



Implications of federal student loan restraints on access to medical education and the rural health care workforce pipeline

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Introduction

As a part of the Public Law 119-21 (formerly H.R. 1, the One Big Beautiful Bill Act), Congress established new federal student loan caps for graduate and professional students and eliminated the Grad PLUS loan program for new borrowers beginning July 1, 2026.¹ The Department of Education's Reimagining and Improving Student Education (RISE) final rule took effect July 1, 2026, creating a \$200,000 aggregate federal loan borrowing limit for professional students, including medical (MD and DO) and dental students.^{1,2} Other graduate students are subject to a lower \$100,000 aggregate borrowing limit.^{1,2} Under prior policy, the loan limit was defined as "cost of attendance" (as defined by the institution).³ Additionally, the separate category of Direct PLUS Loan program (grad PLUS) opportunities have been discontinued for new borrowers under H.R. 1.^{1,2} These loans previously allowed both graduate and professional students to borrow up to their school's cost of attendance.ⁱ

H.R.1 also includes changes regarding how certain health professions such as nursing are categorized under federal borrowing rules.^{1,2} Under the Department of Education RISE final rule, advanced nursing programs are treated as standard graduate degrees rather than "professional degree" programs for the purpose of determining federal borrowing limits.⁵ Other impacted health professions programs include public health, physician associate, behavioral health (except clinical psychology), and physical, speech, and occupational therapy.^{5,ii} Because professional degree programs are permitted higher federal loan caps than other graduate programs, this change reduces the total amount of federal student aid available to students pursuing advanced nursing and other health care degrees not classified as "professional."⁵ As a result, graduate students may experience lower federal borrowing limits, leading to an increase in the use of private loans or alternative financing.⁵

Graduate and professional students in health care programs represent some of the highest debt burdens of all education programs in the United States.⁷ Medical schools specifically are the most expensive professional programs in the nation. Evidence suggests that there has been a "38 percent increase in the average cost of medical school attendance between 2008 and 2020."⁴ Additionally, although medical education tuition itself has increased, students in these programs have already completed and paid for an undergraduate degree and will now be accumulating the costs of graduate or professional school.

ⁱ A with the vice dean of admissions at Washington State University shared in an interview that 60 percent of their medical students use these loans to help with costs of their education.⁴

ⁱⁱ Initially, the Department of Education's Reimagining and Improving Student Education (RISE) final rule established criteria for determining which programs qualified as professional degree programs. However, following a June 2026 federal court order, the Department issued an interim list of specific Classification of Instructional Programs (CIP) codes that will be treated as professional degree programs while litigation proceeds. The list includes medicine (M.D.), osteopathic medicine (D.O.), dentistry (D.D.S./D.M.D.), physician assistant studies, pharmacy (Pharm.D.), nursing practice (DNP), registered nursing master's programs (MSN), physical therapy (DPT), occupational therapy (OTD/MSOT), and several other health professions. Students enrolled in programs not classified as professional degree programs are subject to the lower graduate student borrowing cap.



The National Postsecondary Student Aid Survey aggregated national data to assess students' use of loans, annual borrowing, and total medical student debt.⁸ In 2020, it was found that “40 percent of medical students borrowed more than \$50,000 in a single year, and 14 percent had a lifetime federal debt exceeding \$200,000.”⁸ Students may depend on these loans to pursue a postgraduate degree, particularly those from lower-income backgrounds who could not pay for school on their own. According to the study, “low-income and out-of-state students were most likely to exceed both annual and lifetime loan caps ... Eliminating this program will create substantial financial barriers for students and most likely reduce diversity in the physician workforce.”⁴ As a result of the new policy, medical schools, doctorate programs, and masters' programs may become unaffordable for many rural students, which may lead to shortages of rural practitioners and reduced access to care in these areas.⁹ This policy brief discusses the breadth of financial changes and gaps in situational understanding, highlighting the need for further study of how H.R.1 may affect graduate and professional programs and the rural health care workforce.

Analysis

Current student loan environment

Median household income varies substantially by rurality, with a median household income of \$74,960 in urban counties, \$61,685 in suburban counties, and \$58,961 in rural counties, demonstrating a clear and persistent income gradient between rural and urban populations.¹⁰ Lower income levels reduce an individual's ability to self-finance education and limit access to favorable credit terms, constraining overall borrowing capacity.

