Hearing before the Senate HELP Committee

"Making Health Care Affordable: Solutions to Lower Costs and Empower Patients"

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Thank you, Chairman Cassidy, ranking Senator Sanders, and all of the members of the HELP Committee for the opportunity to speak to an issue that affects effectively every American: unaffordable healthcare.[a]

Before the "One Big Beautiful Bill" (OBBB) was signed into law by President Trump on Independence Day, 27 million Americans were uninsured[1] and many more faced unaffordable healthcare costs because of onerous copays or high deductibles[2]; national healthcare spending was projected to rise to 20% of the Gross Domestic Product (GDP);[3] a third of American healthcare spending was consumed by administration and bureaucracy;[4] private equity and other pernicious profit-seekers were devouring more and more of the nation's precious healthcare resources; one in four Americans went without needed prescription drug because of cost;[2] and thousands of Americans were losing their lives annually due to lack of health coverage.[5–7]

Unfortunately, each one of these dynamics was exacerbated, or at best untouched by the Reconciliation Bill that is now the law of the land. Today the ranks of the uninsured is set to swell by more than 10 million[8] and healthcare costs to surge for many more, while new national Medicaid work requirements programs will further lard healthcare with bureaucracy.[9]

In the testimony that follows, I first outline the fundamental factors driving onerous healthcare costs for American patients and their consequences for our nation's health. Next, I explore the many ways that the OBBB will worsen the crisis of healthcare affordability for American patients. Finally, I explore alternate, evidence-based policies that could, at long last, deliver on the promise of top-quality healthcare for all at a sustainable price, making America a healthier nation in the years to come.

I. Healthcare Before the Reconciliation Bill of 2025

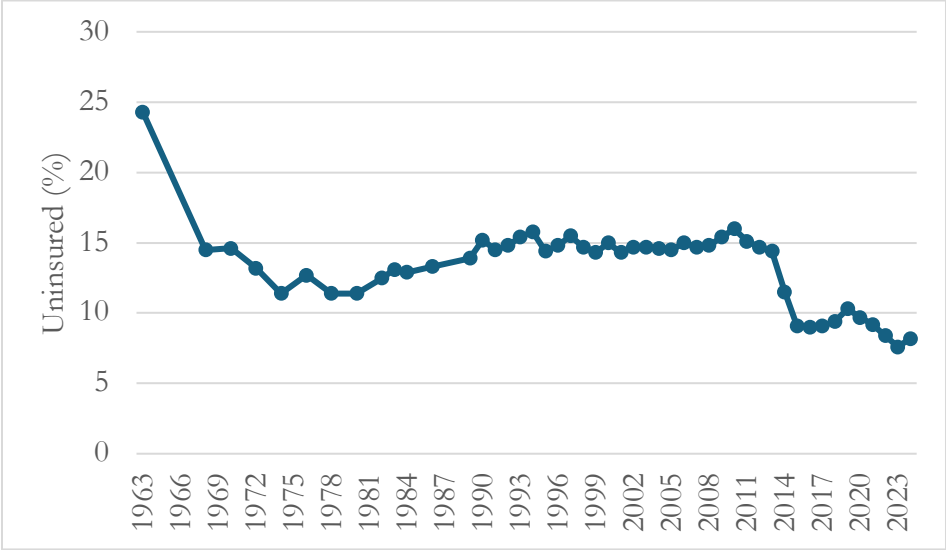
Uninsurance

Despite a rise in the share of the population with health coverage over the past half-century — due to passage of Medicare and Medicaid in 1965 and the Affordable Care Act in 2010 — tens of millions of Americans still lacked health coverage when the OBBB was signed into law. In 2024,

[a] This testimony reflects my opinions as a physician-researcher, and do not necessarily reflect those of any organizations with which I am affiliated.

8.2% of Americans were uninsured.[1] However, this "point in time" estimate reflects coverage at the moment individuals were surveyed: a far higher share of Americans experienced a lapse in insurance coverage during the course of one or two years.[10]

Uninsured in America: 1963-2024



Source for data before 2010: Council of Economic Advisers, "Methodological Appendix: Methods Used to Construct a Consistent Historical Time Series of Health Insurance Coverage," 2014. Available at: https://obamawhitehouse.archives.gov/sites/default/files/docs/longtermhealthinsuranceseriesmethodologyfinal.pdf. Source for data from 2010 – 2024: multiple years of Early Release Estimates from the National Health Interview Survey. Note that survey methodology changed over time.

