# *DECEIVED NATION*

**Primer #3: The Federal Cuts to Medicare**

Summer 2026

Medicare is a federal health insurance program for individuals aged 65 or older, younger people with disabilities, and those with specific diseases like end-stage kidney disease. It is funded by payroll taxes, general revenue, and beneficiary premiums. Medicare was created in 1965, and officially launched in1966 to address a national crisis where nearly half of all seniors lacked health insurance and many lived in fear of being bankrupted by medical costs. Upon inception, it immediately enrolled more than 19 million Americans and as of summer 2026, over 70 million are enrolled. The program's core goal is to provide a guaranteed health safety net for older Americans, regardless of their income or medical history. To date, Medicare has significantly reduced poverty among the elderly and increased life expectancy across the U.S. It is highly popular across all political parties in America.

## Overview Of Medicare Cuts

The deeply unpopular One Big Beautiful Bill Act (OBBBA or H.R. 1), which the Trump administration is now rebranding as the "Working Families Tax Cuts," was signed into law on July 4, 2025. It introduces sweeping cuts to Medicare through indirect budgetary triggers and direct policy mandates. These changes eliminate medical coverage for approximately 100,000 lawfully present immigrant seniors, while making healthcare more expensive and burdensome for the rest of the program's 70.3 million total enrollees. The impacts will resonate far beyond the immediate beneficiary population—who face worse health outcomes from higher out-of-pocket costs and delayed treatments—and trigger economic shocks across the country. Driven by $536 billion in automatic Medicare PAYGO cuts over the next decade, the larger economy faces widespread rural hospital closures, tens of thousands of lost healthcare jobs, and a sharp rise in uncompensated care costs that will ultimately drive up private insurance premiums for everyday Americans. The following is an explanation of these structural changes and how they will damage both Medicare recipients and the broader U.S. economy.

## Indirect Spending Reductions (Sequestration):

The OBBBA triggers $536 billion in automatic PAYGO cuts to Medicare, threatening to reduce provider networks and benefits for all 70.3 million enrollees over the next decade. PAYGO is a federal law designed to prevent the government from increasing the national deficit. If Congress passes a new law that cuts taxes or increases spending, it must pay for those changes. It can do this by cutting spending somewhere else or by raising taxes. If Congress passes a law that increases the deficit anyway, a penalty is triggered. To balance the books, the law automatically cuts funding from a wide range of government programs, including Medicare. This automatic process is called sequestration. Because the OBBBA adds to the national deficit without a way to pay for it, the PAYGO law forces automatic budget cuts to Medicare to make up the difference.

## Direct Policy Changes:

The OBBBA has several specific provisions that directly alter Medicare eligibility and benefits:

- Creates New Eligibility Restrictions for Immigrants: Starting January 1, 2027, the OBBBA terminates Medicare eligibility for 100,000 lawfully present immigrant seniors, even for those who previously paid into the system. Although Trump and other Republicans frequently claim that their healthcare cuts will stop illegal criminals from receiving free healthcare, that is false. Undocumented immigrants have been ineligible for Medicare since August 22, 1996, when President Clinton signed the Welfare Reform Act. But lawfully present individuals who worked and paid into the system have historically been able to qualify for Medicare benefits – including temporary protected status holders, refugees, asylum-seekers, survivors of domestic violence, trafficking victims and people with work visas - that are now losing coverage as the OBBBA begins to kick in, despite the fact that they *do* have legal status. This OBBBA eligibility change will result in growing volumes of unreimbursed care for older patients.

- Blocks Savings Programs: In 2023, the Centers for Medicare and Medicaid Services (CMS) finalized a rule to help low-income Medicare beneficiaries gain access to Medicaid coverage of Medicare premiums and cost sharing, through the Medicare Savings Programs (MSP). The OBBBA prohibits the implementation of those rules until October 2034. By imposing a ban on program improvements, the OBBBA creates government "savings" that come from preventing eligible beneficiaries from accessing programs designed to make Medicare more affordable. This OBBBA ban disproportionately affects disabled people, as they are more likely to have lower incomes than nondisabled people. The Center for Medicare Advocacy estimates that the disruption to enrollment systems will impact 1.38 million low-income Medicare beneficiaries who lose or are blocked from cost assistance. The Congressional Budget Office (CBO) calculated that freezing this rule accounts for an $85 billion reduction in federal healthcare spending over ten years. This money is saved specifically by keeping the application process complex enough that impoverished seniors continue to fail to access the financial help they are legally qualified to receive.