Financial access disparities extend beyond income. Limited or nonexistent credit histories reduce independent borrowing capacity and increase reliance on co-signers for credit approval.^{11,12} Nearly one in four adults in the United States with a credit record has a subprime credit score (below 660), and approximately 4.9 percent of adults have no credit score at all.¹³ Both conditions substantially limit access to traditional credit products, including auto loans, credit cards, and private student loans.^{14,15} This demonstrates that lower-income communities — a demographic more prevalent in many rural areas — have higher shares of adults with subprime credit scores or no credit score, indicating meaningful geographic disparities in credit access and quality.¹³ As a result, individuals from these populations are less able to substitute private lending when federal loan availability is reduced, increasing reliance on federal loan programs to finance higher education when available.

Private student loans are an alternative to federal student loans.¹⁴ However, credit constraints are particularly pronounced among young adults, potentially making private loans less accessible. Credit bureau data and Consumer Financial Protection Bureau analyses indicate that a substantial proportion of college-age individuals lack a conventional credit score.^{11,12} Approximately 65 percent of individuals aged 18 to 19 have no credit score due to insufficient credit history, and among the broader 18-to-24 age cohort, an estimated 20 to 40 percent remain without a scorable credit profile as they begin to engage with credit markets.^{11,12}

Furthermore, private student loans are credit-based and underwritten using both the borrower's and any co-signer's credit history.^{14,15} Because medical students frequently have thin or limited credit profiles, most private lenders require a creditworthy co-signer for loan approval.¹⁶ In the absence of a strong co-signer, applicants are more likely to be denied or offered loans at higher interest rates and with less favorable terms.¹⁷



These financing dynamics may disproportionately affect students from rural backgrounds. Students from rural areas are more likely to come from lower-income households and communities with less accumulated wealth,¹⁰ which can limit access to creditworthy co-signers with strong credit histories or sufficient income.^{11,12} As a result, rural medical students may face greater barriers to securing private educational financing compared with their urban peers, particularly in the setting of reduced federal borrowing capacity.¹⁴ Additionally, federal student loan programs have historically not relied on traditional credit underwriting (such as credit scores or extensive credit history) to determine eligibility.¹⁴ When federal loan availability was sufficient to cover the full cost of attendance, a student's credit profile or access to a creditworthy co-signer was less critical.¹⁴ With reduced federal borrowing capacity, these factors may now play a significantly larger role in determining access to education financing.

Comparative analysis of cost and financing of health professional education

Current estimates of total medical school cost of attendance — including tuition, fees, and required living expenses — commonly range from approximately \$286,000 for public institutions to more than \$390,000 for private institutions over four years.⁷ Proposed federal lifetime borrowing limits of \$200,000 for professional degrees would leave many medical students with a financing gap of roughly \$86,000 to \$190,000.^{1,2} In the absence of alternative institutional or family resources, this gap would likely need to be covered through private student loans, increasing reliance on credit-based financing mechanisms.^{14,15} Additionally, the phased out grad PLUS loans was utilized by approximately 40 to 50 percent of medical and graduate students during their course of study and allowed borrowers to finance up to the full cost of attendance.¹

Figure 1: Projected financing deficits for selected health profession education programs under H.R. federal student loan limits

Profession	Post Undergraduate Training Duration	Average Cost of Attendance	Average Cost of Tuition	Average Allotted Living Funding	Current Federal Loan Amount	Current Loan Deficit	Federal Borrowing Classification
MD/DO Public	4 years	\$286,000	\$167,476	\$118,524	\$200,000	(\$86,000)	Professional
MD/DO Private	4 years	\$390,000	\$268,580	\$121,420	\$200,000	(\$190,000)	Professional
DDS/DMD Public	4 years	\$296,000	\$187,000	\$109,000	\$200,000	(\$96,000)	Professional
DDS/DMD Private	4 years	\$391,000	\$360,000	\$31,000	\$200,000	(\$191,000)	Professional
Au.D.	4 years	\$250,000-\$330,000	\$90,000-\$120,000	\$90,000-\$120,000	\$200,000	(\$50,000-\$130,000)	Professional
PA	24-27 months	\$170,000-\$190,000	\$100,000-\$120,000	\$65,000-\$80,000	\$100,000	(\$70,000-\$90,000)	Graduate*
DNP/APRN	3-4 years	\$110,000-\$180,000	\$70,000-\$120,000	\$40,000-\$60,000	\$100,000	(\$10,000-\$80,000)	Graduate*
CRNA	3 years	\$180,000-\$250,000	\$120,000-\$170,000	\$50,000-\$80,000	\$100,000	(\$80,000-\$150,000)	Graduate*
MPH	2 years	\$70,000-\$120,000	\$45,000-\$75,000	\$25,000-\$45,000	\$100,000	\$0-(\$20,000)	Graduate

