the physicians treating

patients in this country today are within a decade of traditional retirement age. Independent industry analysis describes this as a physician retirement cliff, and it is not evenly distributed across specialties.



Source: Association of American Medical Colleges workforce data, as reported by AMN Healthcare. See References.

Sixty six percent of pulmonologists are already 65 or older. Forty six percent of psychiatrists. Thirty two percent of orthopedic surgeons. These are not fringe specialties. They are exactly the specialties an aging population needs most, the lungs, the minds, and the joints of a country moving deeper into the years when all three begin to fail more often.

> *The baby boomer generation is not only the patient population driving the demand documented in Section 3. In significant part, it is also the physician workforce currently practicing, and it is retiring out of that workforce at nearly the same moment its own aging is driving the largest surge in healthcare demand in modern American history.*

This is what makes the collision documented in this report a pincer rather than a single pressure point. Patient demand is rising fastest in exactly the states where credentialing is slowest. At the same time, a third or more of the existing physician workforce nationally is approaching an exit, and every departing physician must be replaced by a newly licensed one moving through the same slow, fragmented, fifty state system this report has mapped in full. The pipeline meant to backfill a retiring workforce is the identical bottleneck already shown to be struggling with new demand alone.

9. The Villains of This Story

Every strong story needs a clear antagonist, and this one has five, none of them a person, and none of them a single company or vendor.

The first villain is fragmentation itself. Fifty states, fifty boards, fifty budgets, fifty definitions of an acceptable processing time, with no single body responsible for the total national experience a physician or a healthcare organization actually lives through.

The second villain is timing, and Section 7 gave it a face. The demographic surge described in Section 3 is not arriving evenly across an already uneven system. It is concentrating hardest in exactly the states least equipped to absorb it, a pattern with a name now: the collision.

The third villain is the misdirected narrative. An entire industry has organized its marketing budget around solving the fastest, smallest, most visible piece of this problem, application processing, while the structural piece, state government capacity and interstate coordination, receives almost no attention and no investment at all.

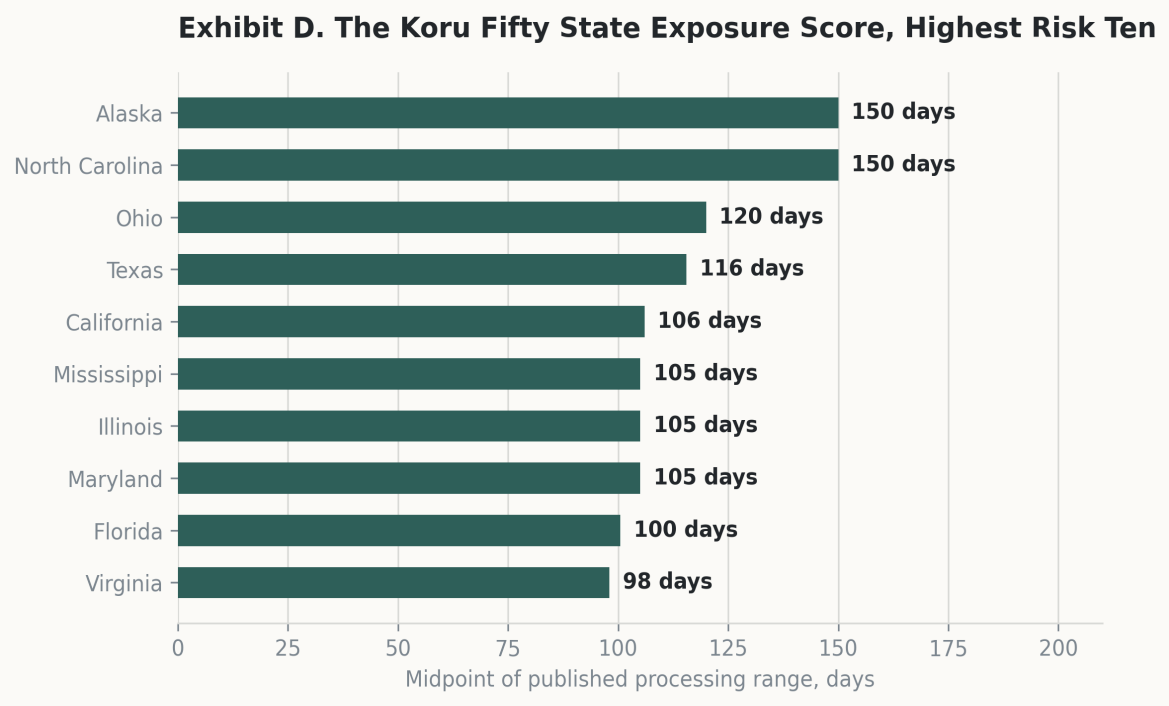
The fourth villain is the silence between two filing cabinets. The data that would have revealed this collision years ago has been publicly available the entire time, in two different government datasets, filed by two different agencies, read by two different audiences who had no reason to compare notes. Nobody hid this pattern. Nobody had to. It simply sat in plain sight, waiting for someone to ask the right question of both files at once.

