Written Testimony of

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before the

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on

"Securing the Future of Health Care: Enhancing Cybersecurity and Protecting Americans' Privacy"

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Mr. Chairman and Members of the Committee,

Thank you for the opportunity to testify today on "Securing the Future of Health Care." I am Robert Weissman, co-president of Public Citizen. Public Citizen is a national public interest organization with more than 750,000 members and supporters. For more than 50 years, we have advocated with some considerable success for stronger health, safety and consumer protections; for corporate and government accountability; and for access to quality health care.

Cybersecurity is a serious issue threatening both the functioning of health care delivery systems and patient privacy – and it's a problem growing rapidly worse. The intensification of cyberthreats is due in part to technological changes that equip hackers and bad actors with more sophisticated tools to undermine data security and patient privacy. But external problems are potentially supercharging the problem. These include:

- Corporate concentration in the health care sector, meaning breaches at one company can affect a vast portion of the nation's population;
- Cuts and reorganization at the Department of Health and Human Services (HHS), which appear both to be undermining data security at the department and gutting its data security enforcement capacity for private sector actors;
- The data centralization efforts of DOGE, which both make HHS data more vulnerable and itself pose potential serious threats to patient privacy;
- The rise of wearables, therapeutic and therapeutic-adjacent chatbots, and artificial intelligence (AI)-assisted devices, which enable the massive collection of health information not subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA); and
- Proposals to restrict state authority to regulate AI.

However, as significant a challenge as cybersecurity is, this hearing's objective of "Securing the Future of Health Care" is far more seriously threatened by the recently passed tax and budget reconciliation bill.

That legislation unconscionably walks back America's slow progress in expanding health care coverage. It will result in lost health care coverage for 17 million Americans, inflicting needless suffering. Those uninsured Americans will skip preventative treatments; they will become sicker than necessary; they will avoid care even for serious conditions; they will suffer severe economic impacts when they do seek care; and many will die, needlessly. Lost insurance will cause on the order of 40,000 deaths annually, according to the best projections; and other provisions in the bill will take the death toll to more than 50,000 annually.

None of this was – or is – necessary. These cruel cuts were undertaken to offset the costs of tax cuts that will disproportionately benefit the rich and corporations. Not only is this

reverse Robin Hood policy morally intolerable, it is a foolish way to "save" money. It is not just that the net economic impacts will be terrible, if the cost imposed on the newly uninsured is properly taken into account; it is that there are much larger and much more just savings available in the health care system.

The first section of this testimony examines cybersecurity issues, focusing on the massive data breach at Change Healthcare and providing an overview of external threats to health care data security. The second section looks at the health and economic harms from stripping health care coverage from 17 million Americans. The third section focuses on massive savings available in the health care system that would promote access and improve care – in direct contrast to the reconciliation bill. These are measures to rein in Big Pharma's price gouging, which could save $200 billion annually or $2 trillion over 10 years; and eliminating privatized Medicare, which could save roughly $1 trillion over the next decade. The testimony concludes by noting the huge savings and health-protecting benefits of adopting a Medicare for All system.

I. The Cyber Threat to American Health Care

Cybersecurity is a serious issue threatening both the functioning of health care delivery systems and patient privacy – and it's a problem growing rapidly worse.

Reports the HIPAA Journal: "It is not just the number of data breaches that is increasing, as the breaches are becoming more severe. 2021 was a bad year for data breaches, with 45.9 million records breached, and 2022 was worse with 51.9 million records breached, but 2023 smashed all previous records with an astonishing 168 million records exposed, stolen, or otherwise impermissibly disclosed."[1] Predictably, 2024 was even worse. The massive Change Healthcare breach itself exposed more than 190 million records.

The Change Healthcare breach – caused by a ransomware attack against the United Health Group subsidiary – disrupted health care provision across the United States and foreshadows greater threats to come. The ransomware attack caused the shutdown of Change Healthcare's sprawling billing and payment system – covering an estimated one in three patients in the country – and thereby paused payments, blocked treatment authorizations, interfered with prescription fulfillment, imperiled the functioning particularly of small medical practices, damaged patient care and compromised patient privacy.[2]

Measured in just monetary terms, the damage of the Change Healthcare breach was astounding. United Health reports spending $2.2 billion to remedy the damage in its 2024

[1] Steve Alder, "Healthcare Data Breach Statistics," HIPAA Journal, May 26, 2025, https://www.hipaajournal.com/healthcare-data-breach-statistics/

[2] Reed Abelson and Julie Creswell, "Cyberattack Paralyzes the Largest U.S. Health Care Payment System," New York Times, March 5, 2024, https://www.nytimes.com/2024/03/05/health/cyberattack-healthcare-cash.html.

10-K report,[3] a number that will surely climb as it pays or settles claims made in private litigation. And, of course, these monetary measures will fall far short of capturing the impact on disruption of patient care and on physician practices, pharmacies and clinics.

The aggregate breach data and the startling impact of the Change Healthcare crisis underscore the need for health care providers to take more aggressive action to prevent data breaches and protect patient privacy – and the need for tougher regulation. In December 2024, HHS proposed updated regulatory standards to protect patient data. The updated Security Rule would impose nontrivial costs but pay for itself if it reduced the number of affected individuals by 7 to 16 percent, as seems extremely likely.[4] It is beyond the scope of this testimony to comment on the merits or details of the proposed Security Rule. But it is worth noting, first, that a serious proposal is on the table to adopt and enforce non-voluntary stronger cybersecurity standards; and, second, that opponents of the rule regularly cite costs but do not focus on benefits – or the broad industry failure to maintain stringent enough standards.

It is fair to assume that the cybersecurity problem will continue to grow worse, potentially far worse, for reasons beyond changing technology and the increased sophistication of hackers. The committee should examine at least five external factors that threaten to worsen cyberattacks.