Lack of health coverage leads to sharply lower use of all forms of healthcare, including preventive services, and financial strain including medical debt.[11–13] A multitude of observational, quasi-experimental, and experimental studies have also confirmed what is common sense to doctors and patients: lack of coverage leads to premature death.[5,14–22]

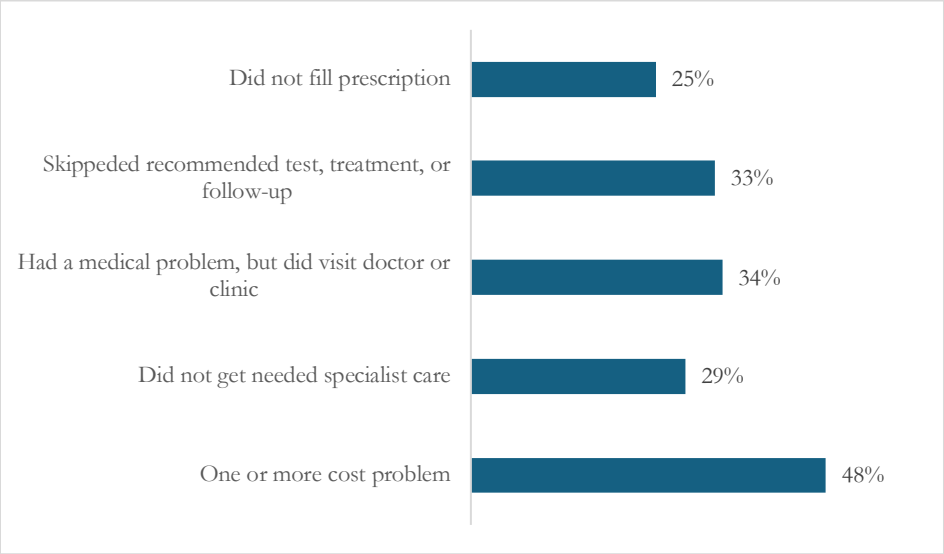
Lack of coverage, in other words, makes healthcare unaffordable for tens of millions of Americans, and is deadly for tens of thousands.

Underinsurance

While most Americans have coverage, even many insured individuals are exposed to the high costs of healthcare in the form of copays, deductibles, co-insurance, uncovered services, denied claims, and out-of-network care. As a result, nearly half of working-age Americans skipped needed care due to cost in 2024, including 29% who did not get needed specialist care and a third who skipped a test, treatment, or follow-up.[2] About one quarter of these individuals are classified as "underinsured"

because they face burdensome out-of-pocket healthcare spending or high deductibles relative to their income, while 29% were burdened by medical debt.[2]

Cost-Related Problems Getting Needed Medical Care, Adults 19-64, 2024



Source of data: The State of Health Insurance Coverage in the U.S. Findings from the Commonwealth Fund 2024 Biennial Health Insurance Survey.[2]

Underinsurance and burdensome out-of-pocket costs, like uninsurance, reduce patients' use of healthcare, including preventive care, and, particularly for those with a chronic illness, the use of medications and a spectrum of other services.[23–28] Incurring high out-of-pocket costs likewise leads to worse health and premature mortality, even among the insured.[28–30]

Both lack of coverage and inadequate coverage, in other words, are principal drivers of the affordability crisis in American healthcare, and contribute to our poor health outcomes relative to other wealthy nations. First-dollar, universal coverage is a medical priority, and should be a policy priority as well.

