An interview with Dr. Stephanie Woolhandler on the impact of Trump's cuts and privatization on health care

Katy Kinner
6 August 2025

The World Socialist Web Site *interviewed Dr. Stephanie Woolhandler about the state of healthcare and the impact of Trump's "One Big Beautiful Bill" (OBBB) on the healthcare industry. Dr. Woolhandler is a prominent health policy expert with extensive experience as a primary care physician and a former Harvard Medical School professor. She served as a Robert Wood Johnson Foundation health policy fellow at the Institute of Medicine from 1990 to 1991. Over her career, she has authored more than 150 scholarly works on topics such as healthcare policy, administrative waste, and the uninsured.*

Dr. Woolhandler is also a co-founder and board member of Physicians for a National Health Program (PNHP), where she co-edits the organization's newsletter and contributes regularly to top medical journals like the Journal of the American Medical Association *and the* New England Journal of Medicine*. She co-authored a recent paper,"Projected Effects of Proposed Cuts in Federal Medicaid Expenditures on Medicaid Enrollment, Uninsurance, Health Care, and Health" in the* Annals of Internal Medicine*. She currently holds the position of Distinguished Professor of Public Health at Hunter College, part of the City University of New York.*

Katy Kinner [KK]: Let's begin with an introduction. Can you tell our readers a bit about yourself and your career?

Stephanie Woolhandler [SW]: I'm Steffie Woolhandler and I have worked for many decades as a primary care physician at Harvard Medical School, where I also worked as a professor of medicine. I moved to the City University of New York at Hunter College, and I still work on a part-time basis at Harvard. I also do a lot of research and work on health policy issues.

KK: I became familiar with your work through your recent study on the projected effects of the cuts to Medicaid. At the time, Trump's OBBB had not yet passed. What impact are we already seeing already since the bill's passage in July?

SW: The effects of the bill haven't been felt at this point. There are other effects, however, related to the unwinding of the Medicaid rules that were put in place during the pandemic and for several years afterward. The rules allowed people to automatically remain on Medicaid even if they were late in providing proof that they were eligible. A lot of people ended up enrolling once and then staying on without having to re-enroll. There were a fairly high number of people on Medicaid, peaking at about 92 million Americans, more than a quarter of the population. Since the unwinding, it's now down in the 70 million range, but that's expected to plummet with Trump's bill.

The budget reconciliation law is fully implemented, so it's been enacted, but a lot of the provisions are delayed. I think strategically, the Republicans delayed the most harmful provisions until after the midterms. A few of them have been delayed until after the 2028 election, and they are front-loading some of the very minimal and temporary benefits. But the long-term harms, such as cuts to Medicaid, are kind of backloaded if you will. They're going to go into effect beginning in early 2027.

In addition to the cuts to Medicaid, there have been some changes to the Affordable Care Act subsidies, which have helped a lot of people who have incomes that might not be below the poverty level, but are still low-income. Those subsidies are very helpful for people buying insurance on the Obamacare marketplace, and those have all been cut by the failure of this Congress to extend them. We are facing losses of insurance for about 15 million people. Fifteen million people will be added to the numbers of uninsured Americans.

35,000 premature deaths every year

KK: Could you explain how this will impact the health of the population?

SW: We know that being uninsured is extremely bad for your health. It causes people to go without doctor visits, to go without mammograms, to go without drugs that they need, to delay care. It does, in fact, cause death. This has been established by many very rigorous peer-reviewed studies. The death rate from losing your insurance is not very high, but at a population level, if you take insurance away from 10,000 people, there will be about 13 deaths, so not a huge share of people, but they're unnecessary deaths, and they could have been prevented with medical care. In our recent paper, we were able to calculate the death rates, but our calculations were based on an earlier version of the bill, which suggested about 7.5 million people would lose insurance. The most recent calculations from the final bill say that 15 million people will lose insurance. So, based on what we published, we said, with seven and a half million people losing insurance, you'd be talking about more than 16,000 premature deaths every year. If we are talking about 15 million losing insurance from the provision of the bill and Congress's failure to expand other health programs, we are talking about 35,000 deaths every year. That's a really big deal.

KK: You also can compound that with the fact that the pandemic continues to disable people, saddling them with chronic medical conditions, which people now won't be able to seek medical care for if they lose insurance. Could you talk about the combined effect of this bill with the current state of the COVID-19 pandemic and the attacks on public health?

SW: Yes, this bill is combined with the fact that the new Secretary of Health and Human Services and the whole administration have been anti-

science. They feel that opinion and emotion are the correct way to make scientific decisions about whether vaccines work, what kind of milk you drink, whether your kids ought to get shots, rather than saying we need to be guiding health decisions with science, with the best science there is. Certainly, this administration has not been committed to the best science, and in many ways is actively undermining it.