First, concentration in the healthcare industry, particularly among insurers and health IT companies, means that cyberattacks on one company can have far more devastating impact than would be the case with more competition. Among others, Senators Hawley and Blumenthal have properly blamed the scale of the Change Healthcare breach on the company's acquisition by United Health in 2021: "The origin of this crisis can be traced back to 2021, when UHG moved to buy Change Healthcare. At the time, UHG's subsidiary Optum was one of Change's primary competitors in the health care IT space. Medical trade groups warned that the merger would not only result in a near-monopoly in health IT, but also give UnitedHealth Care — the country's largest insurer and a subsidiary of UHG — access to competitors' claims and policy information" [footnotes omitted].[5] The Senators noted that the Department of Justice sought unsuccessfully to block the deal. In short, more industry concentration means worse data breach problems and worse incursions on patient privacy. Congress should monitor and take action to prevent further industry concentration.

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[3] UnitedHealth Group, Form 10-K for fiscal year ending December 31, 2024, https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2024/UNH-Q4-2024-Form-10-K.pdf.
[4] Department of Health and Human Services, "HIPAA Security Rule To Strengthen the Cybersecurity of Electronic Protected Health Information," January 6, 2025, https://www.federalregister.gov/documents/2025/01/06/2024-30983/hipaa-security-rule-to-strengthen-the-cybersecurity-of-electronic-protected-health-information.
[5] Senators Josh Hawley and Richard Blumenthal to United Health Group CEO Andrew Witty, April 1, 2024, https://www.hawley.senate.gov/wp-content/uploads/files/2024-04/Hawley-Letter-to-UnitedHealth-Group-re-Cyberattack.pdf.

Second, cuts and reorganization at the Department of Health and Human Services threaten to undermine the development of new federal cybersecurity standards and, probably even more importantly, federal audits and enforcement actions. It is very hard to get an accurate window into restructuring at the department, including because laid off staff have been recalled, closed offices are alleged to be reopened or merely undergoing restructuring, and announced reductions-in-force have been held in abeyance by ongoing litigation. Nonetheless, there is strong reason to believe that personnel changes, layoffs, office closures and restructuring are creating major cybersecurity risks. "Much of the IT and cybersecurity infrastructure underpinning the U.S. health system is in danger of a possible collapse following a purge of IT staff and leadership at the Department of Health and Human Services," whistleblowers have reported to Wired magazine. Senator Jackie Rosen has highlighted this concern, writing to Secretary Robert F. Kennedy, Jr.: "Recent reports indicate the staff responsible for managing hundreds of HHS cybersecurity contractors, including those who work at the Computer Security Incident Response Center (CSIRC), have been removed. Without qualified cybersecurity staff in place, HHS networks will go unprotected against cyber threats, which could enable malicious actors to access departmental data, clinical trial information, and the sensitive, personal health data of millions of Americans."[6]

As consequential, it seems likely that the cuts and chaos at HHS are diminishing or will diminish the department's Office of Civil Rights (or at a successor office's) commitment and capacity to undertake HIPAA breach investigations and enforcement. The office appears to be abandoning its focus on health data security for a new emphasis on anti-DEI enforcement; and has reportedly lost the vast majority of investigators focused on HIPAA enforcement.[7]

These are matters that should draw the Committee's attention, including simply to decipher exactly what is happening at the department. Magical invocations of "AI" cannot serve as an actual accounting of changes in the department and how it will address cybersecurity issues.

Third, the so-called Department of Government Efficiency (DOGE) itself may pose a major threat to data privacy and security. While long-term professionals concerned with health data security appear to have been separated from HHS, DOGE is gaining widespread access to health data, with uncertain purpose and protections. DOGE has reportedly

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[6] Senator Jackie Rosen, Letter to Secretary Robert Kennedy, Jr., April 28, 2025, https://www.rosen.senate.gov/wp-content/uploads/2025/04/4.28.2025.-Rosen-Letter-to-HHS-on-IT-workforce-cuts.pdf.

[7] Chelsea Cirruzzo and Kelly Hooper, "HHS switches gears: Cybersecurity out, DEI bans in," Politico, April 30,2025, https://www.politico.com/newsletters/politico-pulse/2025/04/30/hhs-switches-gears-cybersecurity-out-dei-bans-in-00316786.

obtained access to at least 19 separate databases at HHS.[8] If misused, this access may seriously compromise Americans' health privacy and/or interfere with health care payment systems. If combined with other governmental databases, as DOGE is reportedly doing, the access may create a governmental surveillance system of the type that has long troubled Americans of all political persuasions.[9] There is precious little transparency around the operations of DOGE and even less accountability. This is a matter that should demand the Committee's urgent attention.

Fourth, new technology is facilitating the creation of very large health care information databases that are not subject to HIPAA or virtually any meaningful privacy protection. "Wearable" technologies enable users to wear small devices to monitor exercise, sleep, glucose levels, blood pressure, oxygen levels and more. In many cases, they offer genuine health benefits, and Secretary Kennedy has said he hopes all Americans use wearables within four years.[10] However, most of the makers of wearables are not covered by HIPAA, nor is the personal health information they collect protected under the statute. (HIPAA protections do apply if the data is transferred to "covered entities.")[11] This issue is now being supercharged by the rise of chatbots and AI-assisted medical devices. Americans are now making widespread use of chatbots for therapeutic and therapeutic-adjacent purposes. Some of the chatbots are marketed overtly or implicitly for therapeutic purpose, but the largest ones are not. Nonetheless, the Big Tech and AI companies operating the chatbots are gaining massive troves of health information – conversations, not just data points – not subject to HIPAA. At minimum, the risks to patient privacy are massive, as all the newly gathered health information from wearables, chatbots and AI technologies can be used for intrusive marketing purposes. But the risks extend further, including if the data is misused for insurance purposes or accessed through the kinds of data breaches common in the traditional health sector.