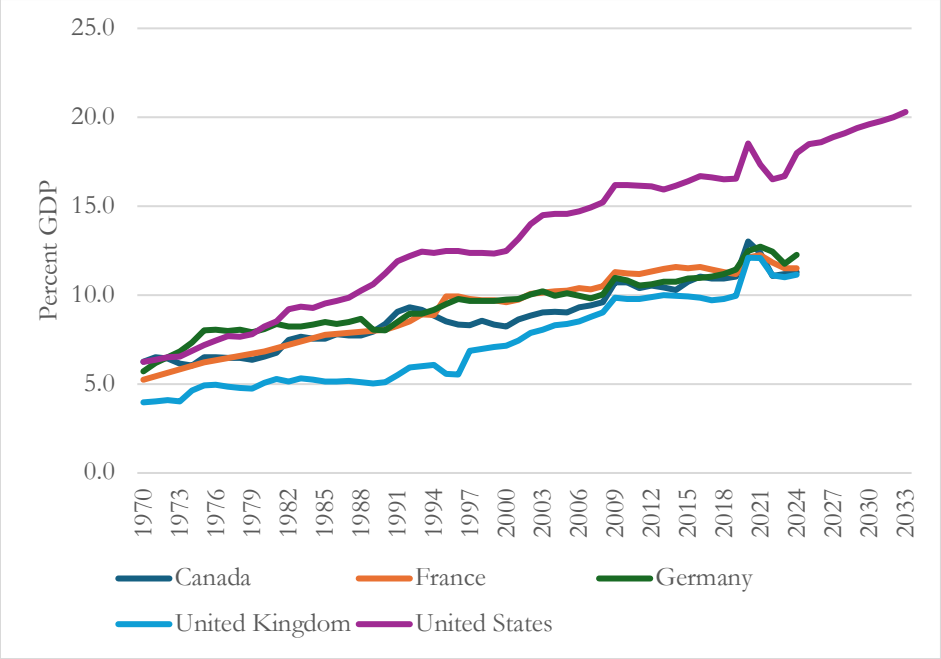
Healthcare Expenditures

Although a substantial share of the US population has no, or paltry coverage — with hazardous consequences for their financial welfare and health — paradoxically, our nation devotes a larger share of our national income to healthcare than any other nation. That was not always the case. In 1980, the US and other high-income nations devoted a more similar share of gross domestic product

(GDP) to healthcare. Subsequently, health spending's share of GDP rose far faster in the US than in our peers. Today, the US is an outlier on healthcare spending, with an estimated 18.5% of GDP spent on health in 2025.[3]

In several recent years, cost growth (as a share of national income) plateaued. However, the latest official healthcare spending projections indicated that rapid cost growth has resumed, with healthcare likely to consume 20% of GDP by 2033.[3] Hence, healthcare reform — in addition to closing the current yawning gaps in health coverage — must also constrain the overall growth in health expenditures to assure the sustainability of our healthcare system.

Healthcare Spending Among 5 High-Income Nations 1970-2024, and US Projected Spending through 2033



Data is drawn from the OECD Data Explorer, downloaded July 29, 2025, with the exception of estimates for the US from 2024 onward, which are drawn from the Center for Medicare and Medicaid Services' latest projected National Health Expenditure Accounts. Projections predate the OBBB.

The extraordinarily high administrative costs of our healthcare system are an important driver of our high healthcare spending. These administrative costs arise from the commercial nature of US healthcare, with vast sums devoted to tasks irrelevant to clinical care but essential for profit-making.

Public policies, including the ongoing privatization of Medicare and Medicaid, contribute to American healthcare's elevated administrative costs. Administrative overhead in the traditional

Medicare program has averaged about 2% of that program's expenditures. In contrast, private Medicare Advantage plans' overhead (profits plus administrative expenses) averaged 13% of revenues in 2023 (equivalent to $1,982 per enrollee).[31] The difference reflects clinically unnecessary costs, including marketing, high executive salaries, share buybacks, dividends to stockholders, and the large administrative apparatus' tasked with contesting claims and haggling with providers and patients.

At the same time, the complex multi-payer US system imposes large administrative costs on America's hospitals, doctors and other healthcare providers. They must negotiate, transact, and haggle with a welter of different insurance plans, each with their own coverage provisions and rules. At one academic medical center, a quarter of total professional revenue received for an ED visit was consumed by internal billing costs (and 8% of a general hospital stay).[32] Overall, US hospitals spend twice as much (as a share of their revenue) on administration relative to Canadian and Scottish hospitals,[33] while physician practices in the US spend four-fold more on insurer interactions compared to practices in Ontario, Canada.[34]

Reform that reduces wasteful administrative costs would help make healthcare more affordable for Americans by freeing up funds that could pay for better coverage for everyone, as discussed in the final section of this report.

