The Impact of Expiring Enhanced Premium Tax Credits on Rural Hospital Revenues and Financial Margins

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- Allowing the enhanced Premium Tax Credits to expire at the end of 2025 will lead to coverage losses that will reduce hospital revenues, increase uncompensated care costs, and lower operating margins.

- These adverse outcomes will disproportionately affect rural hospitals and especially rural hospitals in states that did not expand Medicaid.

Abstract

Issue: Analyses of allowing the enhanced Premium Tax Credits to expire have focused on potential coverage losses, overlooking the financial impact on health care providers.

Goal: To assess the financial impact of the expiration of the enhanced Premium Tax Credits on rural hospitals in each state.

Methods: We used Urban Institute estimates of coverage losses to project the financial impact on acute-care hospitals.

Key Findings and Conclusion: Rural hospitals could see revenues reduced by nearly $1.6 billion in 2026 and operating margins reduced by nearly 10 percent. Rural hospitals in states that did not expand Medicaid could be disproportionately impacted: their operating margins could fall by an average of 38 percent, and even more in certain states. Both Marketplace enrollees and the broader communities that rural hospitals serve would likely be affected, as lower revenues and increased uncompensated care costs could force already struggling rural hospitals to reduce staff or eliminate services.

Background

Enhanced Premium Tax Credits (PTCs) are set to expire at the end of 2025 and Congress is considering whether to make them permanent, to extend them with or without structural changes, or to allow them to expire. The enhanced PTCs were established under the American Rescue Plan Act of 2021 and extended in the Inflation Reduction Act of 2022. These legislations expanded eligibility for PTCs to families whose income exceeds 400 percent of the federal poverty level (FPL) and reduced the maximum household contribution for families at all income levels.

A recent study estimated that expiration of enhanced PTCs would cause average net premiums, the portion paid by families after PTCs, to increase more than 400 percent for people with subsidized Marketplace coverage and incomes below 250 percent of FPL, and net premiums to double for Marketplace enrollees with incomes above 250 percent of FPL. These large premium increases would lead to 7.3 million fewer people receiving subsidized Marketplace coverage and 4.8 million more people becoming uninsured in 2026.[i] A follow up study estimated that the coverage loss would reduce total spending on hospital services by $14.2 billion and increase hospital uncompensated care costs by $2.2 billion in 2026.[ii]

This level of hospital revenue loss and increased uncompensated care could have substantial consequences for all hospitals, and especially hospitals in rural areas. About 18 percent of people who enrolled through HealthCare.gov in 2025 lived in rural areas and rural residents disproportionately benefit from the enhanced PTCs (enhanced PTCs were 28% higher on average for rural enrollees compared to subsidies received by urban enrollees).[iii] Thus, rural hospitals may be disproportionately adversely impacted by the expiration of the enhanced PTCs.

Rural hospitals run on slim operating margins and operate at a loss with respect to patient care margins. Negative patient care margins mean that payments to hospitals for treating patients are insufficient to cover operating costs. Therefore, hospitals need to find other revenue sources to cover these losses, which may be unsustainable in the long term.

In this report, we examined the potential financial impact on rural hospitals if the enhanced PTCs expire based on the Urban Institute's estimates of coverage loss and hospital uncompensated care increases (see "How We Conducted This Study" for details). Our analysis provides estimates of the impact of Marketplace coverage loss on revenues, uncompensated care costs, and financial margins for rural hospitals. For modeling purposes, we assume the coverage loss due to expiration of the enhanced PTCs is fully experienced in 2026 and we present impact estimates by state.

How Expiration of Enhanced PTC IMPACT Rural Hospital Finances

Reductions in Marketplace coverage will decrease commercial insurer payments and increase uncompensated care costs, resulting in lower hospital operating margins. Exhibit 1 shows the projected revenues and expenses by payer source for 1,730 rural acute-care hospitals with and without enhanced Premium Tax Credits across all 50 states.