Fifth, while AI will offer some new and useful tools to combat cyberthreats, it is also creating new cybersecurity issues. AI is enabling bad actors to increase and engage in more sophisticated cyberattacks, including with AI-assisted phishing attacks[12] and, as noted, chatbots and AI-assisted devices are gathering health information outside of the ambit of

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[8] Matt Giles, Leah Feiger, Zoë Schiffer and Caroline Haskins, "Here's All the Health and Human Services Data DOGE Has Access To," Wired, April 22, 2025, https://www.wired.com/story/doge-data-access-hhs.
[9] Stephanie K. Pell, Josie Stewart, and Brooke Tanner, "Privacy under siege: DOGE's one big, beautiful database," Brookings, June 25, 2025, https://www.brookings.edu/articles/privacy-under-siege-doges-one-big-beautiful-database.
[10] Mary Kekatos, "RFK Jr. wants everyone to use wearables. What are the benefits, risks?" ABC News, July 3, 2025, https://abcnews.go.com/Health/rfk-jr-wearables-benefits-risks/story?id=123422287
[11] Kenny Gutierrez, "Privacy in Wearables: Innovation, Regulation, or Neither," UC Law Science and Technology Journal, Volume 13, No. 1, Winter 2022, https://repository.uclawsf.edu/cgi/viewcontent.cgi?article=1109&context=hastings_science_technology_law_journal#page=13.
[12] Health Sector Security Coordination Center, "AI-Augmented Phishing and the Threat to the Health Sector," October 26, 2023, https://www.hhs.gov/sites/default/files/ai-and-phishing-as-a-threat-to-the-hph-white-paper-tlpclear.pdf.

HIPAA protections. In this context, it is vital that the nation adopt new regulations and establish new standards for health information protection. Moreover, those rules will need continuous updating as AI technologies evolve. Yet Big Tech and AI companies are now urging an AI regulatory moratorium, a proposal that could not come at a worse time. Thankfully, the Senate just voted down 99-1 a proposed 10-year moratorium on state-based AI regulation – a moratorium which absolutely would have blocked states from adopting their own AI-related health data protection rules, even in the absence of federal rules. Variants of this proposal are sure to reemerge, however; Congress should dismiss them as summarily as the Senate did this recent proposal.

II. Stripping Health Care from Millions of Americans

If this Senate has an objective of "Securing the Future of Health Care," it could not have done worse than pass the just-enacted budget reconciliation bill. The reconciliation bill betrays the nation's painfully slow but steady march to expand health care coverage to include all Americans, regardless of income or ability to work. It will leave millions more Americans without health insurance coverage and access to care. As a result, people will skip preventative care visits, treatment and prescriptions. They will needlessly become sicker and suffer longer. Tens of thousands will die from preventable conditions, every year. Health care providers, including especially rural hospitals and community clinics, will be hit hard. Hundreds of thousands of health care jobs will be lost – not from increased efficiencies, but directly proportionate to people not getting care they need.

A. Massive Loss in Health Insurance Coverage

By conservative estimates, the reconciliation bill will strip health care coverage from 17 million Americans.[13]

The bill makes a number of complicated changes to Medicaid, limiting eligibility and imposing various paperwork burdens on Medicaid recipients. According to estimates from the Congressional Budget Office (CBO), these changes will throw more than 8 million people off Medicaid.[14] Crucially, that slashing of the Medicaid population is a design feature, because it's what drives the "savings" from reducing Medicaid spending. This projection, however, may be a very substantial underestimate of the impact on Medicaid enrollment, because it makes assumptions about how enrollees and states will react to the

[13] Center for Budget and Policy Priorities, "By the Numbers: Senate Republican Reconciliation Bill Takes Health Coverage Away From Millions of People and Raises Families' Costs," June 30, 2025, https://www.cbpp.org/research/health/by-the-numbers-senate-republican-reconciliation-bill-takes-health-coverage-away

[14] See Congressional Budget Office, "Estimated Budgetary Effects of an Amendment in the Nature of a Substitute to H.R. 1, the One Big Beautiful Bill Act, Relative to the Budget Enforcement Baseline for Consideration in the Senate," June 28, 2025, https://www.cbo.gov/publication/61533 and Congressional Budget Office Letter to Sen. Ron Wyden, et. al., June 4, 2025, https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

complex changes imposed by the reconciliation bill that may prove overly optimistic. The Center for Budget and Policy Priorities estimates the actual impact on Medicaid enrollment may mean loss of coverage for between 9.8 million to 14.8 million people.[15]

Along with the Medicaid losses, the bill cuts Affordable Care Act coverage and makes rule changes that, CBO estimates, will strip coverage from nearly 9 million additional people.[16]

B. Health and Social Impacts

It is a certainty that the health care cuts in reconciliation will leave the nation sicker and weaker. This is because, unsurprisingly, people without health insurance forego health care they need and suffer directly as a result:

- Almost half of uninsured adults report not seeing a doctor in the previous year – three times the rate for people with insurance.[17]
- Uninsured adults are 3-4 times more likely to skip needed care than people with insurance. Uninsured children are 20 times more likely to miss needed care.[18]
- Uninsured people are far less likely to access screening and preventative services, ranging from Pap tests to mammography, cholesterol testing to flu vaccines.[19]
- Uninsured people are more likely to leave serious, chronic conditions untreated. By contrast, Medicaid expansion is associated with increased early-stage diagnosis rates for cancer.[20]

Moreover, health providers offer inferior care to people who present with no insurance, even in acute circumstances, such as asthma attacks or car crashes.[21]

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[15] Elizabeth Zhang and Gideon Lukens, "Senate Bill Expands Medicaid Work Requirements to Include Some Parents, Would Take Away Coverage From Millions: State and Congressional District Estimates," Center for Budget and Policy Priorities, June 18, 2025, https://www.cbpp.org/research/health/senate-bill-expands-medicaid-work-requirements-to-include-some-parents-would-take

[16] Congressional Budget Office Letter to Sen. Ron Wyden, et. al., June 4, 2025, https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf

[17] Jennifer Tolbert, Sammy Cervantes, Clea Bell, and Anthony Damico, "Key Facts About the Uninsured Population," KFF, December 18, 2024, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.