The fifth villain is the clock nobody is watching on the supply side. Every conversation about this crisis focuses on the patients arriving. Almost none of it focuses on the physicians leaving, at nearly the same rate, into the same slow pipeline that is supposed to replace them. A shortage that is being planned for on only one side of the ledger is not being planned for at all.

> *None of these villains has a face. All five are beatable, but only by an operator who can see them clearly enough to stop fighting the wrong one.*

10. Introducing the Koru Fifty State Exposure Score

To translate this dataset into something an operator can act on, Koru Research Institute is introducing the Koru Fifty State Exposure Score, ranking every state by its published processing time midpoint to identify where geographic expansion carries the highest structural risk, independent of compact status.



Illustrative ranking based on the fifty state dataset compiled for this report. Reflects published midpoint processing times as of 2026, subject to change as state boards adjust staffing and application volume.

The presence of Ohio, Texas, and Illinois on this list, all compact affiliated states, is the score's most important finding. An operator who screens expansion decisions using compact membership alone would rate all three as lower risk than the data actually supports. The score is directional, not predictive of any specific applicant's outcome, and is intended to prompt a deeper state specific review before a workforce expansion decision, not to replace one.

11. What This Means for Operators Right Now

An organization's realistic credentialing timeline is overwhelmingly a function of which states its workforce is licensed in, not which software platform manages the paperwork. An organization expanding primarily into states like Michigan, Colorado, or South Carolina is operating in a genuinely different reality than one expanding into Alaska, North Carolina, or Ohio, regardless of how sophisticated either organization's internal systems are.

This has a direct and underappreciated implication for private equity backed platforms pursuing roll up strategy, the subject of this institute's fourth report. A platform's geographic expansion map is not just a market strategy decision. It is a direct, quantifiable driver of the integration debt described in that report, since every new state added to a platform's footprint carries its own credentialing exposure profile, entirely independent of how well the platform's technology stack performs.

12. What Automation Can and Cannot Fix, Revisited

This institute's previous report established that automation cannot compress the portion of a credentialing timeline controlled by a state board. This report's fifty state dataset confirms that finding at national scale and adds a further implication: the real lever available to reduce this variance is not better software. It is better policy, specifically, broader and deeper interstate compact participation, and greater consistency in how individual state boards report and manage their own processing capacity.

Automation still has a real, legitimate role, the same role described in this institute's previous report: eliminating unforced errors, tracking CAQH re attestation deadlines before they lapse, validating PECOS submissions before they are filed. None of that role includes making a state board's own internal review move faster, and no fifty state dataset changes that conclusion. It only confirms it at scale.

13. The Future State: What Winning Looks Like

An organization that internalizes this report's findings operates differently than one that does not, in ways that show up directly in enterprise value, not just operational convenience.

It screens expansion decisions using actual state level exposure data, not compact membership as a simple proxy for speed. It prices credentialing timeline risk into its workforce planning the same way it prices any other geographic risk, rather than discovering it after a hiring decision has already been made. It knows, before a buyer's diligence team ever asks, exactly which states in its footprint are structurally slow, and can explain why, with data, rather than being surprised by the question.

That organization is not immune to the fifty state patchwork this report describes. No organization is, since the patchwork is a fact of the regulatory environment, not a solvable internal process problem. But it is the organization that never mistakes the map for the terrain, and never lets a vendor's marketing claim stand in for its own geographic reality.