Healthcare Financing

While the US healthcare financing system is often characterized as largely private, most healthcare dollars come from government sources, albeit through multiple different – and sometimes obscure – payment streams. Most obviously, taxpayer dollars fund public coverage programs such as Medicare, Medicaid, the Indian Health Service [IHS], and the Veterans Health Administration [VA]. But they also pay for much of the private coverage of tens of millions of federal, state and local government employees, and heavily subsidize (through tax breaks) private job-related health insurance, and (through direct subsidies) Affordable Care Act marketplace plans.

Overall, about two-thirds of our national health expenditures are taxpayer financed.[35] These expenditures represent spending streams that could potentially be redirected to a national health insurance program, without imposing net tax increases. Some tax increases would be needed to cover the additional government costs of national health insurance, but these would be fully offset by reduced costs for premiums and out-of-pocket costs currently borne by employers and patients.

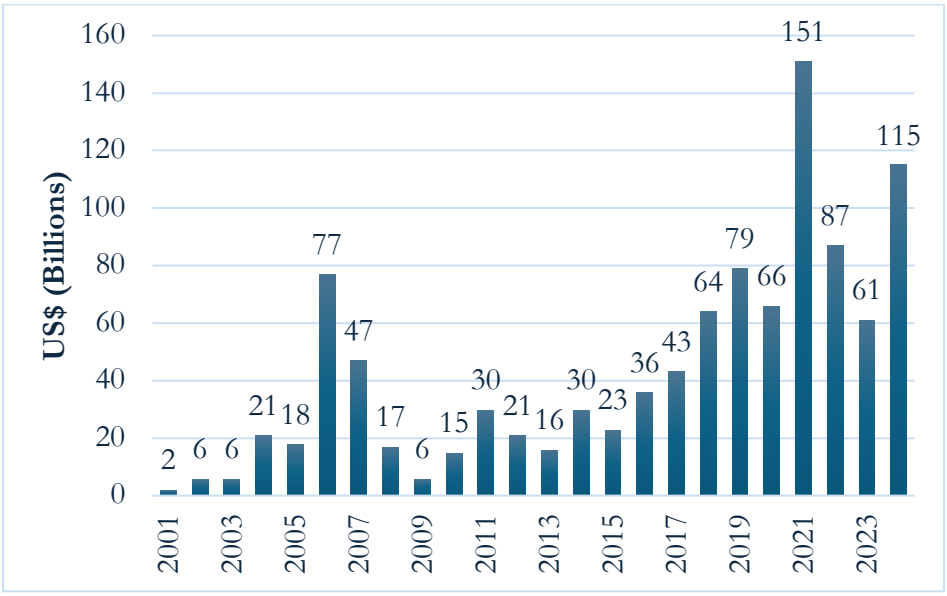
Healthcare Ownership

While taxpayers fund a large (and growing) share of healthcare spending, investors increasingly own American healthcare, and are rewarded with its proceeds. For instance, while a majority of US hospitals remain not-for-profit, more and more are investor-owned, and a majority of nursing homes, hospices, ambulatory surgical facilities, hemodialysis facilities, and home health agencies are already owned by for-profit entities.[35]

Meanwhile, horizontal and vertical integration is giving rise to corporate giants that dominate both the financing and provision of care. The UnitedHealth Group is now: the nations' largest health insurer, covering 30 million privately-insured individuals and 15 million individuals with managed care Medicaid or Medicare plans[36]; the nation's largest employer of doctors, with control of (or affiliation with) over 90,000 doctors[37] treating 100 million patients[36]; a massive pharmacy benefit manager and mail order pharmacy covering 62 million patients[38]; and a leading claims processor, managing some $1.5 trillion in medical claims through its consulting and analytics division.[39]

At the same time, private equity (PE) firms — which pool investor funds to make short-term acquisitions that deliver big and quick payouts, often by selling off assets essential to care — are increasingly buying up American healthcare. Globally, private equity buyouts in healthcare reached $115 billion in 2024, the second highest year on record.

Global Private Equity Buyouts in Healthcare



Figures from 2001-2021 are from: Bain & Company. Global Healthcare Private Equity and M&A Report 2023 [Internet]. [cited 2023 Nov 6]. Figures from 2022-2024 are from Bain & Company, Global Healthcare Private Equity Report 2025. 2024 figure is annualized.

