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Understanding the Impact of Medical Debt in Rural Communities: Perspectives from Rural Hospital Administrators

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Key Findings

- Rural hospital administrators from seven states identified uninsurance and underinsurance, existing community sociodemographics, and emergency room usage as key factors contributing to medical debt.
- Hospital administrators discussed hospital- and patient-level consequences of medical debt. At the hospital, these included financial burdens, challenges with insurers, and cutting/shifting services or supports. For patients, this meant an exacerbating impact on everyday life, including delays and difficulty accessing care.
- Hospital administrators offered recommendations for policy changes to improve the financial health of rural residents and hospitals. These highlighted a general need to consider the impact of legislation on rural hospitals to avoid unintended consequences, as well as addressing low Medicaid reimbursement rates and challenges with Medicare Advantage.

Purpose

Medical debt, or individual debt that incurs due to health care and related costs, is pervasive across the US and is a well-documented burden on access to care and overall well-being. However, less is known about the impact of medical debt on hospitals and patients in the context of rural communities. This policy brief presents findings from key informant interviews with nine administrators representing rural hospitals in seven states (AR, CA, IL, TX, VT, WA, and WV). Using content analysis of interview data, we share findings around hospital and community-level implications of medical debt, and policies that may help or hinder this issue.

Background and Policy Context

Approximately 40% of US adults are affected by medical debt,[1] and there are currently $88 billion of outstanding medical bills in collections.[2] Medical debt is most common among people without health insurance,[3] however many of those who experience medical debt owe money despite having health insurance from at least one source.[4,5] This includes adults age 65 and older, despite 98% of them having health insurance coverage through Medicare.[6] Rural residents are more likely to be uninsured, lower income, over the age of 65, and/or have multiple chronic conditions and other medical needs;[7–9] altogether, this requires more attention to medical debt within the rural context specifically.

From a patient perspective, medical debt impacts financial well-being, which can create barriers to accessing additional health care. It also affects non-medical areas of life, including basic needs like the ability to afford and maintain housing and nutrition,[10–12] which are stressors that can contribute to additional health challenges. From a hospital or medical provider perspective, high rates of medical debt in a community can negatively impact health care providers' and facilities' financial stability.[13] Despite the widespread nature of medical debt in the US, relatively little focus has been placed on how medical debt plays out in rural communities. In this policy

brief, we seek to address that gap by sharing findings from qualitative key informant interviews with administrators at seven rural hospitals across the US.

Approach

In order to better understand the impact of medical debt on rural hospitals and communities, we reached out to administrators at 48 rural hospitals with a disproportionate share of Medicaid utilization, which was defined as having a percentage of patients discharged with Medicaid at or above the state mean plus one standard deviation. We chose this method because it is a commonly used measure of safety net hospitals and it is indicative of hospitals serving a lower-income patient population.[14] In order to so identify these hospitals, we received a list of rural safety net hospitals ranked by Medicaid discharge percentage from the American Hospital Association and then further prioritized by region in order to ensure a national scope. Medicaid discharge percentage in those hospitals we reached out to ranged from 31.6-66.3%. Ultimately, we spoke with nine individuals from seven different rural hospitals located in each of the four Census regions across the US; more information about hospital type and affiliation can be found in Table 1. None of these were designated Sole Community Hospitals. These qualitative interviews were conducted between January and March 2024, primarily via Zoom, though one respondent chose to submit answers via online survey.

Key informants answered questions about an array of topics related to medical debt. These topics included the following: the extent to which medical debt impacts their hospital's financial bottom line and/or their hospital's ability to provide care for patients; the prevalence of medical debt in their rural communities; the circumstances most commonly leading to medical debt among their patient population; the impact of medical debt on their patient population; the biggest challenges relating to finances for their hospital overall.

Open-ended responses were coded by three research team members using inductive coding to arrive at themes. Each individual interview was coded by two different team members, and we arrived at themes using consensus across all three team members involved in coding. The results below present the number of times a theme was mentioned total across all interview responses; several themes were discussed multiple times within the same interview.

Results

In order to more clearly present the information we received from the interviews, our researchers grouped the themes under three different domains, including the following: hospital, patient/community, and policy. Table 2 shows themes under each domain. Each of these themes is discussed in detail below.

Hospital

Hospital administrators identified a number of ways medical debt affected their rural hospital and what they believed led to medical debt, in addition to discussing broader challenges associated with operating a rural hospital. Their responses resulted in six themes.

