

## The Challenge Of Stabilizing Rural Hospitals On The Brink

By **Omur Celmanbet, Kristy Piccinini and Caroline Hardy** (April 20, 2026)

The financial stability of rural hospitals is a long-standing policy concern in the U.S., with implications for competitive dynamics and patient access to quality care.[1]

The outlook for rural hospitals has grown more concerning as recent policy and regulatory developments, such as the One Big Beautiful Bill Act and the expiration of [Affordable Care Act](#) premium tax credits, are expected to exacerbate their long-standing challenges and place further pressures on their financial solvency.

Passed in July 2025, the OBBBA imposed sweeping administrative and eligibility requirements on Medicaid. Under the OBBBA, federal Medicaid spending in rural areas is expected to decline by \$137 billion over the next 10 years, squeezing rural hospital margins.[2]

By 2034, an estimated 101 rural hospitals are expected to be at high risk of closure.[3] The lapse of ACA enhanced premium tax credits at the end of 2025, despite some recent [legislative action](#) in the [U.S. House of Representatives](#), has increased premiums for millions of Americans who were receiving subsidized ACA health coverage.[4]

Without these credits, more people are predicted to become uninsured, increasing uncompensated care — often disproportionately provided by rural hospitals — and costing hospitals an estimated \$2.2 billion in 2026.[5]

The impact of these policy shifts is compounded by the increasing presence of Medicare Advantage plans in rural areas. With lower reimbursement rates and increased administrative burden, the growing reach of these plans is financially straining rural hospitals even further.[6]

By decreasing hospital revenues and increasing the cost of uncompensated care, these regulatory shifts are expected to increase the financial pressure on rural hospitals, which can result in additional hospital closures, service reductions, or mergers and acquisitions.



Omur Celmanbet



Kristy Piccinini



Caroline Hardy

This article discusses unique characteristics of rural hospitals, including their financial challenges. It also examines proposed solutions to preserve care access across rural America and implications for competition.

## **Rural Hospitals at a Glance**

Rural hospitals comprise 35% of the 5,112 community hospitals nationwide.[7]

The roughly 1,800 rural hospitals serve more than 66 million Americans living in rural areas, comprising nearly 20% of the nation's population.[8]

On average, rural hospitals are smaller than their nonrural counterparts — 64% have fewer than 25 beds and only 10% have more than 100 beds — and also have lower inpatient occupancy rates, resulting in higher per patient fixed cost.[9]

Rural hospitals also care for a higher share of patients with public insurance — 72% of rural hospital discharges are Medicare and Medicaid and 53% of hospital discharges in rural areas are covered by Medicare compared to 45% in urban areas.[10] Medicare and Medicaid typically reimburse hospitals at lower rates relative to commercial plans, compounding existing cost pressures for these facilities.

The majority of sole community hospitals — 85% — are rural hospitals.[11] These hospitals, which are the only source of inpatient services available locally, are crucial for healthcare access in these rural communities.

## **What's at Risk**

Rural hospitals are already at the brink of financial solvency. In 2023, nearly 44% of general acute care rural hospitals in the U.S. had a negative operating margin, and nearly one-third operated at a significant loss, with a margin below -5%.[12]

Persistent financial distress heightens a hospital's risk of closure, limits available resources needed to invest in quality and service improvements, and often leads hospitals to seek various affiliation arrangements with other providers — such as strategic partnerships, mergers and acquisitions.[13]

The risk is substantial: Between 2005 and 2023, 146 rural hospitals closed or ceased providing inpatient services, and many others have reduced key service lines due to