In the US, PE acquired 282 hospitals from 2003-17[40], 124 hospices from 2015-22[41], 41 cardiology practices (with 342 clinic sites) from 2013-22[42(pp2013-2023)], and 2,806 behavioral health facilities from 2010-21[43]. PE firms now own 8% of dermatology physician practices, 7% of gastroenterology and urology practices, and 5% of ophthalmology practices.[44]

These trends in ownership have concerning implications for healthcare affordability and quality. Compared to non-profit hospitals, investor-owned facilities are more likely to provide "low-value" healthcare services that do not benefit patients but are often lucrative for the hospital[45]; are more likely to admit patients from the Emergency Department (even accounting for differences in patients' level of illness) suggesting that such excess admissions are financially motivated[46]; are less likely to offer "unprofitable" services that are nonetheless clinically important (e.g. mental healthcare)[47]; and have higher mortality.[48]

For-profit hemodialysis facilities, compared to non-profit providers, have worse patient satisfaction[49] and higher mortality.[50,51] 31.1% of for-profit hospices are rated as "low-performing" according to family assessments of care experiences and quality — twice the proportion of non-for-profit hospices.[52] Private-equity acquisition of nursing home, meanwhile, increases the likelihood that residents are hospitalized,[53] drives up overall costs,[53,54] and sharply increases residents' mortality.[54] PE acquisition of doctors' practices increases patient charges.[55] When PE acquires a hospital, nurse staffing drops,[56] charges (per service) often increase,[57] margins rise,[56] assets are sold off,[58] and hospital-acquired infections rise.[59]

To address shortfalls in both the affordability and quality of American healthcare, healthcare reform must change not only who funds care, but who owns it.

II. The "One Big Beautiful Bill Act": Healthcare Impacts

On July 4, 2025, President Donald Trump signed the "One, Big Beautiful Bill Act" into law. As detailed below, that law will add millions to the ranks of the uninsured and increase healthcare costs for many more. It will also amplify healthcare's bureaucratic bloat.

Medicaid

The "One Big Beautiful Bill" cuts Medicaid in multiple ways, including through a national work requirements program; constraints on Medicaid provider taxes; increased cost-sharing for some Medicaid enrollees; more onerous eligibility and enrollment processes; and other provisions. Overall, the law is projected to cut Federal Medicaid expenditures by nearly $1 trillion over a decade.[60] According to the CBO, much of these cuts will be realized by shedding enrollees, with

more than 10 million Americans projected to lose coverage because of the OBB's Medicaid and related healthcare cuts.[61]

The OBBB provision that will generate savings (and cause the biggest enrollment reductions) is the Medicaid "work requirements," which apply to adults ages 19-64 in the Medicaid expansion (or waiver) population. The provision requires that these individuals document at least 80 hours/month of work or community service, at least part-time education, or that they have a specified exemption such as caring for a child. Yet the vast majority of current adult Medicaid enrollees already work or meet one or more of these exemptions. For instance, in Arkansas, the only state that fully implemented a work requirements program for existing enrollees, 95% of the work requirements' target population met the requirements before they were implemented.[62] Despite this, more than 18,000 individuals in Arkansas lost Medicaid within a year of the program being implemented, far more than would be expected if everyone who worked (or should have been exempt) had been allowed to retain coverage. Similarly, nationwide, 92% of the non-elderly adult Medicaid population without disabilities either works or has an "exempt" reason not to work.[63] Nevertheless, the CBO projected that the work requirement provision in the House bill (closely similar to the provision in the final law) would cause about 5 million individuals — more than 1 in 4 of those subject to the requirements — to lose Medicaid.[64]

Why will many of those who actually meet the work (or exemption) requirement nonetheless lose Medicaid? The CBO's estimates (and the experience of both Arkansas[62,65] and Georgia[66–68], which implemented work requirements as part of a Medicaid expansion) suggest that millions will be deterred from enrolling (or maintaining enrollment) by the new layers of red tape imposed between them and their coverage. Peer-reviewed studies of the Arkansas experiment show, moreover, that work requirements have no effect on employment: individuals who lose coverage consequently will generally lack other coverage options.[62,65]

Work requirements are administratively cumbersome, entail large bureaucratic expenditures, and are difficult and confusing for beneficiaries to navigate. The bureaucracy needed to administer work requirements will also impose significant costs on taxpayers. Colleagues and I recently published projections of the bureaucratic costs of a nationwide work requirements program, based on estimates of the costs of implementing (or preparing to implement) work requirements in 5 states whose programs were studied by the US Government Accountability Office (GAO).[9] On the basis of this past experience, we estimate that $4.9 billion in new administrative spending will be needed to apply work requirements to the 18.5 million individuals that the CBO projects will be subject to these requirements. This translates to $267 per beneficiary subject to work requirements and $950 per beneficiary disenrolled. However, because most beneficiaries disenrolled will actually have met the requirements (but failed to submit proper documentation, as described above) American taxpayers will be paying some $5,340 for each "appropriate" disenrollment, more than half the estimated cost of providing Medicaid coverage for those individuals.