As the most commonly described theme, financial burden responses all detailed how medical debt negatively affects their hospital by placing additional constraints on their bottom line in an already difficult operating environment. Interviewees mentioned concerns about having less revenue to pay their employees, invest in building or equipment upkeep, and that all of this, in turn, affects their patients. For example,

Table 1. Overview of key informant hospital information

Hospital Location (State)	Ownership Type	Critical Access Hospital
Arkansas	Non-profit	Yes
California	Non-profit	No
Illinois	Non-profit	No
Texas	Non-profit	Yes
Vermont	Non-profit	Yes
Washington	Public	Yes
West Virginia	Non-profit	Yes

Table 2. Overview of domains and themes from key informant interviews

Domain	Theme
Hospital	Financial burden
	Challenges with insurers
	Cutting or shifting services or supports
	Workforce challenges
	Low patient volume
	Inappropriate service use
Patient/community	*Causes of medical debt*
	Uninsurance and underinsurance
	Existing community sociodemographics
	Emergency room usage/emergency care
	Consequences of medical debt
	Exacerbating impact of medical debt in life
	Transportation to find other care
Policy	Reimbursement rates
	Difficulties with Medicare Advantage
	Unintended consequences of legislation
	Recruiting and retaining providers
	Need to educate/inform patients

one respondent shared,

"One of the statistics that I think is really relevant is that we are about a $150 million organization net revenue and 65% of those dollars go back in the form of compensation and benefits to our employees. So when we have medical debt that becomes excessive and we're struggling to collect on the work that we do, it impacts our ability to employ [providers] and to serve our patients." (Midwest) Another noted, *"I think the way that it would affect care is that we have less money to invest in the facility. So if people aren't paying their bills or can't pay their bills, we don't have the cash and have to write it off, then we have less cash to influx into our facility for capitol or for raises or basically anything else we want to do."* (Northeast)

Several key informants highlighted the role of losses on uninsured patients as a growing problem for their hospital's financial health. For instance, one hospital administrator said, *"I'm afraid one way medical debt does affect us is – if we do have somebody that is uninsured that we do have a particularly large bill for us, and they pass away, there's no payer source for those. There's no recovery."* (South) Another noted, *"The Public Health Emergency expiring reintroduced Medicaid redetermination, which has increased our volume of true self-pay patients, which will in turn potentially increase our bad debt."* (South)

Finally, respondents also discussed the unique nature of medical debt and how, the fact that it is debt for services rendered can make it difficult to determine how to proceed. In the words of one hospital administrator, *"It's a non-recourse issue. We can't go back and take back what we've done. You can't repossess anything medical like you can with a car or a home or anything like that when there's financial troubles. We end up really just getting unpaid, mostly."* (South)

For the second most prominent theme, challenges with insurers, responses pointed to an array of different frustrations hospital administrators had with

insurers, both from the perspective of the patients they served and related to their own payment. One hospital administrator spoke to both, noting, *"…they call their insurance company, they get left on hold for indefinite periods of time, if they have insurance. Retail plans that they buy off the internet, that are even approved by federal government, health care plans and things like that, they're ineffective. They charge these vulnerable people a premium for a product that has absolutely zero value to them, and no value to the hospital, so. I see insurance companies turning record profits and I'm here working on a 1 or 2% margin for the hospital. It's pretty frustrating that we're talking about medical debt and we're talking about the rising costs of health care, but yet there is absolutely no criticism of health insurance networks, and that's frustrating."* (Midwest)

Another respondent highlighted a similar sentiment, stating, *"In the past the insurance companies had at least a pretense for not paying for care for patients, but they no longer even put up the pretense. The hospital does not get paid, the patient does not get the care they need, and now our hospital's dollars are funding the skyline of Seattle, which is owned by the insurance companies. Insurance companies do nothing for patients, and providers have had it."* (West)

For the theme of cutting or shifting services or supports, key informants brought up a range of consequences that were already occurring or they saw as potential threats because of medical debt and related financial difficulties at their hospital. Some noted difficult decisions about specialty care offered, service lines available, and screening or diagnostic technology. For instance, one respondent shared, *"We cannot provide high-end diagnostic services such as CT scans or MRIs due to our inability to pay for it."* (West)

Others highlighted the effect of financial constraints on the hospital's ability to support patients in other ways. For instance, one hospital administrator shared, *"Most rural hospitals do everything we can do for patients. I've been at the same organization for 35 years; if you had a $5,000 bill, we would do a $20 a week payment plan in the past. But we don't have ability and we don't have the balance sheet to do that anymore."* (Midwest)