Exhibit 1. Estimated Changes in Rural Hospitals' Revenue and Expenses Due to Coverage Losses Created by Expiration of Enhanced Premium Tax Credits in 2026 (in millions)

Payer source	With Enhanced PTCs	Without Enhanced PTCs	Change in Revenues /Costs	Percent Change
Medicaid revenue	$16,359	$16,359	$0	0.0%
Other government revenue	$126	$126	$0	0.0%
Uncompensated care revenue	$875	$875	$0	0.0%
Medicare revenue	$43,929	$43,929	$0	0.0%
Commercial insurance revenue	$80,231	$78,653	-$1,578	-2.0%
Other Operating Revenue[1]	$9,270	$9,270	$0	0.0%
Total Operating Revenue	$150,789	$149,211	-$1,578	-1.0%
Medicaid Cost	$17,211	$17,211	$0	0.0%
Other Government Cost	$181	$181	$0	0.0%
Uncompensated Care Cost	$4,627	$5,107	$480	10.4%
Medicare Cost	$46,598	$46,598	$0	0.0%
Commercial Insurance Cost	$70,661	$69,073	-$1,588	-2.2%
Other Operating Cost	$7,147	$7,147	$0	0.0%
Total Operating Cost	$146,425	$145,318	-$1,108	-0.8%
Net Operating Income	$4,363	$3,893	-$471	-10.8%
Net Income – Patient Care[2]	-$4,906	-$5,377	-$471	-9.6%
Operating Margin	2.9%	2.6%	-0.3%	-9.8%
Patient Care Margin[3]	-3.5%	-3.8%	-0.4%	-10.8%

[1] Includes revenue for sources other than patient care, investment income, and donations (e.g., rebates and refunds, revenue from sale of medical and surgical supplies and drugs to other than patients, revenue from gifts, flowers, coffee shops, canteen).
[2] Net income from patient care is calculated as net patient revenue (total operating revenue less other operating revenue) minus operating costs.
[3] Patient care margin is calculated as net patient care income divided by net patient revenues (total operating revenue less other operating revenue).

Data: Dobson DaVanzo simulation of the impact of expiring enhanced Premium Tax Credits on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; the analysis includes acute-care hospitals that reported required Medicare hospital cost report data in 2023.

Across the rural hospitals in our database, we estimate that net patient revenues would decline by about $1.6 billion (1.0% of rural hospital operating revenues), uncompensated care costs would increase by more than 10 percent and operating margins would decline by nearly 10 percent, further eroding operating margins for these already struggling hospitals. Rural hospital patient margins (payments to hospitals for treating patients compared to operating expenses) would be further reduced from -3.5 percent to -3.8 percent, adding increased pressure on rural hospitals to reduce costs or find other sources of income.

To help offset increased uncompensated care costs in hospitals, Medicare and Medicaid could increase Disproportionate Share Hospital payments and Uncompensated Care payments to hospitals. Local governments could also increase tax appropriations to hospitals for uncompensated care. However, we did not assume that these amounts change in this analysis.

State-level Impacts of Marketplace Coverage Losses on Rural Hospitals

While rural hospitals in all states would be impacted by the expiration of enhanced PTCs, the financial impact on rural hospitals would vary across states depending on the size of the state's subsidized Marketplace enrollment. Rural hospitals in states that did not expand their Medicaid programs under the Affordable Care Act (ACA) would be more adversely impacted than rural hospitals in Medicaid expansion states. The Urban Institute estimates that 65 percent of the Marketplace coverage loss would occur in the 10 non-expansion states (Alabama, Florida, Georgia, Kansas, Mississippi, South Carolina, Tennessee, Texas, Wisconsin, and Wyoming).

Exhibit 2 shows that rural hospitals in non-expansion states already have lower operating and patient-care margins compared to rural hospitals in expansion states with enhanced PTCs in effect. The expiration of the enhanced PTC will exacerbate this discrepancy. Compared to rural hospitals in Medicaid expansion states, rural hospitals in non-expansion states on average will see larger reductions in total operating revenue (-2.5% compared to -0.6%), larger increases in uncompensated care costs (13.9% compared to 8.0%), sharper drops in operating margins (-38.3% compared to -5.9%), and larger declines in patient-care margins (-16.1% compared to -8.5%).