Estimated Administrative Costs of a National Work Requirements for Medicaid Eligibility

	N or $
Beneficiaries Impacted	
Beneficiaries subject to work requirements (n)	18,500,000
Total Disenrollments (n)	5,200,000
"Appropriate" disenrollments (n)	925,000
Administrative Spending	
Estimated total administrative cost ($)	4,939,500,000
Cost per beneficiary subjected to work requirements ($)	267
Cost per disenrollment ($)	950
Cost per "appropriate" disenrollment ($)	5,340

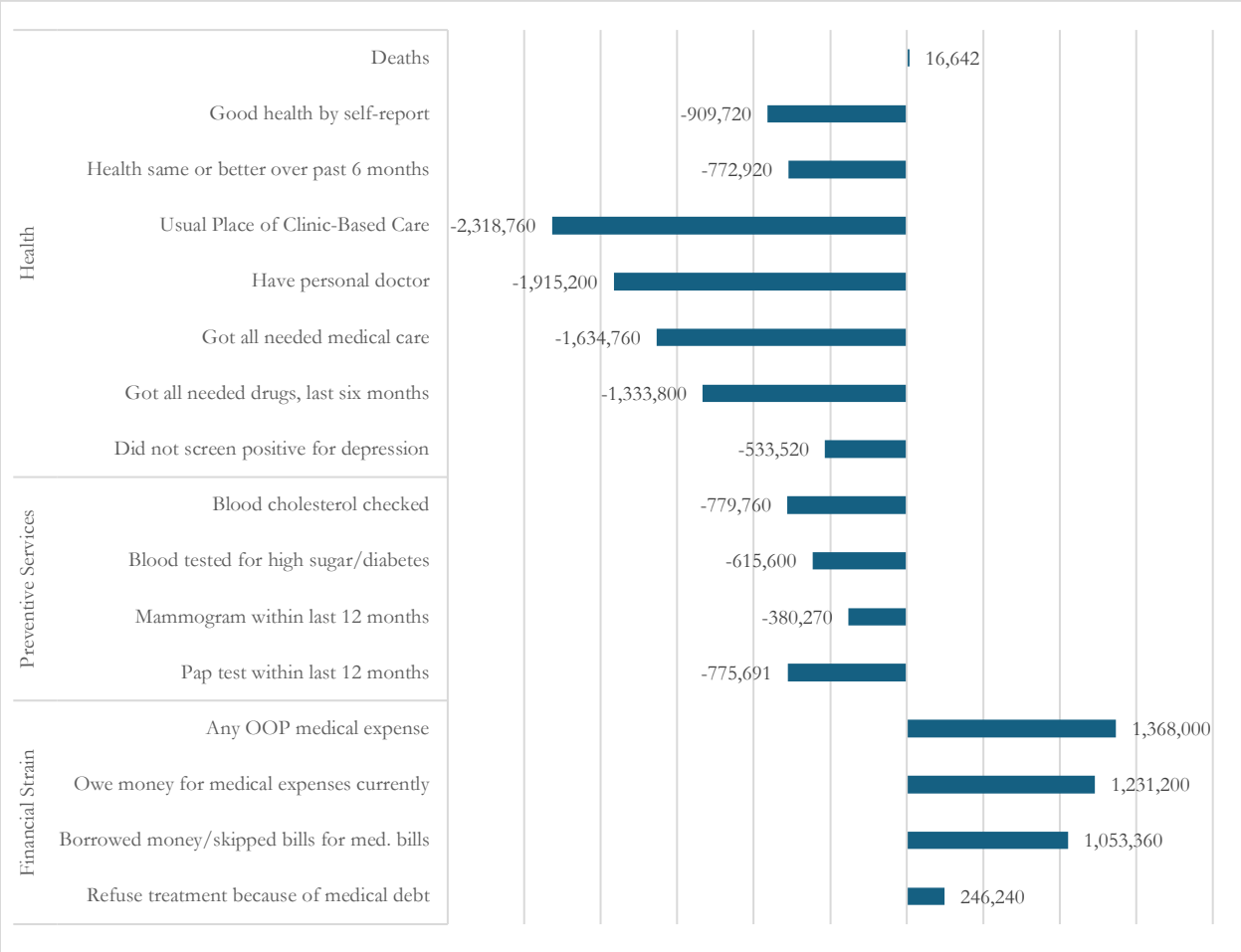
This table is drawn from: Gaffney A, Himmelstein D, McCormick D, Woolhandler S. Recent Experience Shows National Medicaid Work Requirements Would Create Enormous Administrative Inefficiencies. Health Affairs Forefront. July 2, 2025. DOI:10.1377/forefront.20250701.968523. "Appropriate" disenrollments are defined as individuals we estimate will be disenrolled because they do not meet the work requirements or one of the exemptions, i.e excluding those who do meet such standards but simply fail to document them. The number of beneficiaries subject to work requirements and projected disenrollments is drawn from the CBO's analysis of the first version of the bill to pass the House[64]; however, Medicaid provisions in that bill were similar to those ultimately signed into law by the President. See source for details about methods.

