National Rural Health Association Policy Brief

Rural medical debt: A systemic and structural population health crisis

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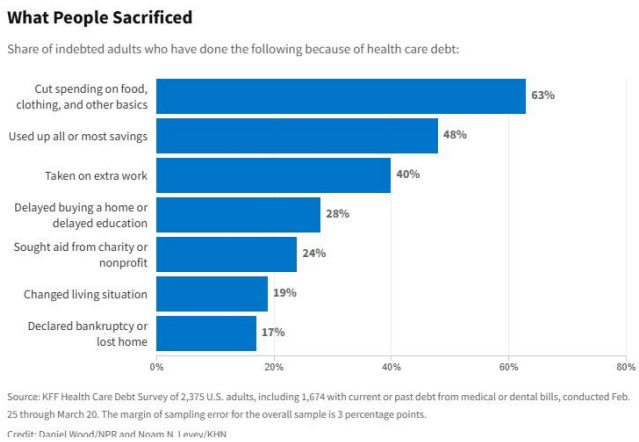
Introduction

Medical debt is defined as "unpaid medical bills owed to a person or entity whose primary business is providing medical services, products, or devices" by the Consumer Financial Protection Bureau (CFPB). This definition can include debts owed to the health care provider directly, to a collection agency, or even credit card or borrowed money used to pay for medical care."[1] Unlike other consumer debts, costs around medical care are rarely planned, and relatively small unexpected medical expenses can be unaffordable. Medical debt has numerous consequences beyond financial hardship. Individuals with medical debt often delay seeking care or forego necessary treatments, worsening health outcomes, and debt-related stress can contribute to anxiety, depression, and other mental health issues.[2] There is also an economic ripple effect, as communities with high levels of medical debt may experience decreased economic activity due to reduced consumer spending and increased reliance on social services.[3]

Rural residents face compounding challenges accessing health care due to geographic isolation, fewer health care providers, and higher rates of underinsurance.[4] Racial and income disparities intensify these effects related to medical debt. Approximately 17 percent of Black and Hispanic rural residents report difficulty paying medical bills, with more than 14 percent of Black rural residents unable to pay at all.[5] In contrast, only 11.5 percent of white rural residents report similar issues.[5] Rural households living just above the poverty line carry some of the highest burdens of medical debt.[6] At the same time, rural hospitals face financial instability exacerbated by uncompensated care and low reimbursement rates, which can drive aggressive billing practices, force hospital or service closures, and increase costs and debt for rural individuals.

While national attention to medical debt is increasing, rural-specific solutions remain limited. This brief explores the drivers of rural medical debt and offers targeted policy recommendations to relieve the burden on individuals and providers.

Figure 1



Analysis

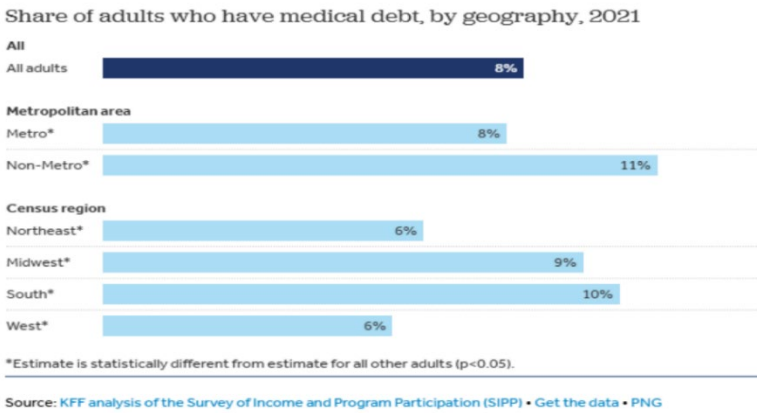
The CFPB estimates approximately $88 billion dollars in debt is reflected in American's credit reports.[17] Factors contributing to rural medical debt include higher rates of chronic disease requiring more care, challenges in access caused by distance to facilities, fewer providers, transportation barriers, and delays in care creating higher reliance on emergency services. Coupled with increased cost sharing, uninsurance or underinsurance, and the prevalence of high-deductible health plans, rural Americans are

[1] Due to limitations inherent in credit reporting, this is likely an underestimate of the true total.

shouldering an increasing debt burden that often forces them to choose between health care and basic necessities (Figure 1).

A recent survey suggests that the true aggregate of U.S. medical debt is approximately $220 billion with nearly 1 in 12 adults owing medical debt.[8] The findings of this survey also demonstrate those living in rural areas were more likely to have medical debt (Figure 2).