Figure 1. Total cost of attendance includes tuition, fees, required educational expenses, and estimated living expenses. Financing deficits represent the difference between average cost of attendance and the current aggregate federal borrowing limit established under H.R.1. **Graduate*** designations indicate clinical health care degree programs that were previously eligible to finance the full cost of attendance through Direct Unsubsidized Loans and grad PLUS loans but are now subject to the graduate federal borrowing limit under H.R.1.^{1,2,7,18-20,31-34}

As seen in Figure 1, these student loan adjustments have the potential to affect numerous health care professions. For example, the total cost of attendance for advanced practice health professions is generally lower in comparison to medical school training. Nurse practitioner, physician assistant, advanced practice registered nurse, and certified registered nurse anesthetist programs typically range from approximately \$80,000 to \$200,000 in total cost, depending on institution type and program length. Many of these programs are now generally classified as graduate-level programs, resulting in fixed borrowing limits of approximately \$100,000.^{2,18-20} Combined with the elimination of the grad PLUS loans, these changes may lead to financing gaps if program costs exceed federal loan limits.²

These limitations are expected to create structural financing gaps for the majority of medical students and a portion of those pursuing other health professional degree pathways. This also raises concerns for



individuals who plan to utilize federal and state loan repayment programs, such as the National Health Service Corps Loan Repayment Program and Public Service Loan Forgiveness.²¹ These programs are designed to reduce educational debt in exchange for service commitments, often in rural or underserved areas. However, these programs typically apply only to federal student loans and do not cover private educational debt.¹⁴ As a result, increased reliance on private loans may reduce the overall financial benefit of these programs, potentially diminishing effectiveness as incentives for health care providers to practice in rural communities.

Policy tradeoffs and considerations

While these changes introduce significant challenges for medical and other health care professional students, several aspects of the bill and concerns identified by proponents of H.R.1 warrant consideration. Over the past two decades, the cost of higher education has increased by approximately 60 percent.⁷ Additionally, approximately 9 to 10 percent of federal student loan balances in repayment are seriously delinquent.²¹ However, a substantial portion of borrowers are not in active repayment. Federal data indicate that many outstanding loan balances are in deferment, forbearance, or income-driven repayment plans with minimal or no required payments, suggesting that traditional delinquency metrics may not fully capture repayment challenges.²¹

Although medical tuition costs have increased substantially over time, individuals who obtain a medical degree experience significantly fewer difficulties with loan repayment compared to the general borrower population.⁴ Medical school graduates have among the lowest default rates of any graduate group – consistently reported at less than 1 percent – reflecting strong repayment capacity driven by higher lifetime earnings.⁴ As a result, the rationale for broadly constraining lending based on repayment concerns is less applicable to those pursuing a medical degree. Additionally, constraints on federal student loans are unlikely to meaningfully impact tuition costs, as demand for medical education remains high relative to available positions. In recent years, U.S. medical school applicants have exceeded 54,000 annually, with total matriculation exceeding 30,000 positions annually.^{4,22} Furthermore, the medical school pipeline is already disproportionately composed of students from higher-income households, with approximately 75 to 80 percent of matriculants originating from families in the top two income quintiles and only about 5 percent from the lowest quintile.²³ Consequently, reductions in access to federal student loans may disproportionately discourage first-generation and lower-income applicants, while medical schools continue to receive a surplus of applicants for a limited number of positions. H.R.1 student loan caps risk shifting the composition of the applicant pool, with limited potential to reduce tuition costs and a greater likelihood of negatively affecting the health workforce pipeline in rural communities.

Potential effects on rural health workforce

Long-term rural health workforce shortages are compounded by an upstream pipeline constraint. Fewer than 5 percent of medical students come from rural backgrounds, despite approximately 20 percent of the U.S. population residing in rural areas.²⁴ Importantly, a rural background is one of the strongest predictors of eventual rural medical practice.²⁵ The financial consequences of educational debt may be particularly salient for students considering rural primary care careers, where physician compensation is often lower than in specialty practice and opportunities available in larger metropolitan markets. As educational borrowing requirements increase, these income differentials can reduce the perceived financial viability of entering rural primary care, further constraining an already fragile workforce pipeline.