Other OBBB provisions will also have detrimental impacts on Medicaid beneficiaries.[69] States use Medicaid provider taxes to augment their Medicaid funding; the OBBB constrains and reduce states' ability to employ this tool, which will translate into reductions in available Medicaid resources. That will force states to cut enrollment, benefits generosity, and/or payments to provider payment reductions. Additionally, the bill ends temporary boosted support for states that have expanded Medicaid under the ACA; requires states to impose out-of-pocket payments for healthcare services on some beneficiaries; restricts retroactive Medicaid coverage; and blocks the implementation of reforms that were designed to ease the process of enrolling in Medicaid. Additionally, the OBBB blocks implementation of a rule that would have improved nursing home staffing, reducing the number of nurses, and undermining patient safety.

Colleagues and I recently published a study in the *Annals of Internal Medicine* that estimated the impacts on health and healthcare of the Medicaid cuts in the preliminary versions of the OBBB, whose provisions were similar to those in the final bill.[70] We found that the coverage reductions caused by the bill would translate into adverse outcomes for many patients, e.g. that nearly 2 million people would lose access to a personal physician, 1.3 million would go without needed medications, 380,000 women would forego needed mammograms, and 1.2 million would go into medical debt.

Additionally, we estimated that between 8,241 and 24,604 people would die unnecessarily each year due to such Medicaid cuts, with a mid-range estimate of 16,642, as seen below.

Estimated Health and Healthcare Impacts of Medicaid Cuts in the "One Big Beautiful Bill"



OOP=out-of-pocket. Source: Gaffney A, Himmelstein DU, Woolhandler S. Projected Effects of Proposed Cuts in Federal Medicaid Expenditures on Medicaid Enrollment, Uninsurance, Health Care, and Health. *Ann Intern Med* 2025; published online June 17, 2025. See source for details on methods and outcomes.

Other researchers have come to similar conclusions. For instance, researchers at Yale and the University of Pennsylvania predict more than 50,000 deaths annually from the Medicaid coverage reductions and the bills' other provisions,[71] such as a provision that will reduce enrollment in a program that reduces drug costs for low-income individuals with Medicare (discussed below), and the reduced nursing home staffing requirements discussed above.

The Affordable Care Act

The OBBB additionally makes changes that will make it more difficult to enroll (or stay enrolled) in Affordable Care Act marketplace plans, or to obtain subsidies that make premiums affordable. The CBO's analysis of a nearly final version of the House bill found that these changes would increase the number who are uninsured by at least 3 million.[64] (No CBO analysis of the final bill that disaggregates coverage loss by payer is currently available).

Notably, these changes will coincide with the expiration of enhanced premium subsidies for the Affordable Care Act at the end of the 2025, absent Congressional action. This will translate into large increases in premiums for millions of Americans; the CBO projects that as a result of the expiration of these subsidies, 4.2 million will become uninsured, in addition to those who will lose coverage as a result of the OBBB.[64] Additionally, the CBO estimates that implementation of a Trump Administration rule on the ACA marketplaces will increase the number of the uninsured by 1.8 million, although some of these coverage losses may be included in the CBO assessment of the OBBB.[64]

Medicare

While most of the OBBB's healthcare provisions affect Medicaid, and to a lesser extent ACA marketplace plans, other provisions affect healthcare affordability for Medicare beneficiaries.