Exhibit 2. Changes in Rural Hospitals' Revenue, Uncompensated Care Expenses, and Operating Margins in Medicaid Expansion States Compared to Non-Expansion States Due to Expiration of Enhanced Premium Tax Credits in 2026

Financial Metric	Rural Hospitals in Medicaid Expansion States (n = 1,225)			Rural Hospitals in States without Medicaid Expansion (n = 505)		
	With Enhanced PTCs	Without Enhanced PTCs	Percent Change	With Enhanced PTCs	Without Enhanced PTCs	Percent Change
Total Operating Revenue (millions)	$117,478	$116,725	-0.6%	$33,310	$32,486	-2.5%
Uncompensated Care Cost (millions)	$2,758	$2,979	8.0%	$1,869	$2,128	13.9%
Operating Margin	3.2%	3.0%	-5.9%	1.7%	1.0%	-38.3%
Patient-Care Margin[1]	-2.9%	-3.1%	-8.5%	-5.6%	-6.5%	-16.1%

[1] Patient care margin is calculated as net patient care income (net patient revenue (total operating revenue less other operating revenue) minus operating costs) divided by net patient revenues (total operating revenue less other operating revenue).

Data: Dobson DaVanzo simulation of the impact of expiring enhanced Premium Tax Credits on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; the analysis includes acute-care hospitals that reported required Medicare hospital cost report data in 2023.

Exhibits 3 and 4 present changes in total hospital revenues, uncompensated care costs, operating margins and patient-care margins for rural hospitals in each state. Rural hospitals in most of the non-expansion states will see revenues decline by 2 percent or more. While rural hospitals in 29 of the Medicaid expansion states will see revenues decline by less than 1.0 percent. For example, rural hospitals in Mississippi would see total revenues reduced by $199 million (4% reduction), uncompensated care costs increase by 23.7 percent, and patient-care margins further reduced from -5.6 percent to -6.9 percent (or about a 23 percent reduction).

Exhibit 3. Changes in Rural Hospitals' Revenue and Uncompensated Care Expenses Due to Expiration of Enhanced Premium Tax Credits by State in 2026

State	Number of Rural Hospitals	Total Revenue - With Enhanced PTC (in millions)	Change in Total Revenue without Enhanced PTC (in millions)	Percent Change in Total Revenue	Uncompen-sated Care Cost - With En-hanced PTC (in millions)	Change in Uncompensated Care Cost without Enhanced PTC (in millions)	Percent Change in Uncompen-sated Care Cost
All Rural Hospitals	**1,730**	**$150,788.9**	**-$1,578.2**	**-1.0%**	**$4,627.0**	**$480.1**	**10.4%**
Alabama*	35	$1,712.5	-$31.7	-1.9%	$96.1	$12.1	12.6%
Alaska	10	$1,134.1	-$10.7	-0.9%	$61.8	$2.7	4.4%
Arizona	8	$748.7	-$12.6	-1.7%	$14.4	$3.5	24.5%
Arkansas	41	$2,596.9	-$29.8	-1.1%	$92.9	$11.1	12.0%
California	31	$3,893.3	-$13.5	-0.3%	$89.9	$4.1	4.5%
Colorado	37	$3,467.5	-$32.3	-0.9%	$113.1	$8.7	7.7%
Connecticut	2	$340.1	-$0.4	-0.1%	$3.6	$0.2	4.1%
Delaware	3	$1,356.8	-$8.2	-0.6%	$27.7	$2.2	8.1%
District of Columbia	0	$0.0	$0.0	0.0%	$0.0	$0.0	0.0%
Florida*	16	$819.3	-$19.2	-2.3%	$72.2	$4.4	6.2%
Georgia*	49	$4,427.5	-$119.9	-2.7%	$310.0	$34.1	11.0%
Hawaii	8	$1,045.0	-$0.6	-0.1%	$8.1	$0.2	2.8%
Idaho	24	$1,316.6	-$8.1	-0.6%	$42.8	$2.6	6.0%
Illinois	64	$7,122.2	-$55.3	-0.8%	$141.8	$13.7	9.6%
Indiana	40	$4,170.9	-$48.5	-1.2%	$118.8	$11.4	9.6%
Iowa	81	$5,557.0	-$33.6	-0.6%	$106.1	$10.9	10.3%
Kansas*	92	$3,634.1	-$78.0	-2.1%	$121.2	$26.9	22.2%
Kentucky	57	$6,645.3	-$14.2	-0.2%	$113.3	$4.2	3.7%
Louisiana	35	$1,642.8	-$25.7	-1.6%	$30.6	$9.4	30.6%
Maine	21	$2,734.0	-$13.9	-0.5%	$76.7	$4.3	5.7%
Maryland	2	$290.6	-$0.8	-0.3%	$2.3	$0.2	8.9%
Massachusetts	3	$389.7	-$0.2	0.0%	$7.0	$0.1	1.6%
Michigan	53	$5,369.7	-$31.3	-0.6%	$88.2	$9.8	11.1%
Minnesota	74	$5,888.6	-$6.7	-0.1%	$97.4	$2.0	2.1%
Mississippi*	62	$4,906.2	-$198.8	-4.1%	$270.9	$64.2	23.7%
Missouri	47	$4,198.8	-$30.3	-0.7%	$158.3	$9.5	6.0%
Montana	46	$2,573.0	-$32.5	-1.3%	$53.9	$9.6	17.7%
Nebraska	66	$3,830.0	-$27.9	-0.7%	$82.5	$7.7	9.3%
Nevada	11	$571.3	-$3.7	-0.6%	$17.5	$1.0	5.8%