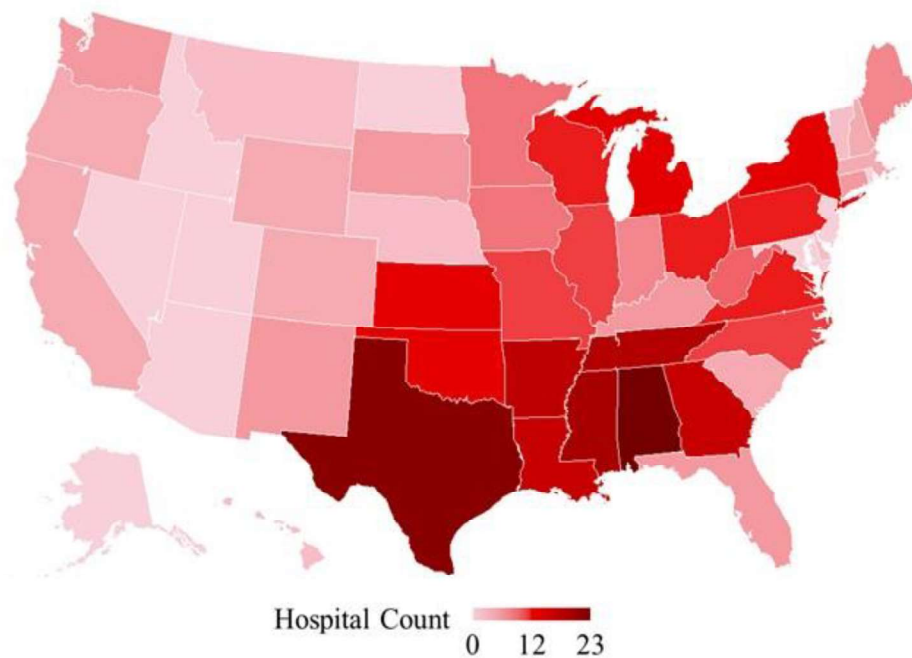
sustained financial pressure.[14]

These reductions in local healthcare capacity can meaningfully affect competitive dynamics. Research shows that rural hospital closures can have an adverse impact on commercial prices at nearby hospitals.[15]

However, efforts to preserve financial solvency and care access — whether through mergers, acquisitions or the reduction of service lines — carry significant legal risk amid heightened federal and state antitrust scrutiny and complex regulatory compliance obligations.[16]

Geographically, rural hospitals with negative margins have been concentrated in the American South. Today, the median rural hospital operating margin is 1%, and the majority of rural hospital revenue comes from government payors that reimburse at lower rates than commercial payors.[17]

### ***Rural Hospitals With Negative Margins***[18]



The anticipated increase in financial instability due to recent policy and regulatory changes discussed above, combined with ongoing challenges, raises the risk of rural hospital closures or service line reductions, with adverse implications for access to care in rural

communities.

Since 2010, 87 rural hospitals around the country have shuttered.[19] In the same timeframe, an additional 65 converted to another facility type, such as an outpatient clinic or nursing or rehabilitation facility, diminishing their scope of available care.[20]

As a result, Americans are traveling further to access care. Analysis by the [U.S. Government Accountability Office](#) found that after a rural hospital closure, Americans in rural areas travel a median of roughly 20 miles further to access general inpatient care and emergency care.[21]

For more specialized services, including treatment for substance use disorders and coronary care, the median travel time is more than 44 and 35 miles, respectively, after a rural hospital closure.[22]

For service lines such as obstetrics, cuts to Medicaid are especially threatening to care access. Presently, Medicaid is estimated to cover nearly half of all rural births.[23] From 2010 to 2022, 238 rural hospitals closed obstetrics units, while only 26 opened new units, and more than 50% of rural hospitals did not offer obstetric care by 2022.[24]

Today, over half of women in rural areas travel more than 30 miles and over 10% travel more than 100 miles to reach the nearest hospital with obstetric services, increasing the risk of infant mortality and pregnancy complications.[25]

Even if rural hospitals are able to maintain service lines amidst diminishing financial solvency, poor hospital financial performance may be associated with decreased care quality and patient safety,[26] increasing the potential of failing accreditation or funding standards from regulators like the [Centers for Medicare and Medicaid Services](#) and the Joint Commission, an accreditation body that sets quality and safety standards for healthcare facilities nationwide.

Accordingly, rural hospital financial distress presents a dilemma for both federal and state antitrust enforcers, who may need to balance competitive concerns against maintaining access to essential care.[27]

## **Proposed Solutions**

A number of potential solutions have been proposed to protect the financial solvency of

rural hospitals and preserve care access across rural America. One approach involves encouraging affiliation or partnership arrangements — including mergers and acquisitions — to channel private investment into financially distressed hospitals, supported by appropriate regulatory oversight to help safeguard care quality and access.