First, according to Congressional PAYGO rules, because the reconciliation bill will increase the deficit it will trigger "sequestration", automatically resulting in $500 billion in Medicare cuts absent Congressional action. Such cuts could have impacts on beneficiaries' access to care.

Second, the law will make it more difficult for seniors to enroll in the Medicare Savings Program (MSP), a Medicaid program that helps cover out-of-pocket costs (premiums and cost-sharing) for low-income Medicare beneficiaries. This will also result in higher drug costs for these vulnerable patients (as a result of reduced enrollment in the Low-Income Subsidy [LIS] program), and — as a result — more prescriptions unfilled, worsened health, and increased deaths.[71]

Third, it exempts more drugs from negotiations under the Medicare drug price negotiation program established by the Inflation Reduction Act (IRA), further worsening the crisis of drug unaffordability.

The law also eliminates Medicare eligibility for some legally present immigrants, among other provisions.

III. Policies To Improve Affordability for Healthcare All Americans

The OBBB is set to only exacerbate the crisis in American healthcare affordability, increasing both the ranks of the uninsured and underinsured while amplifying bureaucratic bloat. Different policy approaches are needed.

Making Drugs Affordable

Across the political spectrum there is little disagreement that Americans pay too much for prescription drugs. However, the Trump Administration claims that the reason we overpay is that other nations *underpay*.[72,73] That is not the case: if drug firms didn't make profits in other nations, they would not sell their products there. High US drug prices reflect pharmaceutical firms' intellectual property ownership and their extortionate pricing practices — and the absence of a US system to aggressively negotiate drug prices at the federal level, as other nations do.[72–74]

Rather than attempting to raise drug prices in other nations, we should use multiple effective, evidence-based tools to bring down US pharmaceutical prices to those paid by other nations. Those tools include: aggressive negotiation with drug companies at the federal level (expanding on the Medicare drug negotiation program in the IRA); compulsory licensing[75] in situations where drug companies are not willing to negotiate; and public manufacture of drugs.[74] We should also restore funding to the National Institute of Health (NIH), which supports the basic research that underlies the development of effectively all modern drugs, and indeed go further by expanding the mission of the NIH to directly fund drug development through the stage of clinical trials, which would permit some drugs to remain in the public domain and be priced as generics immediately after approval.[74]

Reducing Waste in Medicare and Medicaid

There have been many claims about reducing "fraud, waste, and abuse" in healthcare, but thus far no action: instead, the OBBB indiscriminately cuts Medicaid and will push many current enrollees into medical poverty. However, there is vast waste in Medicaid as well as Medicare, namely large sums that fill the coffers of the insurance companies that operate the managed care versions of these programs. MedPAC estimates that we overpay Medicare Advantage firms more than $80 billion annually relative to the cost of covering their enrollees under traditional Medicare, overpayments that have totaled more than $600 billion since 2007.[76]

Similarly, reducing the overhead of privately-managed Medicaid plans (an average of 12.54%[31]) to that of publicly-administered Medicaid (4.9% in states that eschew Medicaid subcontracting[77]) would save $40 billion this year, and $534 billion over ten years.

In other words, transitioning to fully public versions of these programs could save large sums that could be used to expand benefits or reduce out-of-pockets costs for enrollees, improving healthcare affordability for millions.

Medicare-for-All

While such reforms could be useful, they would not make healthcare affordable for all Americans, and for the nation. A Medicare-for-All reform would accomplish those goals. By covering everyone without the copays, deductibles, and insurance networks that deter care and drive medical debt, such a reform would achieve universal and comprehensive coverage, while assuring real choice of doctor and hospital. And by eliminating wasteful insurance bureaucracy (and the administrative costs that bureaucracy inflicts on healthcare providers), it would — according to the Congressional Budget Office[78,79] — free up $400 billion annually in funds that could pay for the cost of such coverage expansions and improvements. Medicare-for-All could also effect a shift in the ownership of care away from increasingly dominant corporate behemoths to Americans and their communities.

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