14. Questions to Ask Before You Expand

Operators evaluating a new state for workforce expansion can apply this report's findings directly, without waiting for a comprehensive internal study.

- Ask where the target state actually ranks on published processing time, not just whether it participates in the Interstate Medical Licensure Compact.
- Ask whether the state's compact status is full, partial, or pending, since the distinction carries a real, measurable difference in expected processing time.
- Ask when the state's own published processing time estimate was last updated, and by whom, since board capacity and backlog can shift meaningfully within a single year.
- Ask whether the organization's existing footprint already includes a state from this report's highest exposure list, and whether that exposure has been priced into current workforce planning.

• Ask what percentage of a planned expansion's workforce could be licensed through a compact pathway rather than a traditional state application, since that ratio is often more actionable than the state's overall reputation for speed.

15. Limitations of This Report

This report's fifty state dataset is compiled from published, publicly available sources rather than direct primary collection from every state medical board, and individual figures are subject to change as board staffing, application volume, and state legislation shift. Several states reported meaningfully different processing times across independent sources, and this report has disclosed those conflicts rather than resolved them by selecting a single preferred figure. Compact status reflects documented membership as of 2026 and is one of the more frequently changing data points in this dataset, since state legislatures continue to introduce and pass compact legislation on an ongoing basis.

The Koru Fifty State Exposure Score is an original, directional framework, not a peer reviewed statistical model, and the group comparison presented in Exhibit B reflects a straightforward average of midpoint estimates, not a controlled analysis accounting for population, application volume, or other factors that plausibly influence state level processing speed. A fully causal analysis of what drives state level variation, isolating the effect of compact membership from confounding factors such as population and board funding, would require a longitudinal research design examining states before and after compact adoption, a natural next step for this institute's future research.

The collision documented in Section 7 is a correlation between two independently published datasets, not a demonstrated causal relationship, and the ten state sample examined is small enough that a different threshold for defining fastest growing senior population could shift which states appear on the list. The underlying mechanism proposed, that large, high volume states carry both the heaviest demographic growth and the heaviest existing credentialing backlog, is a reasonable inference from the pattern observed, not a finding this report claims to have proven beyond dispute. It is offered as a pattern worth further, more rigorous investigation, precisely because no one appears to have investigated it at all before this report.

The physician retirement figures cited in Section 8 reflect national averages and specialty level estimates published by the Association of American Medical Colleges and industry workforce analysis, not a state by state breakdown of physician age distribution, since that data is not consistently published at the state level. The pincer framing connecting Sections 7 and 8 is this report's own analytical synthesis of two independently established facts, not a single integrated dataset, and readers should treat it as a structural argument worth serious attention rather than a precisely quantified compound risk score.

16. Conclusion: The Organization That Sees the Whole Map

The industry has spent its attention, and its marketing budget, on a story about software making credentialing faster. The real story is a fifty state patchwork of government capacity, moving at wildly different speeds, that no application platform touches, arriving at the exact moment the country's demand for healthcare accelerates fastest in a generation.

That story alone would be worth publishing. What makes it urgent is the collision documented in Section 7: the places absorbing that demand hardest, in raw human terms, are disproportionately the same places least equipped to credential the physicians who will treat it. That pattern was sitting in two public datasets the entire time. It required no proprietary data, no special access, and no artificial intelligence to find, only the discipline to ask whether two files that had never been compared might be describing the same emergency from two different angles.

Section 8 closes the pincer. The generation driving the demand and the generation retiring out of the workforce meant to meet it are, in significant part, the same generation. A system already too slow to onboard new demand alone must now also replace a third of its existing capacity, through the identical bottleneck, at the identical moment. This report did not have to build a model to find that. It only had to ask whether anyone had looked at both numbers at once.

> *The operators who protect enterprise value in this environment will not be the ones who bought the fastest software. They will be the ones who drew the map first.*

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Koru Health works with medical groups, behavioral health organizations, urgent care networks, Federally Qualified Health Centers, and private equity portfolio companies to diagnose and rebuild the operational systems that determine whether healthcare organizations can scale.

Koru Research Institute is the research and publishing arm of Koru Health, based in New York, NY. Its mission is to bring rigorously sourced, transparently cited analysis to questions that healthcare executives are otherwise left to answer with vendor marketing or internal anecdote.