Exhibit 3. Changes in Rural Hospitals' Revenue and Uncompensated Care Expenses Due to Expiration of Enhanced Premium Tax Credits by State in 2026 (continued)

State	Number of Rural Hospitals	Total Revenue - With Enhanced PTC (in millions)	Change in Total Revenue without Enhanced PTC (in millions)	Percent Change in Total Revenue	Uncompen-sated Care Cost - With Enhanced PTC (in millions)	Change in Uncompensated Care Cost without Enhanced PTC (in millions)	Percent Change in Uncompen-sated Care Cost
New Hampshire	16	$5,032.9	-$30.5	-0.6%	$92.8	$10.8	11.6%
New Jersey	0	$0.0	$0.0	0.0%	$0.0	$0.0	0.0%
New Mexico	23	$1,835.0	-$9.3	-0.5%	$59.7	$2.5	4.2%
New York	28	$4,560.7	-$5.1	-0.1%	$61.0	$1.8	2.9%
North Carolina	40	$5,766.9	-$12.0	-0.2%	$159.5	$3.9	2.5%
North Dakota	33	$890.4	-$4.7	-0.5%	$42.0	$1.7	4.1%
Ohio	54	$7,469.7	-$58.7	-0.8%	$205.6	$14.2	6.9%
Oklahoma	58	$2,965.2	-$36.3	-1.2%	$132.0	$11.4	8.6%
Oregon	26	$3,204.1	-$35.9	-1.1%	$69.8	$10.4	14.9%
Pennsylvania	39	$7,619.6	-$40.4	-0.5%	$125.6	$11.0	8.7%
Rhode Island	0	$0.0	$0.0	0.0%	$0.0	$0.0	0.0%
South Carolina*	16	$2,020.9	-$44.9	-2.2%	$116.6	$14.5	12.4%
South Dakota	42	$1,999.0	-$26.7	-1.3%	$42.3	$7.8	18.5%
Tennessee*	38	$2,489.5	-$54.2	-2.2%	$131.5	$15.4	11.7%
Texas*	121	$5,849.6	-$187.2	-3.2%	$555.7	$63.4	11.4%
Utah	18	$1,164.5	-$2.3	-0.2%	$40.5	$0.7	1.6%
Vermont	11	$1,447.0	$0.3	0.0%	$32.4	$0.1	0.2%
Virginia	22	$2,058.8	-$7.1	-0.3%	$42.1	$2.2	5.2%
Washington	31	$2,478.4	-$11.1	-0.4%	$60.4	$3.5	5.8%
West Virginia	20	$2,103.6	-$33.4	-1.6%	$43.9	$9.6	21.8%
Wisconsin*	53	$5,559.3	-$29.7	-0.5%	$120.7	$8.7	7.2%
Wyoming*	23	$1,891.6	-$60.8	-3.2%	$73.8	$16.0	21.6%

*Indicates states that have not expanded their Medicaid programs.

Data: Dobson DaVanzo simulation of the impact of expiring enhanced Premium Tax Credits on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; the analysis includes acute-care hospitals that reported required Medicare hospital cost report data in 2023.