[18] Jennifer Tolbert, Sammy Cervantes, Clea Bell, and Anthony Damico, "Key Facts About the Uninsured Population," KFF, December 18, 2024, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.

[19] J. Michael McWilliams, "Health Consequences of Uninsurance among Adults in the United States: Recent Evidence and Implications," Milbank Quarterly, 2009 Jun;87(2):443–494, https://pmc.ncbi.nlm.nih.gov/articles/PMC2881446.

[20] Aparna Soni, Kosali Simon, John Cawley, and Lindsay Sabik, "Effect of Medicaid Expansions of 2014 on Overall and Early-Stage Cancer Diagnoses," American Journal of Public Health, February 2018, http://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2017.304166

[21] J.J. Doyle, "Health Insurance, Treatment and Outcomes: Using Auto Accidents as Health Shocks," Review of Economics and Statistics. February 2005, 2005;87(2):256–70, https://www.nber.org/papers/w11099

When people without insurance do seek care, they not only face inferior care, they face economic hardship and often crisis. Uninsured people are typically charged more, often far more, than those who are insured. The vast majority worry about the impacts of seeking care, for good reason: "Uninsured adults are more likely to face negative consequences due to health care debt, such as using up savings, having difficulty paying other living expenses, or borrowing money," note researchers in The Lancet.[22]

C. Preventable Death

No one should have illusions about what loss of health insurance coverage means in the most dire terms. There is a large body of literature that shows the direct correlation between uninsured status and mortality, and expanded Medicaid has led to reduced mortality.[23] Insurance coverage correlates directly with reductions in deaths from diseases such as cancer, heart disease, liver disease and maternal mortality.[24]

In other words, lack of insurance kills. Stripping health insurance from millions of Americans will cause tens of thousands of excess deaths every year.

Yale and University of Pennsylvania researchers conclude that the reconciliation bill will cause 51,000 deaths annually, due to a combination of loss of insurance and elimination of nursing home standards.[25]

Researchers at Harvard and City University of New York, who are also affiliated with Public Citizen, reach similar conclusions in the Annals of Internal Medicine.[26] Looking only at the impact of Medicaid cuts – which total roughly half of the insurance reductions from the reconciliation bill – these researchers model more than 18,000 excess deaths every year, more than 2.5 million fewer people every year gaining care from providers other than the ER; more than 1.5 million fewer people getting needed medications; an additional 1.4 million people with unpaid medical bills; and more than 275,000 additional people every

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[22] Jennifer Tolbert, Sammy Cervantes, Clea Bell, and Anthony Damico, "Key Facts About the Uninsured Population," KFF, December 18, 2024, https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population.

[23] Sarah Miller, Norman Johnson and Laura R. Wherry, "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data," National Bureau of Economic Research, January 2021, https://www.nber.org/papers/w26081.

[24] Brian Lee, Jennifer Dodge, Norah Terrault, "Medicaid expansion and variability in mortality in the USA: a national, observational cohort study" (The Lancet Public Health, Volume 7, Issue 1, e48 - e55, January 2022) https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(21)00252-8/fulltext

[25] Letter from Rachel Werner and Alison Galvani, et. al., to Senators Ron Wyden and Bernie Sanders, June 3, 2025, https://files-profile.medicine.yale.edu/documents/9726518b-c99b-4cd8-93c0-6962ed6db2b9.

[26] Adam Gaffney, David U. Himmelstein, and Steffie Woolhandler, "Projected Effects of Proposed Cuts in Federal Medicaid Expenditures on Medicaid Enrollment, Uninsurance, Health Care, and Health," Annals of Internal Medicine, June 17, 2025, https://www.acpjournals.org/doi/10.7326/ANNALS-25-00716.

year denied treatment because of medical debt.[27] These impacts will be felt throughout the nation. A state breakdown is available here: https://www.citizen.org/article/house-gop-medicaid-cuts-will-kill-americans.

D. Gut Punch to Rural Hospitals and Community Clinics

People in rural America rely more heavily on Medicaid than their urban counterparts, and rural health care institutions rely disproportionately on Medicaid.

Rural hospitals are not just health care providers, they are community institutions and economic anchors. Unfortunately, even prior to the reconciliation bill, they were in crisis. Nearly 200 rural hospitals have closed in the last two decades.[28]

The reconciliation bill will supercharge the problem. The bill's Medicaid cuts will strip an estimated $155 billion from rural health care, far more than the bill's rural health fund will provide.[29] Modeling from the National Rural Health Association suggests rural hospitals will lose more than $70 billion – a more than 20 percent reduction in their Medicaid funding.[30] KFF predicts the most serious losses in the states with large rural populations that have undertaken Medicaid expansion: Kentucky, North Carolina, Virginia, Illinois, New York, Ohio, Pennsylvania, Michigan, Oklahoma, Missouri, Minnesota, and Louisiana.

The National Rural Health Association study presents directly how dire the situation is: "Reductions in Medicaid funding of this magnitude will accelerate rural hospital closures, and for those rural hospitals that remain open, lead to the elimination or curtailment of critical services, such as obstetrics, chemotherapy, and behavioral health."[31]

Community health centers across the nation provide access to health care to more than 30 million Americans, including many lower-income and vulnerable people. Based in the communities and neighborhoods they serve, community health centers support preventative care, overcome language and transportation barriers, and provide care to

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[27] "House GOP Medicaid Cuts Will Kill Americans," Public Citizen, https://www.citizen.org/article/house-gop-medicaid-cuts-will-kill-americans/

[28] "196 Rural Hospital Closures and Conversions since January 2005," Sheps Center for Health Services Research, https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/

[29] Heather Saunders, Alice Burns, and Zachary Levinson, "How Might Federal Medicaid Cuts in the Senate-Passed Reconciliation Bill Affect Rural Areas?" KFF, July 2, 2025, https://www.kff.org/policy-watch/how-might-federal-medicaid-cuts-in-the-senate-passed-reconciliation-bill-affect-rural-areas/

[30] Manatt and National Rural Health Association, "Estimated Impact on Medicaid Enrollment and Hospital Expenditures in Rural Communities," June 20, 2025, https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/obbb-impacts-on-rural-communities_06-20-25-final_v3-(002).pdf.