The theme of workforce challenges encompassed how medical debt, operating a rural hospital in the current policy and demographic environment, and difficulties with insurers all contribute to difficulties recruiting and retaining health care providers and other staff. One hospital administrator shared that *"…on top of [other financial difficulties], it makes it more difficult for us to recruit services here."* (Northeast) Another emphasized the way they experience insurers contributing, *"Insurance companies are a direct driver of the workforce shortage."* (West) Low patient volume responses spoke to the challenge of having enough patients to keep their hospital financially sustainable. One respondent summed up both themes, saying, *"It costs more to care for rural communities because of the smaller number of patients served. This, along with inflation and workforce shortages exacerbates the bottom line."* (South)

The final theme, which came up as a contributor to medical debt, was inappropriate service use, which primarily referenced utilizing emergency instead of primary care. One hospital administrator described the frustration this way: *"…people that see the ER as a free place to get care because they get a bill, they don't pay it, they don't see any consequence for it. They're using it as a free resource, which is unfortunate. So yeah, we collect about… probably about 11 cents on the dollar in Emergency."* (Midwest) Another administrator stated, *"It's inappropriate use of the emergency room; we built – we even opened an urgent care to kind of address that a little bit. But that's historically been the problem in rural communities."* (South)

Patient/community

Within the domain of patient/community, hospital administrators discussed the ways in which medical debt affects their patient population, as well as how and why they witness medical debt occur for individuals in their rural communities. Their responses resulted in five themes. Three of these described causes, or what respondents thought contributed to medical debt in their rural communities, and two of these described the consequences of medical debt.

Causes of medical debt

When respondents described uninsurance and underinsurance, they spoke to several interrelated aspects of how medical debt might occur for someone without insurance or with limited coverage, and how an increasing trend of underinsurance is playing out in rural communities. For example, one respondent noted, *"Coverages are not what they used to be long ago. Even ten years ago or twenty years ago. Coverages right now…there's more contribution on the employee side, on the individual side, than there used to be."* (South)

Several respondents highlighted the role of high deductible health plans and increased cost-sharing mechanisms so that patients are owing more even when insured. For instance, one key informant shared, *"…even the people who have the ability to pay, when you have more things like high deductible health plan, no matter what your income is, it's not easy for very many people say if you have a $5,000 deductible. When that bill comes that's a difficult thing."* (Midwest) Another stated, *"Insurance companies have started placing more risk onto the patients through higher deductibles, co-insurances, and co-pays as well as have introduced a variety of plan types that limit services patients can receive using their insurance, e.g. ancillary only, practitioner only, etc. This increases the patient's responsibility and can increase medical bad debt."* (South)

Others pointed out that changing the setting for some procedures can change the insurance coverage people get. One said, *"If you want to make it specific, the shift nation-wide of orthopedic cases –we have a lot of sports injuries, we have a lot of ranchers and elderly people up here with [replacement] hip joints – who are moving from inpatient to outpatient and it has crippled quite a few seniors."* (West)

Finally, a few key informants noted that when enrolling in health insurance is not an option or is not financially feasible for rural residents, lack of insurance could be devastating if an emergency occurs. One hospital administrator shared, *"One thing we do see is younger patients who have opted to not enroll in an insurance plan due to a variety of factors, such as unaffordable premiums, that then have an acute or catastrophic illness or injury."* (South)

Existing community sociodemographics included descriptions of pervasive poverty and lack of education and their impact on rural residents and contribution toward medical debt. One key informant highlighted illiteracy, stating, *"…individuals here have not only a very low healthcare literacy rate, we have difficulty with financial literacy, with literacy – written literacy – itself. Some of our folks are, believe it or not, unable to read and write. So, there's challenges for those folks if they get into a major medical issue."* (South) Others pointed out the impact of stigma against asking for help or being seen as needing it, and a strong desire not to seek assistance even when it might be available. One respondent shared that *"they either don't want to apply for free care or don't want to show anyone their business as far as their financials."* (Northeast)

Finally, emergency room usage/emergency care highlighted the expensive nature of this type of health care, from ambulance transportation to when and how patients seek care for an acute injury or illness. While emergency room (ER) care can be critically important, it is also more likely to come at an increased cost to the patient, even when that patient is insured. This may be the result of a combination of factors, from higher deductibles for ER compared to primary or urgent care settings, to hidden facility fees or charges for seeing an out-of-network provider.[15]