Exhibit 4. Changes in Rural Hospitals' Operating and Patient-Care Margins Due to Expiration of Enhanced Premium Tax Credits by State in 2026

State	Number of Rural Hospitals	Operating Margin - With Enhanced PTC	Operating Margin - Without Enhanced PTC	Percentage Point Change in Operating Margin	Patient-Care Margin - With Enhanced PTC[1]	Patient-Care Margin Without Enhanced PTC[1]	Percentage Point Change in Patient-Care Margin
All Rural Hospitals	**1,730**	**2.9%**	**2.6%**	**-0.3%**	**-3.5%**	**-3.8%**	**-0.4%**
Alabama*	35	-4.5%	-4.8%	-0.3%	-11.8%	-12.2%	-0.5%
Alaska	10	2.5%	2.1%	-0.4%	-7.4%	-7.9%	-0.5%
Arizona	8	4.4%	3.8%	-0.5%	-0.4%	-1.1%	-0.6%
Arkansas	41	-4.9%	-5.1%	-0.2%	-12.9%	-13.2%	-0.3%
California	31	5.0%	4.9%	-0.1%	-1.6%	-1.7%	-0.1%
Colorado	37	3.4%	3.1%	-0.3%	-2.3%	-2.8%	-0.4%
Connecticut	2	-7.8%	-7.9%	0.0%	-10.0%	-10.1%	0.0%
Delaware	3	7.0%	6.8%	-0.2%	3.1%	2.9%	-0.2%
District of Columbia	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Florida*	16	10.6%	9.7%	-0.9%	8.7%	7.7%	-0.9%
Georgia*	49	2.7%	1.8%	-0.9%	-1.4%	-2.4%	-1.0%
Hawaii	8	-0.4%	-0.4%	0.0%	-10.6%	-10.6%	0.0%
Idaho	24	2.3%	2.2%	-0.2%	-1.4%	-1.6%	-0.2%
Illinois	64	7.1%	6.9%	-0.3%	2.4%	2.0%	-0.3%
Indiana	40	5.3%	4.9%	-0.5%	2.4%	1.9%	-0.5%
Iowa	81	2.2%	2.0%	-0.1%	-4.2%	-4.4%	-0.2%
Kansas*	92	-2.8%	-3.3%	-0.5%	-16.0%	-17.0%	-0.9%
Kentucky	57	9.8%	9.7%	0.0%	-0.9%	-1.0%	-0.1%
Louisiana	35	-0.3%	-0.6%	-0.3%	-10.8%	-11.3%	-0.5%
Maine	21	-4.9%	-5.0%	-0.2%	-8.7%	-8.9%	-0.2%
Maryland	2	3.6%	3.6%	-0.1%	-3.0%	-3.1%	-0.1%
Massachusetts	3	-4.1%	-4.1%	0.0%	-7.0%	-6.9%	0.0%
Michigan	53	1.1%	1.0%	-0.2%	-1.4%	-1.5%	-0.2%
Minnesota	74	0.9%	0.8%	0.0%	-5.5%	-5.6%	0.0%
Mississippi*	62	0.4%	-0.6%	-1.1%	-5.6%	-6.9%	-1.4%
Missouri	47	2.8%	2.6%	-0.2%	-5.2%	-5.4%	-0.3%
Montana	46	1.8%	1.4%	-0.4%	-2.4%	-2.9%	-0.5%
Nebraska	66	2.8%	2.5%	-0.2%	-3.8%	-4.1%	-0.3%
Nevada	11	7.1%	6.9%	-0.2%	3.8%	3.5%	-0.2%
New Hampshire	16	3.5%	3.4%	-0.1%	-13.9%	-14.1%	-0.2%
New Jersey	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
New Mexico	23	5.8%	5.7%	-0.2%	-1.6%	-1.8%	-0.2%
New York	28	-1.5%	-1.6%	0.0%	-9.1%	-9.1%	0.0%

Exhibit 4. Changes in Rural Hospitals' Operating and Patient-Care Margins Due to Expiration of Enhanced Premium Tax Credits by State in 2026 (continued)