[31] Manatt and National Rural Health Association, "Estimated Impact on Medicaid Enrollment and Hospital Expenditures in Rural Communities," June 20, 2025, https://www.ruralhealth.us/nationalruralhealth/media/documents/advocacy/2025/obbb-impacts-on-rural-communities_06-20-25-final_v3-(002).pdf.

those with and without insurance. Similar to rural hospitals, community health centers are heavily dependent on Medicaid – and the reconciliation bill's cuts are poised to have a devastating effect on community health centers.

George Washington University Public Health School researchers project that the reconciliation bill's changes will return community health centers to pre-Affordable Care Act status, meaning:

- More than 6,000 (out of 15,000) community health center sites will close.
- Staffing will decline by nearly half, with a cost of 150,000 jobs and health care providers.
- The number of patients served will drop by 10 million – or more than 30 percent – from more than 31 million to 21 million.
- The percentage of uninsured patients at community health centers will nearly double, to 35 percent.[32]

E. Major Job Loss

The huge withdrawal of Medicaid funding will lead to the loss of hundreds of thousands of health care jobs. The Commonwealth Fund estimates the direct loss of 500,000 health care jobs (and 1.2 million jobs in the overall economy taking into account the macroeconomic effect of Medicaid and SNAP cuts).[33]

As noted, major job loss among community health centers is anticipated, along with substantial cuts at rural hospitals (both those that close and those that manage to survive). Home health care work jobs are another sector that will be hit hard. The Paraprofessional Healthcare Institute (PHI) notes that Medicaid cuts that result in increased state costs will result "in reduced support for older adults and people with disabilities, with home and community-based services (HCBS) the hardest hit, since HCBS are optional for states to provide." This directly translates into lost jobs; it pulls many home health workers out of the workforce, since they themselves have people at home who may have been receiving Medicaid support.[34]

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[32] Feygele Jacobs, Kay Johnson, Sara Rosenbaum, Maddie Krips, "What Does it Mean for Community Health Centers, their Patients, and Communities, to Lose the Post-ACA Gains?" Geiger Gibson Program in Community Health, June 2025, https://geigergibson.publichealth.gwu.edu/what-does-it-mean-community-health-centers-their-patients-and-communities-lose-post-aca-gains

[33] Leighton Ku, Kristine Namhee Kwon, Maddie Krips, Taylor Gorak and Joseph J. Cordes, "How Medicaid and SNAP Cutbacks in the "One Big Beautiful Bill" Would Trigger Big and Bigger Job Losses Across States," Commonwealth Fund, June 23, 2025, https://www.commonwealthfund.org/publications/issue-briefs/2025/jun/how-medicaid-snap-cutbacks-one-big-beautiful-bill-trigger-job-losses-states

[34] Paraprofessional Healthcare Institute, "Protect Medicaid: Unconscionable Cuts Will Set Back the U.S. Economy–and Endanger Millions," May 13, 2025, https://www.phinational.org/protect-medicaid-unconscionable-cuts-will-set-back-the-u-s-economy-and-endanger-millions/

America is, or should be, better than this.

III. Health Care Savings, Expanding Access to Care and Improving Quality

There's no doubt that there's enormous waste and fraud in the health care system – and therefore huge savings to be obtained through remedial measures – but that waste and fraud is not coming in any consequential way from poor and low-income people. The most serious and costly abuses in the health care system, by far, are perpetrated by large, profiteering health care corporations. Adopting systemic changes to address their abuses could save far more money than the "savings" from reducing health insurance access. Moreover, these changes – foremost among them, ending Big Pharma's price gouging and eliminating privatized Medicare – would increase access to vital treatments and improve quality of care.

A. Ending Big Pharma's Price Gouging

The United States spends more – a lot more – than other countries on prescription drugs. Prescription drugs in the United States are three to four times the price in other rich countries.[35] The reason for the price discrepancy is simple: Other countries maintain policies to prevent price gouging by Big Pharma. In the United States, there are few restraints on Big Pharma's monopoly pricing.

The rip-off is even worse than it seems at first blush. The federal government pays for almost half of all drug purchases in the United States through the Department of Health and Human Services.[36] Governmental drug purchases overall – including by states and municipalities and covering governmental employees – constitute nearly 60 percent of spending on prescription drugs.[37] But with the important exception of the Veterans Health Administration, the U.S. government – the largest purchaser of medicines in the world – fails to leverage its purchasing power to lower drug prices. Compounding the outrage, U.S. government funding contributes at least in some way to the invention and development of virtually every new drug[38] – and the federal government does not even demand reasonable

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[35] "U.S. prices for brand drugs were 422 percent of prices in the comparison countries, or at least 322 percent if we adjust for estimated rebates in the U.S., but not for estimated rebates in other countries (for which data are generally unavailable)." https://aspe.hhs.gov/sites/default/files/documents/d5541b529a379d1f908ed2f9c00a9255/aspe-cover-idr-pricing-availability.pdf.

[36] U.S. Department of Health and Human Services, Office of Inspector General, "Drug Spending," December 16, 2024, https://oig.hhs.gov/reports-and-publications/featured-topics/drug-spending.

