What We Are Watching Disappear

A young mother, a rural nurse, a state Medicaid director, and the public healthcare system being quietly withdrawn from the Americans who need it most

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On the second of April, 2024, in the middle of the night, in a rural home on the outskirts of Baker City, in the eastern quarter of Oregon where the land climbs into the Blue Mountains and the towns thin out and the distances between them lengthen, a woman named Teela Banister went into labor with her second child, and she and her husband raced out the door of that house and into their car and onto the highway toward La Grande, hoping to reach the hospital there before the baby arrived, and knowing already, before they had gone a mile, that they probably would not.

They could not go to the hospital fifteen minutes away. That hospital, Saint Alphonsus Medical Center in Baker City, had closed its labor and delivery unit in August of 2023, only weeks before Teela and her husband learned they were expecting again. When Saint Alphonsus announced the closure that June, the reasons sounded almost bloodless: too few nurses, too few births, a service the hospital could no longer sustain. But beneath those words was a far more intimate fact. An entire corner of Oregon had lost the place where its children were born, and from that moment forward, pregnancy itself would require something more of the women who lived there: more miles, more planning, more time away from home, and, when something went wrong, more risk.

Teela Banister gave birth to her daughter, Lakelynn, in the passenger seat of the car, roughly halfway between the town where she lived and the town with the working maternity ward. The baby had fluid in her lungs. She was unable to make sounds. Teela, who was twenty-five when she told this story to a reporter from InvestigateWest for a piece published a year later, in September of 2025, described her single biggest fear during the pregnancy in language plain enough that the reporter used it verbatim. “My biggest fear was that I was going to give birth on the highway driving to the hospital.” Lakelynn survived without complication. Teela said the experience, and the closure that produced it, had her weighing whether she could bring herself to have another child at all.

This is one story. There are others.

The One Big Beautiful Bill Act, H.R. 1, was signed into law on July 4, 2025. Saint Alphonsus had closed its Baker City labor and delivery unit nearly two years earlier, in August of 2023. That chronology matters. H.R. 1 did not close that unit, and it did not send Teela Banister onto the highway to give birth. What it will do is reach an Oregon rural health system in which stories like hers were already possible, hospitals were already retreating from essential services, and the distance between a pregnant woman and the care she might suddenly need was already growing. The new law does not create the conditions in Baker City. They are what the new law is arriving on top of. Baker City is not a prediction of what might happen next. It is a warning of what was already happening before the next pressure arrived.

For nurse Doris Harper, the Blue Mountain Hospital in John Day, Oregon, is more than a workplace. It is where she gave birth, decades ago, ninety rugged miles from the next nearest hospital in rural Oregon. Her daughter Jessie Saul grew up in Grant County and became a nurse herself, working alongside her mother, and when the doctor who had delivered Jessie entered hospice care in recent years, Jessie helped take care of him. Both women, mother and daughter, have said that a tight-knit rural community can be the difference for patients who have nowhere else to turn.

In an article published in Oregon Public Broadcasting on September third of this year, three days ago, by the reporter Monica Carrillo-Casas, Harper described what has been happening to her hospital. “It's gotten to the point where the staff will come back from time off and ask what cuts have been done this week.” Between January and June of 2026, three longtime physicians resigned from Blue Mountain, leaving the hospital with one staff doctor and a traveling physician to cover a 25-bed acute care facility, two clinics, a hospice, and a 40-bed elder-care center in nearby Prairie City. In April, 120 hospital workers voted to unionize with the Oregon Nurses Association. Nine employees had been let go the previous September, shortly after the district hired a new chief executive, Misty Robertson, who cited financial pressures and anticipated Medicaid cuts. The district, Robertson told OPB, lost $1.6 million last fiscal year and another $818,000 in the current one, a trajectory she described in the language executives reach for when there is no softer language available, calling it unsustainable and requiring difficult changes.