- Limits Drug Price Negotiation: The OBBBA broadens the exemption for "orphan drugs" (medications for rare diseases), exempting them from Medicare price negotiations even if they are approved for multiple conditions. This directly increases out-of-pocket costs for seniors. Under the original rule in the 2022 Inflation Reduction Act, Medicare was allowed to negotiate prices for high-cost drugs. Rare disease medications ("orphan drugs") were exempt from negotiations, but only if they were approved to treat a single rare disease. If a drug company started selling the drug for a second condition, Medicare could step in and negotiate a lower price. The OBBBA Modification broadened this exemption. Now, a drug can be approved for multiple different rare diseases and still remain exempt from Medicare price negotiations. It also delays the timeline for when these drugs can ever be considered for pricing limits. Many "orphan drugs" are actually massive, multi-billion-dollar blockbusters—especially heavily used cancer treatments like *Darzalex*. By shielding these highly profitable, multi-use medications from price talks, the OBBBA allows pharmaceutical companies to keep prices high. This single OBBBA provision that blocks the government from negotiating lower prices is projected to increase Medicare costs by $8.8 billion over a decade.

  Elimination of Medication Subsidies: The financial impact to seniors by the OBBBA exemptions for orphan drugs is exacerbated by the Trump Administration's Summer 2026 elimination of the Medicare Part D Premium Stabilization Demonstration program. Previously, this $9.8 billion federal subsidy program actively flattened premium hikes by paying private insurance companies directly, absorbing the financial shocks of

healthcare market restructuring and keeping monthly senior premiums low. However, the administration's decision to pull this federal funding forces private insurers to face rising medication costs—including the unnegotiated orphan drugs—without a government safety net. As a direct result, insurers are shifting these costs onto consumers, causing monthly standalone Part D premiums to spike by an estimated $11 to $20 per month for roughly 45% of enrollees. This cumulative burden hits 25 million older Americans on fixed incomes, who must now pay significantly more each month just to maintain basic prescription drug coverage.

The Premium Stabilization Cut directly raises seniors' monthly bill just to have insurance. The OBBBA Provision keeps the wholesale price of the medicine high. Together, they ensure seniors pay more every month to keep their plan, and every time they pick up a prescription.

- Lowers Nursing Home Standards: Medicare pays for long-term care for over one million Americans in nursing homes. To protect patients, the government previously required these facilities to maintain a **minimum number of staff** on duty. However, the OBBBA law placed a moratorium on national minimum staffing requirements for nursing homes until 2035, blocking implementation of national minimum staffing requirements for nursing homes that were designed to improve quality of care. As a result, federal courts threw the staffing mandates out, and the government officially erased the safety rules in December 2025. This change severely lowers quality-of-care standards. Without federal rules, nursing homes can legally operate with fewer workers. Consumer groups like the **AARP** warn this will lead to neglected patients, longer wait times for medical help, and more injuries. The OBBBA strips away vital safety protections, allowing billions in Medicare funds to flow to understaffed facilities.

## Economic Impacts:

The health sector is an economic engine, representing nearly 17% of the total U.S. Gross Domestic Product (GDP). Squeezing its primary payer creates a multi-layered economic domino effect:

- **Preemptive Layoffs:** Because Medicare payments drop immediately by billions under a 4% sequestration cap, facilities cannot easily absorb the revenue drop without cutting their highest internal cost: labor.
- **Medical Brain Drain:** As hospitals freeze hiring, eliminate contract nurse positions, or lay off support staff, medical professionals migrate out of economically depressed areas. This creates "care deserts," leaving remaining regional employers without a viable workforce and lowering local tax bases.
- **The Downstream Jobs Multiplier:** For every primary healthcare job lost, adjacent local businesses suffer. Medical supply distributors, local pharmacies, ambulance companies, and even neighborhood grocery stores or retail shops experience a direct drop in consumer spending as hospital payrolls shrink.
- **Systemic Financial Strain on Infrastructure:** Medicare cuts undermine the foundational financing that hospitals use to build, expand, and maintain their physical facilities. When a hospital's projected revenue from Medicare drops, credit rating agencies (like Moody's or S&P) downgrade the hospital system's financial outlook. A lower credit rating makes it much more expensive for a hospital to borrow money. This blocks them from issuing bonds to build new emergency rooms, purchase updated MRI machines, or repair aging

infrastructure. Financially strained health systems lose their bulk-purchasing power. When a hospital falls behind on payments to medical device manufacturers or pharmaceutical distributors, the unit cost of basic medical supplies rises, aggravating the internal operational crisis.