[37] Elizabeth Schrier, David U. Himmelstein, Adam Gaffney, Danny McCormick and Steffie Woolhandler "Taxpayers' Share of US Prescription Drug and Insulin Costs: a Cross-Sectional Study," Journal of General Internal Medicine, October 2024, https://doi.org/10.1007/s11606-024-09032-x.

[38] "NIH funding contributed to published research associated with every one of the 210 new drugs approved by the Food and Drug Administration from 2010-2016." Ekaterina Galkina Cleary, Jennifer M. Beierlein, Navleen Surjit Khanuja, Laura M. McNamee, and Fred D. Ledley, "Contribution of NIH funding to new drug

pricing in return. In other words, the world's largest drug purchaser also funds the development of every new medicine – and then, with some exceptions, lets Big Pharma set whatever monopoly price it chooses. Then, the U.S. government agrees to pay that same inflated price.

There's no question the U.S. government could lower drug prices dramatically, if it chose. Canada pays about one third the U.S. price for branded drugs. France and Japan pay less than a quarter.[39] Before Medicare was empowered to undertake limited drug price negotiations, the Department of Veterans Affairs (VA) paid about half of what Medicare Part D did.[40]

The United States spent nearly $500 billion on drugs in 2024, after discounts were applied, and the amount is soaring year over year.[41] If the country cut its drug spending by 40 percent it would have saved roughly $200 billion from 2024 levels – and much more on an annual basis over the next decade. Even with that savings, the U.S. would still be paying prices somewhat higher than the VA and considerably higher than other rich countries.

The U.S. government has tools under existing law to lower drug prices. It can license generic competition – which lowers prices dramatically, often as much as 90 percent – for drugs purchased by the U.S. government and for drugs invented with U.S. government support. And Medicare now has authority to negotiate prices for top-selling medicines, after they have already been on the market for seven or more years. There's a lot of room for much tougher Medicare negotiation – without waiting seven years, covering all drugs and demanding greater price reductions. Even after negotiation, Medicare will be paying more than twice what other rich countries do.[42]

The potential savings from controls on drug corporation monopoly pricing are more than twice the amount to be saved by the reconciliation bill's cuts. And, in contrast to the reconciliation bill measures that will massively reduce access to care, lowering drug prices would expand access to needed treatment.

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approvals 2010–2016," *PNAS* 115, no. 10 (February 2018): 2329-2334, https://www.pnas.org/doi/10.1073/pnas.1715368115.

[39] Assistant Secretary for Planning and Evaluation (ASPE), U.S. Department of Health & Human Services, "Comparing Prescription Drugs in the U.S. and Other Countries: Prices and Availability," February 2024, https://aspe.hhs.gov/sites/default/files/documents/d5541b529a379d1f908ed2f9c00a9255/aspe-cover-idr-pricing-availability.pdf.

[40] Government Accountability Office, "Department of Veterans Affairs Paid About Half as Much as Medicare Part D for Selected Drugs in 2017," December 2020, https://www.gao.gov/assets/gao-21-111.pdf.

[41] https://www.iqvia.com/insights/the-iqvia-institute/reports-and-publications/reports/understanding-the-use-of-medicines-in-the-us-2025

[42] Deena Beasley, "US will still pay at least twice as much after negotiating drug prices," Reuters, September 3, 2024, https://www.reuters.com/world/us/us-will-still-pay-least-twice-much-after-negotiating-drug-prices-2024-09-03/

While the administration has power under existing law to lower prices, Congress should adopt a robust and comprehensive program to reduce drug prices. (Unfortunately, the reconciliation bill contained a $5 billion giveaway to Big Pharma that will impinge on the scope of Medicare drug price negotiation.[43]) This program should leverage the U.S. government role in supporting biomedical research and as the world's largest drug purchaser, and rely on generic competition to drive down prices that are unreasonably high. A combination of much stronger price negotiation and authorization of generic competition could easily move drug prices more in line with other countries – and the prices currently obtained by the VA – and save American consumers and taxpayers hundreds of billions annually.

B. Shutting Down Privatized Medicare

Medicare accounts for more than one-in-five dollars spent on health care in the United States – more than $800 billion annually and fast growing. Although Medicare is a public insurance program, the passage of the Medicare Modernization Act in 2003 launched the current era of privatized Medicare – "Medicare Advantage" – plans.[44]

Now, more than half of seniors enrolled in Medicare are members of private plans paid for in large part with Medicare funds.[45] This partial privatization of Medicare is delivering inferior care to patients, fattening insurance corporation bottom lines and costing taxpayers hundreds of billions of dollars.

Just last year, private insurers offering Medicare Advantage plans cost Medicare an excess of $84 billion.[46] From 2007 to 2023, privatized Medicare overpayments totaled more than $600 billion.[47] Over the next decade, these excess payments to insurance companies that delay and deny care to seniors and people with disabilities are on track to exceed $1 trillion.[48]

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[43] https://www.cbo.gov/publication/61420

[44] Yash M. Patel and Stuart Guterman, "The Evolution of Private Plans in Medicare," Commonwealth Fund, December 8, 2017, https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare.

[45] Meredith Freed, Jeannie Fuglesten Biniek, Anthony Damico, and Tricia Neuman, "Medicare Advantage in 2024: Enrollment Update and Key Trends," Kaiser Family Foundation, August 8, 2024, https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-enrollment-update-and-key-trends/#:~:text=More%20than%20half%20(54%25),enrolled%20in%20Medicare%20Advantage%20plans.

[46] MedPac, Report to Congress, https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_ExecutiveSummary_MedPAC_Report_To_Congress_SEC.pdf.

[47] Adam Gaffney, Stephanie Woolhandler and David Himmelstein, "Less Care at Higher Cost—The Medicare Advantage Paradox," JAMA Internal Medicine, JAMA Intern Med. 2024;184(8):865-866. doi:10.1001/jamainternmed.2024.1868, June 10, 2024, https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2819817.