To the East Oregonian, in a September 2025 interview about the layoffs, Robertson had put the underlying arithmetic in plainer terms. “We're already at a net operating loss”, she said. “We're not getting enough revenue now, and we know 24% of it could potentially be decreased, or people could find themselves uninsured and needing care, and we still have to provide and want to provide care. There just wouldn't be a reimbursement for it.” The precise composition of that twenty-four percent, whether it represents Medicaid revenue directly, the share of the district's patient population that could become uninsured, or some broader exposure to the coming federal changes, Robertson did not itemize. About a third of Grant County's residents are on Medicaid, according to the Oregon Office of Rural Health.

“I didn't get into healthcare to watch it disappear”, Harper told Carrillo-Casas. “I became a nurse to help care for our community.”

The title above these pages belongs to Harper. It was hers before it was mine. And the country in which a longtime rural nurse says out loud that she did not enter her profession in order to watch it disappear is the country that follows.

Blue Mountain Hospital sits in a town of roughly sixteen hundred people in a county of roughly seven thousand. It is one of Oregon's thirty-seven rural and frontier hospitals, twenty-five of which, including Blue Mountain, hold the federal designation of Critical Access Hospital, a category created precisely for facilities serving communities with limited alternatives. When the Center for Healthcare Quality and Payment Reform published its analysis earlier this year, it found that one in five Oregon rural hospitals were at risk of closing, and that more than forty percent of them had already cut back services to make ends meet. Cut back services means, in most cases, the departments that produce the least revenue, which means, disproportionately, obstetrics and labor and delivery, which means the reason Teela Banister could not go to the hospital fifteen minutes from her home.

The pressure that produced Saint Alphonsus's closure of its Baker City maternity ward in 2023, and that is producing the layoffs and resignations and unionization drive at Blue Mountain Hospital in 2026, and that is producing quieter versions of the same story in rural hospitals throughout the eastern half of Oregon, is about to become considerably worse.

It is worth being clear about what Medicaid actually is inside Oregon, because most Americans, including most Oregonians, do not encounter the program in the way its critics describe it.

Medicaid, administered in Oregon under the name of the Oregon Health Plan, is not primarily a government check sent to poor people. It is a financing stream. Federal and state dollars flow through OHA to sixteen coordinated care organizations that in turn contract with the hospitals, physicians, pharmacies, behavioral health providers, dentists, and maternity services that deliver the actual care to the 1.4 million Oregonians currently enrolled. That is approximately one-third of the state.

Of those 1.4 million, roughly half a million are children, and Medicaid now covers more than half of the children in Oregon. Roughly 870,000 are working-age adults. Tens of thousands qualify through disability categories, tens of thousands more through the elderly category. Medicaid pays for roughly four in ten births in Oregon. And among the non-elderly adults enrolled, the great majority live in households where somebody works, often full-time, sometimes at more than one job. These are not, on the whole, the Americans that political rhetoric about Medicaid tends to conjure. They are the Americans who work at gas stations and grocery stores and farms and restaurants and small vineyards.

Oregon expanded its Medicaid program more broadly than most states. Beyond the Affordable Care Act expansion, the state established Healthier Oregon, which extends OHP eligibility to undocumented residents who meet the income threshold, a program whose budget has risen roughly tenfold in a decade to just over $1 billion in the current biennium. That expansion is part of why the coming federal contraction hits Oregon particularly hard: the state built a broader Medicaid tent than most, and now the federal matching structure underneath the tent is being narrowed.

When OHA and Governor Kotek's Advisory Group on Medicaid Sustainability project that H.R. 1 will cost Oregon $9.41 billion in combined state and federal funding by 2031, that number does not represent a $9.4 billion reduction in a check the government mails somewhere. It represents federal funding removed from the larger financing structure through which Oregon insures Medicaid recipients and pays the institutions that care for them. It is Blue Mountain Hospital's revenue. It is Saint Alphonsus's revenue. It is the revenue of the Federally Qualified Health Center in Woodburn and the community health clinic in Ontario and the pediatric dental

office in Medford. Medicaid is a substantial share of the operating revenue of the average Oregon hospital. For some rural hospitals, it approaches half.