KK: Could you talk more about the impact of the COVID pandemic on the healthcare system?

SW: The thing everybody is talking about is that a lot of people left the workforce, right? It became dangerous for older doctors and nurses to be working in face-to-face patient care, and those who could retire, retired. Some got sick and left, so that has created workforce shortages that are still reverberating in 2025.

The other thing that happened during the pandemic was that the federal government continued to pay these large premiums to the private insurance companies that run Medicare Advantage plans and Medicaid Managed Care, even while use of routine services really shrank. Despite all those sick people with COVID, the total use of services was actually quite low during the pandemic because anyone who could avoid medical care did so at the height of the pandemic. Because the government continued paying the full premiums to these insurance companies that subcontract with Medicare and Medicaid, they poured billions of dollars of additional cash into the coffers of insurance giants like United Healthcare and Aetna.

These companies have used that liquidity, that new wealth, to accelerate their takeover of health resources, like the purchases of physician practices, the purchases of home care agencies and pharmaceutical benefit management companies, which used to be something separate from insurance companies but are now mostly owned by insurance companies. And if we want to start talking about physicians, 90,000 physicians are employed by United Healthcare now. That's 10 percent of all US physicians.

The pandemic brought this giant explosion of corporate investment and purchase of health resources, which has accelerated not just the privatization of healthcare but the growth of these giant conglomerates at multiple levels. They own the insurance company, the pharmaceutical benefit management, the doctor's practices, nursing homes, home care agencies, etc. This increases the opportunities for profit-making, but it's also driving out small competitors like small pharmacies and small physician practices. They are unable to compete against these kind of conglomerates.

KK: How does the bill's increase in spending toward Medicare Advantage play into the privatization of healthcare?

SW: I'll return to the Medicare Advantage in just a minute. First, I want to talk about the cuts to Medicare. There's a complex budgetary process called sequestration. And currently, the way the bill is written, it will trigger sequestration. And that will mean that Medicare will face a mandatory cut of 4 percent. Congress could act to take Medicare out of sequestration, but they were expected to do so before the bill passed and they didn't, and they haven't done anything about it yet. If nothing is done, there will be an automatic 4 percent cut to Medicare spending, so Medicare recipients will be feeling these cuts as well. Additionally, a large number of Medicare recipients have wrap-around coverage through Medicaid for drug coverage, for example. Medicaid cuts will affect many Medicare recipients, particularly poor Medicare recipients.

The role of Medicare Advantage

In addition, there are provisions to allow for experiments with prior authorization within the traditional Medicare program. The traditional Medicare program, as opposed to Medicare Advantage, has very few restrictions and prior authorization requirements. But the Trump administration is taking this on, is putting out bids to get private companies to run utilization review, which will be automated by AI, allegedly. Presumably, they plan to run AI and prior authorization algorithms within the Medicare program, so we may see traditional Medicare start to look a whole lot more like Medicare Advantage.

Now, Medicare Advantage was initiated in the early 80s. It had a lot of different names: Medicare HMOs, Medicare Plus Choice, and then Medicare Advantage. The federal government subcontracted with private insurance companies to administer the Medicare Advantage program, and they were able to retain as profit any money they saved through Managed Care restrictions and other methods. The programs have grown, despite the fact that they never saved the taxpayers any money. In fact, according to the official Medicare payment advisory commission of Congress, Medicare Advantage is costing the taxpayers 22 percent more than it would cost to take care of their enrollees under traditional Medicare.

Nonetheless, Medicare Advantage has grown. It enrolls half of all seniors. They entice seniors with promises of increased benefits, like dental, or coverage for reading glasses, which have proven quite overblown. In general, based on research, people with Medicare Advantage have no lower out-of-pocket costs for medical care than people in traditional Medicare. They have similar amounts of unmet needs for vision and hearing care. Benefits to the patients are pretty minor. But the companies benefit. The way they can increase their profits is primarily by cheating on the risk adjustment algorithms that the federal government uses to pay the premiums for the Medicare Advantage programs. Average premiums, I believe, are in the $14,000 per year range, but they're adjusted upward for very sick seniors, say someone with pancreatic cancer, and they're adjusted downward for very healthy seniors who don't have medical conditions. That's the risk adjustment algorithm, but it determines how much the taxpayers pay for Medicare Advantage.