[48] Committee for a Responsible Federal Budget, "New Evidence Suggests Even Larger Medicare Advantage Overpayments," July 17, 2023, https://www.crfb.org/blogs/new-evidence-suggests-even-larger-medicare-advantage-overpayments.

Eliminating privatized Medicare could thus save $100 billion a year or more than $1 trillion over 10 years – with improved care for Medicare beneficiaries.

To make the contrast with the reconciliation bill's cuts to Medicaid clear: By eliminating privatized Medicare, Congress could choose to save the same amount of money it "saved" by Medicaid cuts, except it would do by improving overall care and without any reduction in access.

There is overwhelming evidence that privatized Medicare Advantage companies are doing a worse job serving beneficiaries than traditional Medicare.[49] Companies offering privatized Medicare Advantage plans make it difficult for patients to get the care they need and for doctors to provide necessary care. With profit incentives to deny care, Medicare Advantage plans regularly refuse to authorize or reimburse care that patients need.[50] A study by the Department of Health and Human Services inspector general found that 13 percent of the Medicare Advantage denials for prior authorization were for services that met Medicare coverage rules, "likely preventing or delaying medically necessary care for Medicare Advantage beneficiaries." The inspector general emphasized that "these denials may be particularly harmful for beneficiaries who cannot afford to pay for services directly and for critically ill beneficiaries who may suffer negative health consequences from delayed or denied care."[51]

Just as denying patients needed care is part of the business model for privatized Medicare plans, so are a series of tricks to manipulate the system and impose extra costs on Medicare.

Cherry-Picking: The Medicare Advantage system is structured in a way to enable insurance companies to gain revenue and offload high-risk patients with expensive health conditions to traditional Medicare. Private insurers often limit their coverage pool to lower-risk parties – which, in the case of health insurance, means insuring only healthier people.[52] This "cherry picking" problem is pervasive in seniors' health insurance markets and is

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[49] Center for Medicare Advocacy, October 31, 2024, "Ongoing Medicare Advantage Overpayments and Barriers to Care Prompt More Congressional Interest in Oversight," https://medicareadvocacy.org/ongoing-medicare-advantage-overpayments-and-barriers-to-care; CMS Office for Minority Health in association with Rand Corporation, "Disparities in Health Care in Medicare Advantage Associated with Dual Eligibility or Eligibility for a Low-Income Subsidy and Disability," May 2023, https://www.cms.gov/files/document/2023-disparities-health-care-medicare-advantage-associated-dual-eligibility-or-eligibility-low.pdf.

[50] Christi Grimm, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," Office of the Inspector General, April 2022, https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

[51] Christi Grimm, "Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care," Office of the Inspector General, April 2022, https://oig.hhs.gov/oei/reports/OEI-09-18-00260.pdf.

[52] Adam Gaffney, David U. Himmelstein, and Steffie Woolhandler, "Medicare Dis-Advantage: Overpayments and Inequity," July 1, 2024, The Nation, https://www.thenation.com/article/society/medicare-advantage-privatization-inequity-fraud.

practically unavoidable: Medicare Advantage insurers can attract those healthier people by offering lower premiums for plans with less access to the more expensive treatments and services that less healthy people need. The result is to leave traditional Medicare with a pool of less healthy people, raising its per-patient cost.

Lemon-Dropping: These same plans offer barriers and inferior care when people do become seriously ill. Sicker seniors are more likely to switch from Medicare Advantage to traditional Medicare.[53] A Government Accountability Office (GAO) analysis concluded that roughly one third of the Medicare Advantage plans with high dis-enrollment rates were biased against sick people, presumably prompting sick people to leave the plan when they become ill.[54] Similarly, seniors in the final year of life – when health care costs are disproportionately high – shift from Medicare Advantage and to traditional Medicare at more than twice the rate of other Medicare Advantage beneficiaries.[55] This pattern indicates that these patients were unable to receive necessary care and were incentivized to return to traditional Medicare where their choice of provider and access to services are guaranteed.[56] This phenomenon is often referred to as "lemon-dropping."

Upcoding: Medicare Advantage insurers drive overcharges by "upcoding," the practice of adding medical codes to patient charts to make them appear to be sicker than they are.[57] With more diagnoses, they appear to be riskier patients, and Medicare pays the insurers more.[58] By way of illustration, Medicare Advantage plans "received an estimated $9.2 billion in payments in 2017 for beneficiary diagnoses reported solely on chart reviews or health risk assessments, with no other records of services for those diagnoses in the

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[53] Fred Schulte, "As Seniors Get Sicker, They're More Likely To Drop Medicare Advantage Plans," NPR, July 5, 2017, https://www.npr.org/sections/health-shots/2017/07/05/535381473/as-seniors-get-sicker-theyre-more-likely-to-drop-medicare-advantage-plans.

[54] "Medicare Advantage: CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight," U.S. Government Accountability Office, April 2017, https://www.gao.gov/assets/690/684386.pdf. Other studies have reached very similar findings. One study found "that the switching rate from 2010 to 2011 away from Medicare Advantage and to traditional Medicare exceeded the switching rate in the opposite direction for participants who used long-term nursing home care (17 percent versus 3 percent), short-term nursing home care (9 percent versus 4 percent), and home health care (8 percent versus 3 percent). Momotazur Rahman, Laura Keohane, Amal N. Trivedi, Vincent Mor, "High-Cost Patients Had Substantial Rates Of Leaving Medicare Advantage And Joining Traditional Medicare," *Health Affairs.* 2015 Oct; 34(10): 1675-81, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4676406.

[55] "Medicare Advantage: Beneficiary Disenrollments to Fee-for-Service in Last Year of Life Increase Medicare Spending," U.S. General Accountability Office, last modified July 28, 2021, https://www.gao.gov/products/gao-21-482.