To reduce Medicaid, in other words, is not primarily to reduce a category of spending. It is to reduce the revenue base of a set of American healthcare institutions, in a set of American communities, that are already carrying the largest per-capita share of uncompensated care and are already, in many cases, at the edge of viability.

On July 4, 2025, President Trump signed the reconciliation legislation known as the One Big Beautiful Bill Act, or H.R. 1. The largest single provision of the law by dollar value is a reduction in federal Medicaid spending that the Kaiser Family Foundation, using an estimate from the Congressional Budget Office, has placed at approximately $911 billion over the ten-year period from 2025 through 2034. In Oregon, the Governor's Advisory Group on Medicaid Sustainability, working from Oregon Health Authority analysis, has projected that H.R. 1 will cost the state $9.41 billion in combined state and federal funding through 2031, an unprecedented contraction of the federal partnership on which Oregon's healthcare system, and particularly its rural healthcare system, has been built.

The strongest version of the case for that contraction, as its supporters make it, is that the Medicaid expansion enacted under the Affordable Care Act was intended as a bridge rather than as a permanent alternative to employment-linked coverage, and that able-bodied working-age adults should participate in employment, education, or community service in exchange for public assistance. Supporters argue further that states have exploited provider taxes and state-directed payments over the past two decades to draw down federal matching dollars beyond the program's original scope, that Medicaid's spending growth requires fiscal discipline, and that the new Rural Health Transformation Program will replace a portion of that indiscriminate federal reimbursement with targeted investment in rural infrastructure. These arguments deserve engagement. They also, as the Oregon reporting begins to make clear, do not fully account for what Oregon's own Medicaid leadership is now describing as the foreseeable effect of the law on the state's healthcare system.

Vivian Levy is the Interim Medicaid Director for the Oregon Health Authority. On July 29 of this year, she sat for an interview with Dave Miller of Oregon Public Broadcasting to explain what is coming. About 600,000 Oregon adults, she said, will need to be evaluated under the new

work requirements taking effect in January 2027. That is nearly three times the number who had to be reviewed under similar SNAP work requirements. Data available to her office showed that between 100,000 and 200,000 Oregon adults could end up losing coverage. And then, in a sentence I have been unable to stop thinking about since I first read the transcript, she offered a precise clarification about what that coverage loss would represent.

"That is not as a result of not meeting the eligibility requirements", she said. "That's a result of a very complex and difficult-to-understand process as a result of these new requirements."

Read that sentence twice. Between one hundred thousand and two hundred thousand adult Oregonians are expected to lose their health insurance not because they have become ineligible for it, but because the process of proving that they remain eligible has been made complicated enough that they will fall out of the system before they can complete the paperwork. Whatever one's view of work requirements as policy, Oregon's own Medicaid director is saying something important about the people the state expects to lose coverage: many will not lose it because they fail the substantive eligibility rules. They will lose it because they fail the administrative process.

I know at least one category of the people hidden inside those numbers because I have employed them.

I run a small company in the Willamette Valley. We employ people. We are proud that we do, and we are proud that among the things we offer them is health insurance for every full-time employee, an expense that is genuinely substantial for a small business but that we consider a moral obligation of being an employer at all. And yet, over the years, more than once, an employee has quietly declined the plan we were offering. Not because they did not want health insurance. Because their family already had OHP coverage that, for a spouse and children at the family income levels available to a full-time worker in the Willamette Valley wine industry, met the family's needs more completely than a small employer's group plan could.

The people who made that decision were not gaming the system. They were performing the math that the system had presented to them, and they were performing it in exactly the way any responsible parent would perform it. And the number of Americans making that same decision, in some version, in some industry, in some small town or agricultural county or service economy, is far larger than the political conversation about Medicaid ever quite acknowledges.