- **Uncompensated Care Surge**: Under the federal Emergency Medical Treatment and Labor Act (EMTALA), hospitals are legally required to screen and stabilize anyone who walks into an emergency room, regardless of their insurance status or ability to pay. Without routine Medicare access, seniors delay treating chronic illnesses like diabetes, hypertension, or heart disease. When they eventually collapse and enter the ER, their conditions require intensive, highly expensive ICU care rather than low-cost preventative care. Because these patients cannot afford six-figure intensive care bills, the debt is written off by the hospital as "uncompensated care." This rapidly eats away at the facility's cash reserves, driving vulnerable safety-net hospitals directly toward bankruptcy.

## The Double-Whammy of Medicare and Medicaid Cuts

There is significant interplay between Medicaid and Medicare. Millions of low-income seniors and individuals with disabilities are "dual eligibles - simultaneously enrolled in both programs. While Medicare handles their acute medical care (e.g., hospital stays and doctor visits), Medicaid functions as a vital safety net. It covers out-of-pocket Medicare premiums, co-pays, and long-term care services that Medicare excludes.

But the OBBBA slashes federal Medicaid funding by roughly $1 trillion over the next decade. It directly targets how states fund their programs - freezing and rolling back state "provider taxes" and caps state-directed Medicaid payments to health networks. Because states are losing billions in federal matching funds, they face immense pressure to scale back optional Medicaid benefits. Chief among these endangered programs are Home and Community-Based Services (HCBS), which allow fragile seniors to age safely in their homes rather than in costly nursing facilities.

With the OBBBA Medicaid cuts (see Deceived Nation's Primer #2 - Medicaid Cuts), these individuals may have to rely more heavily on Medicare for optional Medicaid programs such as home and community based services. This is a particularly challenging time to put additional pressure on Medicare, because the program is already strained by the nation's aging population. In the 20-year period from 2004 to 2024, the share of Americans ages 65+ (i.e., those eligible for Medicare) rose from 12.4% to 18%.

## Impacts On Rural Areas

While the Medicaid cuts threaten hospitals by dropping coverage for low-income patients, the Medicare cuts act as a direct squeeze on hospital revenue. The primary reasons why Medicare cuts disproportionately damage rural health infrastructure include:

- **Heavier Reliance on Medicare Revenue:** Rural communities have a much higher concentration of senior citizens and retirees compared to urban centers. According to the National Rural Health

Association (NRHA), rural hospitals rely far more heavily on Medicare reimbursements for their daily cash flow than urban facilities, leaving them highly exposed to federal rate reductions.

- **The Weight of Sequestration:** The ongoing 2% automatic Medicare sequestration cap cuts roughly $540 million per year from rural healthcare providers.. When combined with a 35% reduction in bad-debt charity care reimbursements, rural hospitals lose hundreds of millions in expected revenue for care they have already delivered.
- **Widespread Negative Operating Margins:** Even before the cuts, nearly 50% of all rural hospitals in America were already operating at a financial loss. A sudden drop in outpatient clinic funding can be enough to push a vulnerable rural hospital into permanent closure.
- **Exacerbating "Care Deserts":** When Medicare squeezes physician pay, local clinics are forced to downsize. Independent data from Chartis indicates that healthcare groups are already closing rural clinics due to shifting safety-net funding risks, leaving local seniors with dwindling access to immediate medical professionals.

## Impact on the Healthcare Workforce

The massive $536 billion in automatic Medicare cuts will trigger severe, compounding impacts across the nation's healthcare labor market, a crisis dramatically worsened by the Trump Administration's termination of Temporary Protected Status (TPS). This intersection of budget slashes and sudden immigration crackdowns is crippling the pipeline of essential personnel required to sustain senior care. (Established by Congress, TPS is a humanitarian program that grants legal work permits and deportation relief to foreign nationals who cannot safely return home due to war or natural disasters. Following a Supreme Court ruling clearing the way for nationwide terminations, hundreds of thousands of legally present immigrants—including over 330,000 from Haiti and Syria alone—are losing their legal work authorizations.)