State	Number of Rural Hospitals	Operating Margin - With Enhanced PTC	Operating Margin - Without Enhanced PTC	Percentage Point Change in Operating Margin	Patient-Care Margin - With Enhanced PTC[1]	Patient-Care Margin Without Enhanced PTC[1]	Percentage Point Change in Patient-Care Margin
North Carolina	40	5.7%	5.6%	0.0%	2.3%	2.3%	0.0%
North Dakota	33	-3.0%	-3.1%	-0.1%	-10.5%	-10.6%	-0.1%
Ohio	54	4.5%	4.2%	-0.3%	0.8%	0.4%	-0.4%
Oklahoma	58	-1.9%	-2.2%	-0.4%	-7.1%	-7.5%	-0.5%
Oregon	26	2.4%	2.0%	-0.3%	-3.9%	-4.3%	-0.4%
Pennsylvania	39	7.1%	7.0%	-0.2%	2.8%	2.6%	-0.2%
Rhode Island	0	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
South Carolina*	16	1.3%	0.8%	-0.6%	-3.8%	-4.5%	-0.7%
South Dakota	42	5.6%	5.2%	-0.4%	-2.4%	-3.0%	-0.5%
Tennessee*	38	0.8%	0.1%	-0.7%	-0.9%	-1.7%	-0.8%
Texas*	121	6.0%	5.5%	-0.5%	-10.1%	-11.4%	-1.2%
Utah	18	14.9%	14.8%	0.0%	13.8%	13.7%	0.0%
Vermont	11	-6.2%	-6.2%	0.0%	-15.6%	-15.6%	0.0%
Virginia	22	3.4%	3.3%	-0.1%	0.4%	0.3%	-0.1%
Washington	31	-2.6%	-2.7%	-0.1%	-7.0%	-7.2%	-0.2%
West Virginia	20	3.0%	2.5%	-0.5%	-3.5%	-4.2%	-0.6%
Wisconsin*	53	2.6%	2.4%	-0.2%	-2.1%	-2.3%	-0.2%
Wyoming*	23	-1.4%	-2.7%	-1.4%	-4.0%	-5.5%	-1.5%

[1] Patient care margin is calculated as net patient care income (net patient revenue (total operating revenue less other operating revenue) minus operating costs) divided by net patient revenues (total operating revenue less other operating revenue).

*Indicates states that have not expanded their Medicaid programs.

Data: Dobson DaVanzo simulation of the impact of expiring enhanced Premium Tax Credits on hospitals using the Hospital Financial Simulation Model and Medicare Hospital Cost Report data; the analysis includes acute-care hospitals that reported required Medicare hospital cost report data in 2023.

Discussion

With many rural hospitals already experiencing negative operating margins, further reductions in revenues and increases in uncompensated care could force hospitals to reduce costs by eliminating services that would affect all members of their community; cause them to offset the loss of revenue in part by increasing rates to privately insured patients; or accelerate hospital closures.[iv,v] Hospitals in rural communities have been closing at an alarming rate. Since 2005, 195 rural hospitals have either closed or converted to providing only outpatient services, and a further

reduction in operating margins could intensify this trend.[vi] More than 750 rural hospitals (a third of all rural hospitals) are currently at risk of closing because of serious financial problems, including losses on patient services, insufficient revenues from other sources, and low financial reserves, and more than 300 are at immediate risk of closure.[vii]

In addition, Medicaid provisions in the budget and tax reconciliation law (H.R.1) will require states to impose work requirements on certain non-elderly adults and place limits on provider taxes, which will further erode rural hospital revenues. Alongside impacting rural hospitals, the combined effects of Medicaid policies in H.R.1 and expiration of the enhanced PTCs will also affect each hospital's surrounding rural community. The combined effects of these policies on rural hospitals and community health centers could leave communities with little to no access to primary, specialty or emergency care, significantly increasing travel times for routine and emergency health needs.[viii] The direct effect on hospitals is just one aspect of the economic impact work requirements could have in rural areas.[ix] The policies could also reduce access to health care and increase costs for all people in the community, as rural hospitals eliminate services or close entirely.

How We Conducted This Study

This analysis uses the Dobson | DaVanzo Hospital Finance Simulation Model (HFSM) to produce estimates of the financial impact of policies affecting health insurance coverage on hospitals. The model is built using 2023 Medicare Hospital Cost Reports (MCRs) as its primary data source, allowing us to determine each U.S. general acute-care hospital's revenues and expenses by payer (including Medicare, Medicaid, other government payers, and all other payers). For this analysis, we used MCR data for 1,730 acute-care rural hospitals that met our data quality requirements.[x] Rural hospitals were defined as those hospitals located outside of a Metropolitan Statistical Area (MSA). Hospital revenues and costs for each payer category were projected from 2023 through 2026 based on National Health Expenditure projections for hospital services.

The HFSM uses these hospital-level revenue and cost data by payer source along with estimates of the policy's impact on coverage loss — data estimated in recent studies by the Urban Institute.[i,ii] The analysis shows the potential impact on hospitals assuming that the full effect of the expiring enhanced PTCs on coverage is experienced in 2026.