The line between the American who works for a living and the American who receives public health coverage is not a line. It is the same American, in the same household, sometimes on the same tax return, arranging the family's coverage across two systems because neither system alone is sufficient to the family's actual medical needs.

Some of the people at risk from what is coming will look very much like people I have employed.

The Oregonians projected to lose coverage will still get sick. They will still need care. The effects will not be distributed evenly. Rural counties in Oregon carry considerably higher Medicaid enrollment shares than urban counties. Malheur County, on the eastern border, has Medicaid enrollment around 54 percent. Multnomah County, containing Portland, sits around 36 percent. The rural counties are also the counties where the hospitals are already thinnest, where the drives are already longest, where the emergency departments are already carrying disproportionate uncompensated care loads.

Levy herself, in the OPB interview, laid out the mechanism in language available to any careful reader. When large numbers of people lose health coverage, she said, it creates ripple effects across the entire health care system. Those folks would still be seeking care and often seeking care in less ideal situations like the emergency room, which we know are much more expensive and suffer from overcrowding already. The financial impacts and the utilization impacts, she added, could be substantial.

There is a difference, worth naming, between reducing an expenditure and eliminating a cost. If the federal government reduces Medicaid spending by $911 billion over ten years, and Oregon's share of that reduction runs to billions, the government's ledger will show the reduction cleanly. But the underlying medical need on which that spending was previously being applied does not disappear. The person loses Medicaid. The government's Medicaid spending on that person falls. The diabetes remains. The pregnancy remains. The infected tooth remains. The heart condition remains. And the cost migrates. It migrates to an emergency room visit that the hospital must legally provide but for which it will not be reimbursed at the same rate. It migrates to an uncompensated care line on that hospital's operating statement. It migrates to a family budget already stretched, or to a credit card, or to a bankruptcy filing. It migrates to delayed care that becomes urgent care that becomes catastrophic care. Or it becomes simply untreated illness, which

is to say suffering, quietly borne, invisibly borne, in the specific American way of bearing something the country has decided not to see.

The cost does not disappear. Only the federal expenditure disappears. The two are not the same thing. What Americans are watching disappear, in the end, is the visible part of a transaction whose invisible part continues, undiminished, on less visible ledgers, in less politically legible forms.

Oregon's Medicaid budget faces an immediate shortfall of $421 million in the 2027-2029 biennium, doubling to more than $800 million by 2029. Governor Tina Kotek's Advisory Group on Medicaid Sustainability delivered its report to the governor's office this summer with more than forty different options for how the state might absorb the impact. Miller, in the OPB interview, reduced Oregon's choices to three broad levers, and Levy agreed the framing was accurate. Reduce the number of people on the plan. Reduce what the plan covers. Reduce what the plan pays providers. In practice, over the next three years, Oregon is likely to do some combination of all three.

Reducing the number of people is an effect the new administrative requirements are expected to produce, whether that is their explicit intent or, in Levy's own framing, their foreseeable outcome. Reducing what the plan covers means eliminating optional benefits such as adult dental care and physical therapy, both of which the Advisory Group has floated. Reducing what the plan pays providers means further compressing reimbursement rates that Oregon hospitals and clinics have long described as inadequate to cover the cost of Medicaid patients. All three levers, in different ways, transfer costs from the state's ledger to somebody else's ledger. Which is to say: to the ledgers of hospitals, and physicians, and patients, and families, and communities, and small business owners.

There is a piece of the law that its authors have offered as compensation for what it takes away. H.R. 1 includes a Rural Health Transformation Program that will distribute federal funds to rural hospitals in states with heavy Medicaid impact. Oregon received its Notice of Award from the Centers for Medicare and Medicaid Services on December 29, 2025, for $197.3 million for the program's first year in 2026. If subsequent federal awards are similar, Oregon could receive roughly

$1 billion over the five-year life of the program, although later awards are not guaranteed and depend on the state's progress against the federally approved program plan.