Another approach focuses on ensuring adequate funding, including targeted public financial support to rural hospitals aimed at stabilizing rural hospitals and maintaining essential healthcare services across rural America.[28]

Affiliation arrangements, which may result in consolidation, are not atypical for hospitals. Rural hospitals are increasingly integrated into larger healthcare systems, granting them access to a larger suite of financial resources and the ability to make transformative investments that improve care for the rural populations they serve.

Between 2005 and 2016, there were 380 rural hospitals mergers with some merging more than once.[29] Today, 52% of rural hospitals are part of a broader health system, compared with 78% of hospitals in urban areas.[30]

Research has shown that mergers and acquisitions of rural hospitals have been associated with mixed results regarding improvements to profitability, clinical outcomes and patient experience.

The impact of affiliation on these outcomes is likely to be highly dependent on the healthcare delivery environment for a specific rural hospital; key factors include the service needs of area residents, other local options for receiving those services, and the complementarities between affiliation partners.[31]

While the [Federal Trade Commission](#) has stated that "[i]f a rural hospital is truly failing financially and the proposed merger is the only way for it to remain viable, then the FTC is unlikely to challenge the merger[,]" how this principle will apply in the current enforcement climate remains uncertain.[32]

Healthcare provider mergers and acquisitions are subject to heightened scrutiny at both the federal and state levels, including closer review of transactions involving private equity ownership or investment structures.[33]

Some states have expanded their roles through attorney general oversight, and new healthcare transaction review statutes, all of which may add procedural steps and

lengthen review timelines.[34]

In this environment, affiliation or partnership arrangements involving rural hospitals — including mergers and acquisitions — may face extensive review, even when proposed as a means of preserving access to care.

Regarding targeted funding mechanisms, payment adequacy is essential for maintaining the solvency of rural hospitals and ensuring reimbursement rates accurately reflect the higher costs and complexities of delivering care in the rural setting.[35]

Options involve rethinking current payment mechanisms, including Critical Access Hospital and Low Volume Hospital payment programs.[36] The rural emergency hospital designation[37] also offers a promising strategy for preserving emergency access in areas facing closure, but must be complemented with additional interventions to address specialty service deserts, such as the growing crisis of maternity care access.[38]

To help offset the impacts on rural hospitals from increased Medicaid eligibility requirements, policymakers allocated \$50 billion of targeted funding for a new Rural Health Transformation Program in the OBBBA.[39]

Under the program, \$10 billion will be allocated annually for the next five years, with 50% distributed equally to all approved states and 50% allocated by CMS based on forthcoming criteria.[40] However, this allocation of \$50 billion covers only 37% of the estimated loss of federal Medicaid funding to rural hospitals and does not account for the long-term funding impacts of the OBBBA.[41]

Across such proposed solutions, rural hospitals are likely to confront a complex regulatory and policy landscape — whether to demonstrate low risk of anticompetitive harm in proposed consolidations, ensure compliance with federal and state regulatory requirements, or navigate the rules governing the allocation and use of supplemental federal funding.

## **Conclusion**

There is no simple solution to ensure the financial stability of rural hospitals. Underlying issues include shrinking populations and the high investment costs required for cutting-edge medical care and updating aging infrastructure.

These challenges are compounded by recent policy shifts including OBBBA-related Medicaid cuts, the expiration of ACA premium tax credits and MA expansion, which threaten to reduce revenue and increase the burden of uncompensated care in hospitals across the nation.

While federal programs such as the Rural Health Transformation Program and various affiliation arrangements with other providers may offer partial relief, their limited scale and uncertain outcomes risk leaving many rural hospitals financially vulnerable unless other measures for ensuring payment adequacy are implemented.

Consequently, each of these shifts reinforces the importance of continued evaluation of policies and antitrust regulatory frameworks to ensure the preservation of care access for rural populations. Stakeholders working to preserve access should consider all potential options in crafting multi-faceted solutions tailored to the care needs of a specific rural area.

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*Omur Celmanbet is a senior managing director, [Kristy Piccinini](#) is a managing director and [Caroline Hardy](#) is an economic consultant at [FTI Consulting](#).*

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