Responses included care sought in an inappropriate setting as referenced above under hospital-level impacts, as well as emergency care sought appropriately, that can still result in medical debt incurred for the patient. One key informant stated that high out-of-pocket costs happen especially when *"…using the emergency room for unexpected events, whether it is a trauma or appendicitis or even something chronic."* (Midwest) Another shared *"The other hospital in the county runs a ground ambulance service, which is by nature an emergency, and this can easily result in $6,000 medical bills."* (West)

Consequences of medical debt

Within the category describing the consequences of medical debt, the most commonly occurring theme

was exacerbating impact of medical debt. Within this theme, respondents spoke to a range of different situations that occur for patients in their communities due to medical debt. This included broader, more general affects as well as some specifically related to health and seeking medical care. Key informants described the painful impact of medical debt on the daily lives of rural residents, with one noting, *"They have to choose between buying food and paying us. That is what it comes down to."* (Northeast) Another respondent emphasized these difficult decisions, stating, *"People shouldn't have to choose which of their basic life necessities, food, water, medically necessary care, etc. are met based on medical debt or the worry of medical debt."* (South)

Several responses in this theme spoke to the complex and interconnected nature of medical debt on patients' financial position, and how owing money for health care can create other problems for their overall health and well-being. One respondent shared *"…if they get into a major medical issue, that's gonna cause them to accumulate medical debt. For some of those things it is just a snowball rolling down a hill they just can't stop; they've got no point of reference on how to deal with it."* (South) Another highlighted a similar issue: *"I mean it's compounding. It adds to the inflationary costs that we're seeing across the country with food and fuel and housing. I think it's another layer of stress, contributes to mental health problems, the overall ability to provide for a family, and access all the resources that they need as a young or growing or even a mature family. So those are all tied together and all very much a real problem."* (Midwest)

Finally, a few responses under this theme described the effect particularly in terms of delayed care and resulting impact both for patients and the hospital and broader community. One respondent shared, *"So for the people who don't have the money, sometimes they delay their care because they can't pay their bill. Then they end up coming in as what we call 'train wrecks,' which is not a nice way to put it. But people who end up having inpatient stays and are really sick people and end up with these hundreds of thousands of dollars in bills where a few doctors' visits might have stopped that. But it just ends up adding more cost to the system."* (Northeast)

The other theme under this category was transportation to find other care. Respondents primarily noted how patients with medical debt at local facilities may not be able to continue to receive health care at those facilities because the facilities will not allow it without them having paid the debt down. Being denied access especially to primary care may lead to delaying necessary care, which can result in ER use when the condition becomes impossible to ignore, in turn leading to even greater financial consequences.[16] When patients are unable to seek care locally, in addition to postponing care or using emergency care, they may attempt to travel to find care elsewhere, which requires reliable transportation. One hospital administrator stated, *"…it is a little bit difficult to seek care if you are not able to seek it from your physician or your hospital in your community. It's not like it is in Western Kansas or in North Dakota where you might have hours to travel, but even that transportation challenge for some people who have a significant amount of medical debt they might have other economic challenges and transportation might be one of them."* (Midwest)

Policy

Finally, under the policy domain, respondents shared particular challenges or suggestions within the policy environment that could help, continue to hinder, or even worsen their financial health and ability to serve patients in their communities. Their responses resulted in five themes, the most common of which was reimbursement rates.

Under this theme, key informants detailed a range of current and possible future difficulties with reimbursement rates. One respondent summarized their Medicaid reimbursement rate woes saying, *"they have to recognize that we need to be paid cost in order to be able to provide the services for these people with or without medical debt."* (Northeast) Another hospital administrator described the struggle of being a mid-sized rural hospital, stating, *"I think it is unsustainable for those of us "tweener" hospitals; we are not Critical Access Hospitals or academic*

medical centers. We don't have any of those enhanced reimbursement methods that other hospitals have, or at least fewer." (Midwest)

A few responses mentioned the challenge rural hospitals face if potential reductions in fee schedules from payers pan out. One highlighted that the problem of reimbursement rates generally is even worse specifically for behavioral health, noting that while the need for mental health services in rural communities is higher than ever, *"The behavioral health inpatient rate we receive right now, I believe they were updated in the mid '90s."*(South)