That is substantial money, and it complicates any honest account of the law. It is also, by every available comparison, meaningfully smaller than what H.R. 1 is projected to take out of Oregon's Medicaid financing. Of the $197.3 million first-year award, the Oregon Health Authority has announced that $50 million will be distributed directly, with $35 million going to Oregon's rural hospitals, $10 million to rural health clinics, and $5 million to local public health authorities. The remainder flows through catalyst grants and other awards.

Blue Mountain Hospital District is eligible for a share of that direct funding. As of this writing, the exact amount has not been publicly announced. Separately, Blue Mountain will receive a share of a $37.5 million state-directed payment approved by CMS in May 2026 to support maternity services at 21 rural Oregon hospitals. Both funding streams are real. Both will help. At the statewide level, neither replaces, at scale, what H.R. 1 is projected to take out of Oregon's Medicaid financing.

The Oregon that will emerge from H.R. 1's implementation is not being made by monsters. It is being made by people acting within budgets. By hospital administrators trying to keep their institutions solvent. By state officials trying to comply with federal law. By legislators who describe the changes as necessary for program integrity, fiscal restraint, and the encouragement of work. By voters who chose the administration that authored the bill. The Oregon that is coming is being made in board meetings and legislative sessions and CMS approval letters and staffing spreadsheets. It is being made by the aggregation of many individual decisions, most of them administrative, most of them defensible in the language of whatever pressure the decider was responding to.

That is what makes what is happening difficult to see clearly. The maternity ward in Baker City did not disappear because anyone decided to eliminate maternity care in eastern Oregon. It disappeared because staffing and reimbursement conditions made it financially untenable for Saint Alphonsus to keep the department open. Three longtime physicians disappeared from Blue Mountain's staff during the first half of 2026, even as the hospital's financial condition deteriorated. The 100,000 to 200,000 Oregonians projected to lose OHP coverage will not disappear from Medicaid rolls because anyone in the Oregon Health Authority believes they should. They will

disappear because the paperwork required to prove their continued eligibility, twice a year instead of once every two years, with new work verification requirements attached, will exceed what many of them can complete under the actual conditions of their lives.

America made an incomplete promise. In 1965, the same act of Congress that created Medicare for the elderly created Medicaid for the poor. Medicare became nearly universal, politically inviolable, the same benefit for every citizen who reached the qualifying age. Medicaid was left conditional, state-administered, means-tested, politically vulnerable, different in every state, different for every population, subject to periodic reconsideration by every Congress. The country made one promise to old age that hardened into permanence, and another promise to poverty that remained argumentative. What H.R. 1 does, over the years of its implementation, is exercise the political vulnerability that the poverty promise has carried from the beginning, retracting a significant portion of the expansion that the Affordable Care Act built onto the 1965 foundation, through administrative mechanisms that Oregon's own Medicaid leadership says will have the foreseeable effect of removing eligible people from coverage.

Teela Banister told the reporter, in the September 2025 InvestigateWest piece, that the experience of delivering Lakelynn in a car had her weighing whether to have another child. Imagine that decision. Imagine the calendar of it, the mental math, the way she and her husband must talk about it late at night in a house on the outskirts of Baker City, in a county whose hospital, fifteen minutes from their door, has not reopened the department where a baby is supposed to be born, and where every indication is that it will not reopen. Imagine what she has to weigh.

That is where the reporting ends and the imagination begins, because this country we are living in is the country that will produce whatever Teela Banister decides.

As of today, Doris Harper is still nursing at Blue Mountain Hospital. Vivian Levy is still administering the Oregon Health Plan. Governor Kotek is still working through more than forty options with her advisory group. Rural hospitals across the state are still calculating what they can absorb before they cannot. And on the second of April, 2024, in the passenger seat of a car on

the highway between Baker City and La Grande, a young woman named Teela Banister was already inside the arithmetic that the coming law will now compound.

The maternity ward disappeared.

The baby was still coming.