[56] Adam Gaffney, David U. Himmelstein, and Steffie Woolhandler, "Medicare Dis-Advantage: Overpayments and Inequity," July 1, 2024, The Nation, https://www.thenation.com/article/society/medicare-advantage-privatization-inequity-fraud.

[57] Paige Minemyer, "Medicare Advantage risk assessments driving billions in costs each year," Fierce Healthcare, May 9, 2024, https://www.fiercehealthcare.com/regulatory/medicare-advantage-risk-assessments-driving-billions-costs-each-year.

[58] Robert M. Kaplan and Paul Tang, "Upcoding: One Reason Medicare Advantage Companies Pay Clinicians to Make Home Health Checkups," Stat, January 19, 2013, https://www.statnews.com/2023/01/19/rein-in-upcoding-medicare-advantage-companies.

encounter data," according to Erin Bliss of the inspector general's office for the Department of Health and Human Services.[59] A Wall Street Journal investigation found that privatized Medicare upcoding cost Medicare $50 billion from 2018-2021.[60] The Journal notes that insurers can add diagnoses that the treating physician does not, and that insurers have an incentive to add diagnoses that generate more income. UnitedHealth members were about 15 times more likely to be diagnosed with diabetic cataracts than patients in traditional Medicare, the Journal found, a ratio that experts said was implausible. The Journal found other elevated diagnosis rates among privatized Medicare providers for diseases such as morbid obesity, heart failure, depression and emphysema.

Not all of the Medicare Advantage corporate manipulations are legal. In fact, illegality seems baked into the business model, with most Medicare Advantage insurers submitting improper bills or engaging in fraud.[61]

These problems are all specific to privatized Medicare. Medicare has its problems and needs to be improved, but all of the problems highlighted here would disappear immediately with the end of privatized Medicare, generating immediate savings – and improved patient care.

IV. Conclusion: The Justice and Efficiency of Medicare for All

To return to the issue of cybersecurity: There is no escaping that effective cybersecurity preventative measures will require nontrivial investments by health care corporations, though these investments will generate societal net benefits. Moving now to ensure the federal government is equipped to develop and enforce standards – including outside of the HIPAA context -- and to protect the health data it maintains is urgently necessary and will require a major pivot from this administration's policies.

Costs are inevitable in health care. As a rich society, we can and should spend money to provide ensure quality health care for all. But especially because costs are inevitably high, we shouldn't waste money. And the U.S. health care system is replete with corporate waste and profiteering.

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[59] "Protecting America's Seniors," Testimony Before the United States House Committee on Energy and Commerce Subcommittee on Oversight and Investigations, June 28, 2022 (testimony of Erin Bliss, Assistant Inspector General for Evaluation and Inspections), https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/Witness%20Testimony_Bliss_OI_2022.06.28_1.pdf.

[60] Christopher Weaver, Tom McGinty, Anna Wilde Mathews and Mark Maremont, "Insurers Pocketed $50 Billion From Medicare for Diseases No Doctor Treated," Wall Street Journal, July 8, 2024, https://www.wsj.com/health/healthcare/medicare-health-insurance-diagnosis-payments-b4d99a5d?mod=hp_lead_pos7.

[61] Reed Abelson and Margot Sanger-Katz, "'The Cash Monster Was Insatiable': How Insurers Exploited Medicare for Billions," New York Times, October 8, 2022, https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html

There are very large, genuine savings available in the health care system. Technology may provide some efficiencies. Serious efforts to crack down on fraud and abuse – starting with large corporations and including abuses by providers – can save real money. These potential savings are real, because they would increase efficiency or eliminate waste; they contrast with the fake savings of denying care. Those savings are fake not just because they are unjust but because they simply privatize and personalize costs – instead of society supporting health care, poor and low-income individuals have to absorb the cost of going without (or overpay for when they do decide to obtain health services).

The greatest possible, real savings in the health sector would come from eliminating the structural waste in U.S. health care, along with the monopolistic practices that allow price gouging in the pharmaceutical and other sectors.

The most effective path to obtaining those savings is by moving to a Medicare for All system, which would eliminate the rampant administrative waste in the current system. Billing, insurance and other administrative costs are vastly higher in the United States than other countries, and make up as much as a quarter of overall U.S. health spending. Medicare for All would wipe away most of these wasteful expenditures, potentially saving as much as $700 billion or more annually (based on comparison of administrative spending with Canada).[62]

Of course, the monetary savings are a secondary advantage of Medicare for All; the primary benefit is that it would ensure every American has access to the health care they need, irrespective of ability to pay.

There is little doubt we can do better than we are now doing, if we choose. The United States pays far more for health care than other rich countries – as much as two times more than other rich nations – and, by almost any measure, has far worse health outcomes.[63] Medicare for All would redress the double failure of the current health care system – costing more while delivering inferior and rationed care – by enabling massive savings and ensuring access and quality care for all.

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[62] See Health Affairs, "The Role Of Administrative Waste In Excess US Health Spending," October 6, 2022, https://www.healthaffairs.org/content/briefs/role-administrative-waste-excess-us-health-spending; Steffie Woolhandler and David U. Himmelstein, "Single-Payer Reform: The Only Way to Fulfill the President's Pledge of More Coverage, Better Benefits, and Lower Costs," Annals of Internal Medicine Volume 166, Number 8, https://doi.org/10.7326/M17-0302, https://www.acpjournals.org/doi/10.7326/M17-0302.

[63] David Blumenthal, Evan D. Gumas, Arnav Shah, Munira Z. Gunja and Reginald D. Williams II, "Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System - Comparing Performance in 10 Nations," Commonwealth Fund, September 29, 2024, https://www.commonwealthfund.org/publications/fund-reports/2024/sep/mirror-mirror-2024

The “Future of Care” in America is far less secure than it was before the reconciliation bill was passed. But it wasn’t secure before reconciliation, either. Medicare for All offers the best path to genuine health security for America.