The second most prominent theme within the policy domain was difficulties with Medicare Advantage. While key informants did not make a direct link between Medicare Advantage beneficiaries and medical debt, they did highlight their beliefs that these difficulties caused their hospitals to be in more precarious financial positions, and that patients were not receiving the care they needed as a result. Respondents voiced frustration with Medicare Advantage plans from their perspective as administrators, as well as how they saw Medicare Advantage negatively impacting health care providers and patients themselves. One respondent emphasized the outsized impact these types of insurance plans have on them, saying, *"Medicare Advantage is absolutely the biggest threat to rural communities, rural hospitals. Without a question."* (South) Another key informant detailed the reason for the concern over Medicare Advantage, stating, *"We are a low volume provider to insurance; those insurance plans are not counted as a Medicare payer for our cost report, which has a very significant impact on our cost reimbursement, and then the delays in care with PA – prior authorization and that sort of thing – is really, to me, a bigger threat than the uncompensated care."* (South) Yet another summed up their feelings by saying that *"Medicare Advantage plans should be taken to the woodshed."*(West)

Six responses from three key informants highlighted the unintended consequences of legislation on their hospital. These hospitals were located in states that in recent years have enacted laws to help protect individuals from medical debt. Respondents saw this legislation as a good source of protection for patients, but with negative impact at the hospital level. One hospital administrator said, *"We really can't pursue it in the state of [state name]. We don't sue people if they don't pay their medical bill. It really falls on the hospital to just write it off. There is more hope for the individual, it is going to be less stringent on what is required to become eligible [for free care]. But the burden is going to fall on the hospital."* (Northeast) A hospital administrator in another state described how the medical debt burden on patients has gone down, but the burden on the hospital has increased, *"The legislation recently passed was not well thought out; it puts the financial burden of care on the hospitals, which impacts hospitals' ability to care for patients."* (West)

Recruiting and retaining providers was another theme that came up in the policy domain, and primarily spoke to the need for more policies that addressed the difficulties recruiting and retaining health care providers in rural areas. And finally, need to educate/inform patients responses described policies like the No Surprises Act and legislation around price transparency that help patients make decisions about care or seek assistance to cover cost.

Discussion and Implications

Themes that emerged from our interviews with rural hospital administrators reveal many causes and consequences of medical debt. These play out at multiple levels, including for individual patients and in the broader rural community context, as well as for the hospital.

Respondents highlighted uninsurance and underinsurance as a key contributor to medical debt for their patients, pointing to an increase in cost sharing and the rising popularity of high-deductible health plans in influencing the amount patients pay for medical care. This higher cost interplays with existing community sociodemographics, where residents in their rural communities are oftentimes financially unstable and lack the health care literacy necessary for navigating complex medical systems. Oftentimes and for a variety of reasons, patients sought care in inappropriate settings, like going straight to the emergency room rather than utilizing urgent care or seeing a primary care provider. Further, emergency care, even when medically necessary, can be financially devastating for patients and lead

to medical debt.

When medical debt occurs, key informants pointed out the exacerbating impact on patients' lives, including delays and difficulties seeking health care in addition to spiraling financial tolls in other areas. At the hospital level, medical debt increases the overall financial burden rural hospital administrators are increasingly facing, and can result in difficult decisions to cut services or patient supports. Respondents shared a number of challenges with insurers that compound the problem, highlighting low Medicaid reimbursement rates and difficulties with Medicare Advantage plans as particular pain points.

Interviews also revealed ongoing policy challenges, as well as possibilities for policy intervention to improve medical debt and strengthen rural hospitals. Rural hospital administrators in two states (VT and WA) expressed frustration with the unintended consequences of recent legislation passed in their states that protected patients but did not consider the impact on rural hospitals. These administrators have seen their own hospitals' financial challenges worsen as a result, which has contributed to cutting certain services or otherwise hindered their ability to serve patients. It is clear from our interviews that future policy surrounding medical debt must consider potential impact on hospitals and health care systems, particularly for rural areas.

Other policy opportunities include increasing reimbursement rates for Medicaid, addressing challenges with Medicare Advantage, improving efforts for recruiting and retaining providers, and educating patients about medical debt and relief opportunities. Additionally, expanding avenues for patients to receive care in the most appropriate setting (instead of the emergency room) may improve debt for both individuals and hospitals.

This study demonstrated that the adverse impacts of rural patient medical debt are not limited to the individual patient, but directly affect rural hospitals and the communities served by them. While our sample size was small, the geographic spread of interviews show that these issues persist across multiple states and US census regions.

Conclusion

Medical debt has an adverse impact on both the lives of rural patients and the financial health of rural hospitals. Interviews with nine administrators from seven rural hospitals across the US highlighted the burden that medical debt puts on the hospital and how it impacts their ability to provide services in their rural communities. They also discussed the causes and consequences of medical debt for rural patients and communities. Future policy and research should consider how to address medical debt for both patients and hospitals alike.

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