Figure 2



Access to affordable, comprehensive insurance

Recent estimates suggest approximately 25 million Americans are uninsured, with higher rates in rural areas (8.4 percent) than urban areas (7.8 percent). People in rural areas are less likely to have access to private insurance coverage (61.8 percent compared to 68.0 percent) and much less likely to have access to employer-sponsored insurance (47.8 percent compared to 56.0 percent) than their urban counterparts.[9] This lack of access – along with lower wages and the number of self-employed individuals in agriculture – also leads to higher rates of underinsurance. Both groups are vulnerable to significant financial burdens in the event of acute illness or injury, which is a large driver of national medical debt.

Medical debt in rural communities is further complicated by preventative care and chronic disease management, which disproportionately affects rural patients. Tackling the rural medical debt crisis requires more than temporary financial relief; it demands systematic reform that ensures health care is accessible, predictable, and financially manageable, especially for marginalized rural residents.

A significant driver of current medical debt is high-deductible private insurance plans.[12] This will likely be exacerbated by Medicaid cuts passed in H.R.1 (119th Congress, 2025) and greater emphasis on catastrophic health insurance plans for those seeking affordable coverage options.[13] High-deductible or catastrophic plans offered to rural populations, particularly through small employers or individual markets, have limited benefits that exclude essential services like mental health, dental care, or preventive services. These exclusions lead to higher out-of-pocket expenses when patients seek care outside their insurance network or for services not covered.

The American Rescue Plan (ARP) of 2021 extended advance payments of the premium tax credit for Affordable Care Act (ACA) Marketplace coverage to include individuals earning more than 400 percent of the federal poverty line (FPL). This change – along with other policies aimed at providing more generous support in the health insurance marketplace – had a significant impact on access to affordable health coverage. As benchmark premiums tend to be higher in rural areas, enhanced tax credits are especially important for making coverage affordable for rural consumers.[14] In 2021, more than three-quarters of Marketplace enrollees in rural areas of states using HealthCare.gov could select a zero-premium plan, representing a 13-percentage point increase.[15] The Congressional Budget Office estimates that 3.8 million

people will lose coverage due to affordability unless Congress extends the enhanced premium tax credits, which expired at the end of 2025.[14]

Medicaid expansion and rural debt burden

One and four rural residents utilize Medicaid as their primary health care coverage.[16] States that expanded Medicaid with the ACA saw significant reduction in medical debt for individuals and families. One study found that expansion states experienced a 34 percent greater decline in average medical debt in collections compared to non-expansion states.[17] Those living in Medicaid expansion states had better credit, were able access more favorable loan terms, and had a reduction in financial strains leading to bankruptcies and evictions than their counterparts in non-expansion states.[18]

The recent passage of H.R.1 and the sweeping cuts to Medicaid included in the legislation are expected to result in loss of coverage for an estimated 16 million Americans.[19] This will force families to pay higher out-of-pocket costs, leading many to delay or forgo necessary treatments and ultimately producing more negative health outcomes. As outlined above, Medicaid coverage is critical to mitigating medical debt in rural communities. While Medicaid cuts have been legislated, opportunities may remain to ensure Medicaid qualification requirements are not overly cumbersome or restrictive.

Medical debt in credit reports

The Consumer Finance Protection Bureau's 2025 rule aimed to remove all medical debt — past, current, and future — from credit reports. The intent was to recognize that medical debt is largely a product of systemic issues such as opaque billing practices, insurance coverage gaps, and unforeseen medical emergencies rather than consumer creditworthiness.[20] By removing medical debt from credit reports, the rule sought to improve credit scores for approximately 15 million Americans, potentially increasing their credit scores by an average of 20 points and expanding access to housing, auto loans, and business credit.[20]

However, the rule was deemed unlawful by federal court in July 2025, and the CFPB has decided not to reissue.[21,22] In addition, H.R.1 has cut funding to the agency and halted much of their regulatory work. While states have moved forward with additional safeguards, their efforts have largely focused on removal of medical debt from credit reports versus strengthening financial assistance programs and community benefit standards.

Billing practices and financial assistance

Co-morbidities experienced by rural populations increase the frequency and intensity of health care utilization, placing more financial burden on both patients and the health care system. While Medicare provides an essential coverage framework for many older rural residents, significant gaps remain. Rural providers such as Critical Access Hospitals (CAHs) and Rural Health Clinics (RHCs) receive cost-based reimbursement under Medicare to help sustain access as low-volume providers.[23] Rural patients enrolled in traditional Medicare may experience higher coinsurance at CAHs for outpatient services than they would pay for the same service at a prospective payment system (PPS) hospital due to Medicare payment policies that apply 20 percent of charges (i.e. the list prices hospitals set for their services) rather than the capped PPS rate. These cost-sharing requirements can exacerbate medical debt for rural beneficiaries. A June 2025 Medicare Patient Advisory Commission report to Congress found that cost

sharing varied widely across services and rural cost-based providers. In their report, the Commission recommended that CAH coinsurance for outpatient services provided to FFS beneficiaries be set at 20 percent of the outpatient payment amount and subject to a cap per service equal to the current Medicare inpatient deductible. While the Commission suggested that setting more uniform and predictable coinsurance levels by capping coinsurance at 20 percent of the lower of an RHC's all-inclusive rate (subject to payment limits) or 20 percent of the actual charges could benefit beneficiaries, they felt that charge-based coinsurance could undermine new RHC payment limits set by the Consolidated Appropriations Act (2021).[24]