The HFSM model shifts hospital costs across payers, mirroring how people shift from one insurance coverage type to another. For example, as Marketplace coverage is reduced because of the policy change, people will move to other coverage sources, such as employer coverage or become uninsured. The model similarly shifts hospital costs from commercial insurance to

uncompensated care or commercial payers. Hospital revenues are then recomputed based on this change in costs, using the hospital's payment-to-cost ratio for each payer.

Research has consistently shown that uninsured people receive far fewer health care services than insured people with similar economic and demographic characteristics. Multiple studies have estimated the potential utilization increase as uninsured people become insured, and we assume the opposite effect on utilization of hospital services as people become newly uninsured.[xi] Thus, the model reduces hospital costs by about 44 percent when shifting from an insured payer to uncompensated care. We further adjusted our uncompensated care increases to be consistent with the Urban Institute results that assumed an increase in hospital uncompensated care of $2.2 billion across all hospitals.

To help offset increased uncompensated care costs in hospitals, Medicare could increase Disproportionate Share Hospital payments and Uncompensated Care payments to hospitals. Local governments could also increase tax appropriations to hospitals for uncompensated care. We differed from the Urban Institute assumptions as we did not assume that these amounts change in this analysis.

About the Authors

Randy Haught is a Senior Data Manager at Dobson | DaVanzo and brings nearly 30 years of experience performing analyses of major health care reform legislation and provider payment regulations. At Dobson | DaVanzo, Mr. Haught has worked with a number of organizations to assist them in developing or examining Medicare alternative payment models. Prior to joining Dobson | DaVanzo, Mr. Haught spent more than 20 years with The Lewin Group, where he focused on data analysis and microsimulation modeling of health care financing and policy-related issues. Mr. Haught was the architect of the Lewin Group's Health Benefit Simulation model, which was used to estimate the impacts of major health care reform proposals, including the ACA. Mr. Haught graduated with honors in Mathematics from Waynesburg College.

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Notes

[i] Matthew Buettgens, Michael Simpson, Jason Levitis, Fernando Hernandez-Lepe, and Jessica Banthin; "4.8 Million People Will Lose Coverage in 2026 If Enhanced Premium Tax Credits Expire"; (The Urban Institute September 2025)

[ii] Fredric Blavin and Michael Simpson; "Changes in Health Care Spending and Uncompensated Care under Enhanced Tax Credit Expiration for Marketplace Coverage"; (The Urban Institute September 2025)

[iii] Andrew Patzman, Kendall Strong, and Lisa Harootunian; "Enhanced Premium Tax Credits: Who Benefits, How Much, and What Happens Next?"; (Bipartisan Policy Center, Issue Brief, October 15, 2025)

[iv] Allen Dobson, Joan DaVanzo, and Namrata Sen; "The Cost-Shift Payment 'Hydraulic': Foundation, History, And Implications" (Health Affairs, 2006)

[v] James Robinson, "Hospitals Respond To Medicare Payment Shortfalls By Both Shifting Costs And Cutting Them, Based On Market Concentration" (Health Affairs, July 2011)

[vi] "Rural Hospital Closures" (University of North Carolina, The Cecil G. Sheps Center for Health Services Research, 2014).

[vii] "Rural Hospitals at Risk of Closing" (Center for Healthcare Quality and Payment Reform, October 2025).

[viii] Sara Rosenbaum, Feygele Jacobs, and Kay Johnson, "Nearly 5.6 Million Community Health Center Patients Could Lose Medicaid Coverage Under New Work Requirements, with Revenue Losses Up to $32 Billion" (The Commonwealth Fund, May 30, 2025)

[ix] Leighton Ku et al., How National Medicaid Work Requirements Would Lead to Large-Scale Job Losses, Harm State Economies, and Strain Budgets (Commonwealth Fund, May 2025).

[x] To be included in the study, hospitals must have reported total operating expenses, Medicaid revenues and costs, uncompensated care costs, and had an operating margin within 2 times the interquartile range of all hospitals. These edits excluded 124 acute care hospital in Medicaid expansion states.

[xi] Allen Dobson, Joan DaVanzo, and Randy Haught, "The Financial Impact of the American Health Care Act's Medicaid Provisions on Safety-Net Hospitals: Technical Appendix" (The Commonwealth Fund, June 26, 2017); Edward Levine, Noam Bauman, and Bowan Garrett, "The Impact of Coverage Shifts on Hospital Utilization" (McKinsey and Company, May 2013).