Longitudinal evidence shows that rural background and related factors identifiable at matriculation strongly predict eventual rural practice, with approximately 45 percent of graduates with key predictors



going on to practice in rural areas compared with 12 percent among those without such predictors.²⁶ Meta-analytic evidence further demonstrates that rural background is associated with significantly higher odds of rural practice (odds ratio approximately 2.7).²⁷

Consequently, policies or financing barriers that disproportionately reduce rural students' ability to matriculate or persist in medical training risk, exacerbating existing shortages in the rural physician workforce.²⁸ Financial barriers introduced through federal loan caps may disproportionately reduce matriculation among rural students, further constraining the rural physician pipeline. Using established estimates of rural medical student representation and practice patterns, even modest reductions in rural student matriculation could produce measurable downstream effects on the rural physician workforce. A modeled 20 percent reduction in rural could result in approximately 1,300 fewer rural physicians over a decade.²⁴⁻²⁷ For context, this magnitude of loss is equivalent to removing care capacity for approximately 3.2 to 4.5 million patients, based on commonly reported rural physician panel sizes,²⁹ and is comparable to the entire physician workforce of some smaller, predominantly rural states.³⁰

Implications

This analysis demonstrates how recent federal student loan policies translate into downstream effects on the rural physician workforce. Federal loan caps under H.R.1 create a financing gap between the cost of medical education and available federal borrowing. Under these changes, private credit becomes a more prominent source of financing, with access determined by income, credit history, and the availability of creditworthy co-signers. Because students from rural backgrounds are more likely to come from lower-income households and have reduced access to strong credit profiles, they face greater barriers to private financing. As a result, these barriers could limit matriculation and persistence among rural students. Because rural background is one of the strongest predictors of eventual rural medical practice, this reduction in representation ultimately contributes to worsening physician shortages in rural communities.

Policy recommendations

NRHA recommends the following actions to support the education of health professions students.

- Reinstatement of grad PLUS loans to ensure equitable access to financing for education and living expenses for students pursuing graduate degrees. Almost half of all current medical students rely on graduate PLUS loans to finance their education,⁴ and the discontinuation of this loan for future graduate students will force them to rely on private loans, some of which have fewer safeguards and require a credit score that rural students are less likely to have.^{11,12,14}
- Increase federal direct unsubsidized loan limits to cover the full cost of education for health professions programs.
- Categorize all graduate health professions programs as “professional” programs rather than “graduate” programs to ensure equitable funding access.
- Direct the U.S. Government Accountability Office to study how federal student loan funding is used by medical schools. Investigate the root causes of high tuition costs for health professions programs and medical schools specifically. Determine how tuition and education expenses paid by students via federal and/or private loans are used. Medical schools are not currently required to disclose how tuition is used and are only specifically required to disclose cost of attendance.²⁸



Recommended actions

To implement these recommendations, NRHA supports the passage of the following bills in the 119th Congress.

H.R.6718 - The Professional Student Degree Act: This legislation focuses on redefining and expanding what programs qualify as “professional” for federal loan purposes after restrictions introduced by H.R.1.¹

H.R.6677 - Professional Degree Access Restoration Act: This legislation proposes to reverse student loan limits imposed by H.R.1, which caps borrowing and narrows the definition of a “professional student.”¹ Nurse practitioner and physician assistant programs are now capped at \$100,000 in federal borrowing, which could drive students away from pursuing this training due to funding concerns.² In addition, programs that do qualify as “professional” such as medical schools are capped at \$200,000 in federal borrowing over four years, which does not cover the cost of tuition at the majority of medical schools.⁷

S.4568/ H.R.8691- Nursing is a Professional Degree Act: This bill would establish nursing as a professional degree category for federal aid purposes, as well as allow graduate nursing students to access higher borrowing limits associated with professional programs.

Conclusion

H.R.1 has drastically changed the financial landscape for health professions students. Through decreases in federal funding allowed and/or reclassification of certain programs as “non-professional,” these changes will have major impacts on the future of graduate health education. Rural students are likely to be disproportionately affected, as they often have lower credit scores, come from lower socioeconomic status, and rely more on borrowing to finance their education. Research indicates that rural background and training make a graduate more likely to return to a rural area to practice. Constraining education financing makes it more difficult for rural students to become health care professionals and could exacerbate the persistent workforce shortage in rural areas.

The rural health care workforce is already struggling, and changes to health care education financing do not exist in a vacuum. The changes in H.R.1 disproportionately affect rural students, which could lead to fewer new providers choosing rural practice. Additionally, many rural health care institutions provide loan repayment as incentives for new practitioners. With greater financial burden from private loans with higher interest rates, institutions may choose to stop offering this incentive, inadvertently driving providers away from rural areas and compounding the shortage of rural providers. Loan repayment programs also generally only cover federal loans. With lower federal loan limits, new health care providers may not consider loan repayment programs worthwhile, which could dissuade them from pursuing careers in rural areas.



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