RHCs and CAHs often operate with limited patient volume, which necessitates higher prices for services to offset fixed operational costs. Financial pressures stemming from low reimbursement rates and minimal economies of scale can result in elevated charges compared to urban facilities.[23] These costs are often passed on to patients already working with limited financial resources in the form of coinsurance. While financial assistance programs are critical tools used by health care institutions to ensure access to care for individuals who are uninsured or underinsured, these programs differ significantly between for-profit and nonprofit health care systems in terms of motivation, regulatory obligations, scope, and implementation.

Nonprofit hospitals in the United States are legally required to provide financial assistance under the Internal Revenue Code §501(c), which mandates the development and public availability of a written financial assistance policy as a condition for tax-exempt status.[25] These hospitals typically have more expansive eligibility criteria, often covering patients up to 200 to 400 percent of FPL or even higher in some institutions. Many also include scale discounts and provisions for underinsured patients.[26] Furthermore, nonprofit systems are more likely to forgive medical debt and proactively screen patients for eligibility, sometimes using presumptive eligibility algorithms.[27]

In contrast, for-profit hospitals have no legal obligation to offer financial assistance and may cap eligibility at lower income thresholds (150 to 200 percent of FPL), exclude underinsured patients, or require more extensive documentation.[28] Their financial aid policies are typically voluntary and vary significantly across institutions. As a result, access to financial relief in for-profit systems can be more limited and inconsistent.

The American Hospital Association (AHA) has established voluntary guidelines that focus on encouraging health care transparency, reducing medical debt, and empowering patients. These guidelines have been adapted from what is already required in federal law for tax-exempt hospitals and aim to align with a core principle of universal coverage.[29] While not broken down by rural or urban areas, nearly 2,800 hospitals and health systems have affirmed these guidelines.

Encouraging both federal and state-level policy reforms that align with the AHA guidelines would help combat the medical debt crisis in rural communities. State-level policies such as regulation around charging interest on medical debt could also be impactful and help prevent the snowballing of medical debt that affects millions of Americans. Some states including Delaware and Maine now prohibit charging interest on medical debt, while New Jersey and New York have established caps on interest rates. In addition, in FY24 New Jersey appropriated $10 million to launch a pilot program aimed at eliminating personal medical debt.[30]

Finally, nonprofit organizations like Undue Medical Debt have partnered with city, county, and state governments across the country along with hospitals, health systems, physician groups, and others to purchase and forgive medical debt for pennies on the dollar. Since 2014, Undue Medical Debt has abolished more than $22.8 billion in medical debt and provided debt relief for over 14.72 million people in the United States.[31]

Monitoring rural medical debt

Many Americans, even those with private health insurance, do not have enough liquid assets to meet deductibles or out-of-pocket maximums, with rural residents having even fewer resources than their urban counterparts.[32] As a result, medical debt does not always appear in an easily discoverable way on credit reports, with some people using credit cards or personal loans to pay medical bills. This makes data on rural medical debt sparse, inconsistent, and often obscured by broader national trends related to health insurance availability and affordability.

Current information on medical debt comes from a variety of sources such as credit reporting agencies, national surveys (Medical Expenditure Panel, National Health Interview Survey, and Behavioral Fisk Factor Surveillance System), hospital financial reports, Medicaid and state-level data, local surveys, and community health needs assessments.[33] Limitations and challenges exist with the sources available when understanding how medical debt is impacting rural communities.

Monitoring rural medical debt is essential to aid in policy development and targeted interventions. Examining the rural impact provides a transparency mechanism that can lead to accountability among health care providers and insurers. Understanding debt trends can help health systems anticipate care needs and improve affordability and accessibility strategies. Reducing medical debt can improve population health outcomes, particularly in underserved rural areas where health burdens are already high.[34]

Policy recommendations

Medical debt is a complex issue that requires broad interventions across health coverage, insurance affordability, individual credit reports, billing practices, and debt monitoring. Polices that address medical debt must incorporate the unique needs of rural Americans.