- **Severe Direct-Care Staffing Disruption:** Immigrants make up a large share of direct care workers, including home health aides, personal care aides and nursing assistants. This sector already faces a severe nationwide shortage. Demand will continue to skyrocket as the U.S. population aged 65 and older jumps from 58 million to 82 million by 2050. Nearly half of all U.S. nursing homes are already forced to limit new patient admissions due to these staffing shortages. The crisis will deepen as TPS expiration places an estimated 50,000 vital healthcare services workers nationwide in immediate legal jeopardy.C**ollapse of Senior Care Support:** An estimated 21,000 Haitian TPS holders function as dedicated caregivers. Their abrupt termination strips daily support for roughly 77,000 vulnerable elderly patients.

- **Compounded Workforce Attrition:** Combined with the OBBBA's elimination of national minimum staffing standards (see above), the surviving workforce is left dangerously overextended. Operating under severe patient-to-staff ratios spikes employee burnout.

- **Foreign medical graduates:** International Medical Graduates (IMGs) constitute roughly 25% of the total active U.S. resident workforce, filling nearly 10,000 first-year positions annually. New York State serves as a primary hub, with IMGs comprising 35% of NY medical residents and exceeding 50% in

primary care tracks. Safety-net programs, such as Nassau University Medical Center, exhibit higher dependency, with 55% to 70% of residency slots filled by foreign-born doctors. These data highlight the crucial role of IMGs in sustaining regional primary care infrastructure. However, this vital pipeline faces severe strain under federal immigration crackdowns and administrative processing holds targeting "high-risk" countries, which have already forced several hospitals to place physicians on administrative leave. If these administrative holds transition into outright visa cancellations or deportations, the American Medical Association (AMA) warns it will cause immediate, catastrophic staffing vacancies, forcing safety-net hospitals to collapse their clinical capacity and leave millions of patients in underserved communities entirely without care.

- **New York State/Long Island Impacts:** Approximately 40,000 Haitian TPS holders live in New York — more than any other state. The sudden termination of TPS threatens New York's healthcare sector, where immigrants constitute 34.9% of the workforce, with an estimated 7,000 working as core caregivers. This action has triggered immediate staffing shortages, layoffs, and increased pressure on nursing facilities. The situation is so dire, that the New York State Health Facilities Association, a coalition representing 400 New York nursing homes is asking the Trump Administration to shelve its decision, fearing destabilization of the workforce and devastating impacts on services to frail elderly residents.

The growing staffing vacuum confronting the healthcare industry directly reduces care capacity. For aging Americans and their families, this leaves fewer care options, longer placement delays, and a lower overall quality of clinical care.

## Medicare Advantage

Medicare Advantage (MA) is an alternative to "Traditional Medicare" where private, Medicare-approved insurance companies provide bundled hospital (Part A) and medical (Part BI) coverage, and often prescription drugs (Part D), as well. As of mid-2026, the program serves 35.2 million people, representing 55% of the total Medicare population, with many beneficiaries choosing these plans for additional benefits and capped out-of-pocket spending limits. However, critics and independent researchers note that these plans restrict choice to limited provider networks and frequently require prior authorizations, which can lead to care delays or denials for seriously ill patients.

Dr. Mehmet Oz, Administrator of the Centers for Medicare & Medicaid Services, faces conflict-of-interest criticism. Official ethics disclosures show he holds up to $600,000 in UnitedHealth Group stock, the nation's largest private Medicare Advantage provider. While Dr. Oz has publicly pledged to combat fraud, investigative reporting by Roll Call notes that critics argue his personal financial ties and past advocacy for privatized healthcare severely compromise his ability to objectively regulate these insurance giants.

## IN CONCLUSION:

The OBBBA introduces severe financial headwinds to the program, due to the PAYGO automatic spending cuts of $45 billion per year starting in 2026 (or $536 billion over a nine-year period (2026 through 2034). Private insurers are absorbing these federal funding rollbacks by aggressively reducing their service areas, eliminating unprofitable PPO plans, and shrinking extra benefits like dental, vision, hearing, and wellness allowances. Additionally, the OBBBA rolled back federal Medicare subsidies for prescription drugs, driving up copays and prompting insurers to exit less profitable markets. As a direct result of these OBBBA-fueled contractions, **over 1 million beneficiaries** are being forced off their existing Medicare Advantage plans in 2026, facing fewer zero-premium plan choices and higher out-of-pocket costs.

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