- **Improve access to affordable, comprehensive, and understandable health care coverage.**
    - *Subsidize rural ACA premium reforms.* Targeted reforms that lower premiums and prioritize plans with low out-of-pocket costs can reduce financial strain on rural families. Increasing income-based subsidies is particularly important in rural areas, where incomes are often below the national average and insurance premiums tend to be higher. Subsidies make comprehensive coverage more attainable for lower-middle income families.
    - *Improve coverage for low-income individuals through sustaining, and where possible expanding, access to Medicaid in all states.* The loss of coverage will force families to pay higher out-of-pocket costs, leading many to delay necessary treatments and ultimately producing more negative health outcomes.
    - *Expand insurance literacy and outreach.* Many rural residents lack access to clear, relevant education about coverage options. Improved education initiatives can help individuals better

understand the limits of their insurance, avoid underinsurance, and make informed decisions about selecting plans that meet their health care needs.

- *Mandate insurance companies to provide clear, plain language policy documents* that the average American consumer can understand to help them make informed decisions regarding available coverage.
- *Reduce rural residents' exposure to inflated charges tied to cost-based reimbursement.* Address concerns that rural beneficiaries pay more due to a 20 percent copay on cost-based reimbursement at CAHs and RHCs.

- **Provide long-term financial stability and empower rural residents to build credit without the fear and burden of unavoidable medical debt.**
  - *Develop a comprehensive medical debt protection framework* that addresses both medical debt on credit reports and financial assistance programs.
  - *Reinstate the Consumer Financial Protection Board's ability to regulate consumer protections* and reissue rules limiting reporting of medical debt on credit reports. Restricting the use of medical debt in credit scoring would prevent families from facing long-term financial penalties for circumstances beyond their control.

- **Improve billing transparency and standardize financial assistance to protect rural patients.**
  - *Incentivize patient-friendly billing.* Encourage all hospitals including CAHs and other rural facilities to adopt the AHA's patient billing guidelines. These guidelines emphasize transparency, clear communication, and fairness in billing and collections, ensuring patients can understand.
  - *Establish minimum standards for financial assistance programs.* Create consistent financial assistance policies across hospitals, regardless of their tax status.
  - *Develop uniform eligibility criteria and proactive screening.* Standardize income thresholds and eligibility rules for financial assistance programs nationwide and establish screening of all patients at the point of care. This would help identify eligible rural residents before debt accrues, reducing the likelihood of medical bills progressing to collections.
  - *Establish medical debt forgiveness programs.* Create structured debt forgiveness programs and pathways that patients and health care facilities can access, particularly in rural areas where unpaid medical bills contribute to hospital financial strain. These programs could include federal, state, and private funding to offset uncompensated care while protecting patients from collections and wage garnishment.
- **Strengthen medical debt monitoring to guide rural health policy and investment.**
  - *Establish a national rural medical debt registry.* Create a federal database that tracks levels and trends of medical debt in rural communities. This registry would allow the problem to be further scoped to identify high-burden regions and evaluate effectiveness of debt relief programs.
  - *Develop a standardized set of medical debt indicators in community health needs assessments for use by hospitals, public health departments, and health systems* contingent on the availability of reliable and reportable data from billing, financial assistance, and revenue cycle. This ensures that medical debt, recognized as a barrier to community wellness, is measured consistently across institutions while acknowledging variations in data capacity, especially in rural facilities.

Recommended actions

- Support the restoration of Medicaid funding at levels prior to passage of H.R.1 and encourage all states to expand Medicaid coverage.
- Keep Marketplace insurance coverage affordable by making permenant the enhanced tax credits as proposed in S.46/H.R.247 Health Care Affordability Act.
- Support policies that align outpatient coinsurance at CAH, cap CAH outpatient coinsurance, and cap RHC coinsurance at 20 percent as proposed in H.R. 3684 Save America's Rural Hospitals Act.
- Support the reissue and codifying of the CFPB rule to limit reporting of medical debt on credit reports to prevent rollback by future administrations.
- Take congressional action to amend the Fair Credit Reporting Act explicitly prohibiting medical debt from being reported or allowing reporting only after a verified period of time or for very large, documented amounts. Reinstate funding to the CFBP to implement the statutory change.
- Codify financial assistance obligations of nonprofit rural hospitals by strengthening IRS enforcement of community benefit requirements.
- Incorporate medical debt into community health assessments.

Conclusion

The persistence of medical debt — despite record-high rates of insurance coverage — underscores systemic failures in the U.S. health care and economic systems. Rural Americans are particularly at risk, as they face higher health care costs, limited provider networks, and fewer economic opportunities, all of which exacerbate cycles of debt and poverty. The burden of medical debt not only compromises access to care but also forces difficult trade-offs between basic necessities and health, contributing to poorer outcomes and deepening disparities. Breaking this cycle requires comprehensive interventions including reforms to insurance affordability, protections against aggressive billing and collections, and investments in debt monitoring. Without deliberate policy change, medical debt will continue to erode the well-being of rural communities and perpetuate intergenerational inequities.

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