The Medicare Advantage programs have huge administrative apparatuses designed to game the risk management system to recruit healthy seniors, and then once they are recruited, they can make them sound way sicker than they really are. They can assign them a lot of trivial and sometimes completely false diagnoses. As it turns out, as people get older, there's a lot of little things about the body that break down, you can say it's disease, but a lot of them are never going to really bother you in your lifetime and are not going to require treatment. By listing all those minor bodily changes as diseases, they can say that that senior is very high risk according to the risk adjustment algorithm. That's been the major way Medicare Advantage has gotten overpaid by the taxpayers. Additionally, if you started out healthy, and then you got a diagnosis like pancreatic cancer, you'd go from a patient who is profitable for Medicare Advantage to a patient who is not. They are very effective at getting those people to leave.

KK: What does that look like for a patient? How are they getting them to leave?

SW: Say you need wound care. Now you'll be told you have to drive 30 miles across the county because we only have one wound care center. Or you need home care, so Medicare Advantage sends a nurse once or twice and then drops you from home care. You need some medicine and they just refuse to cover it. They refuse to cover the doctor you're seeing. They delay your access to care for months or maybe forever. So we know that when people get seriously ill, many of them are bullied into transferring out of Medicare Advantage. At that point, it can be really expensive to get out of the plan and people end up paying for a lot of care on their own.

KK: Just to be clear, who is benefiting from Medicare Advantage if it's not the patients?

SW: It's a major boondoggle for the insurance companies. The majority

of major insurance company revenues do come from the public purse, from the combined effects of Medicare and Medicare Advantage and Medicaid Managed Care.

The danger of privatization

KK: You've spoken well on the privatization of healthcare. What has research shown about how privatization affects the quality of care?

SW: There's an older study that did find significantly lower quality in the for-profit hospitals and investor-owned hospitals. In new studies, they find that the costs are higher in for-profit hospitals, so we're confident of that. For-profit ownership tends to raise costs. We're less confident about the quality effects. At this point, we do know that private equity, specifically, which is a particularly aggressive form of capitalism that has recently entered the health care field, tends to raise healthcare costs and reduce the quality of care in hospitals and physicians' offices. We also have good data that private ownership of dialysis facilities lowers quality. We also know that private ownership of hospices lowers quality.

KK: Can you speak more on private equity in healthcare? I know that this is very widespread, that private equity firms own hospitals, but also they own staffing companies for healthcare workers.

SW: Yes, private equity firms own hundreds of hospitals across the country. Their strategy when they own a hospital is different from the strategy when they own, say, a physician group. When a private equity firm buys a hospital or a nursing home chain, they put a lot of money in and are aiming to get out fast with a big profit. They often accomplish this by what is called "asset stripping." They do a leveraged buyout, which means they borrow money to do the buyout, and then they place the responsibility for repaying the debt on the hospitals themselves. Then they can go and sell the real estate of the hospital and force the hospitals to pay rent on the property that they once owned. The private equity firm will then set themselves up as a separate corporation from the hospitals, even though private equity owns the hospital, so that firm gets the proceeds of the sale of the regular estate, but the hospitals themselves are forced to pay the rent. They cause closures and full hospital bankruptcies, including recently, Steward, which was once one of the biggest hospital chains in the United States, but it's now completely bankrupt.

Private equity firms can make a lot of money this way, especially because hospitals and nursing homes often have very valuable real estate and a lot of fixed assets. By stripping those assets, you can make a lot of money. In the staffing world and physician employment world, they use a different strategy. It kind of depends on what we're talking about. For anesthesiologists and emergency room physicians, they try to corner the market on staff.

Then the hospitals who are desperate for anesthesiologists or emergency room personnel have to go to the firm and beg for staff, which puts the firm in the position to say, well, we'll send staff, but we're going to be out-of-network so we aren't bound by your contracts and we can directly bill the patient.

Sometimes the firm will say, look if you hire us, we'll tell our doctors to admit lots of patients to your hospital to boost your occupancy and revenue. The private equity firms do a lot of bad things at the hospital level. On the physician employment level, it depends on the field. There's very good evidence that when private equity buys dermatology practices, they'll try to buy a lot of practices in one area to corner the market locally. Then they substitute mid-level personnel for dermatologists. They'll put pressure on all of the staff to boost their performance of profitable procedures and have them do multiple skin biopsies, for example. Often, you need one skin biopsy, but they are having people come back every two months for another skin biopsy. It's unnecessary, and of course, it's painful.

KK: I wanted to ask one more question and refer back to your recent study on the impact of the OBBB. You discussed in your paper that the bill threatens states to remove coverage for undocumented immigrants. Could you speak more on this?

SW: Trump's anti-immigrant rhetoric and threats have had a very big effect on healthcare. They did threaten to do specific cuts to the states that were using their own state funds to provide healthcare for undocumented immigrants. Several states, for instance, will cover undocumented children whether they're in the country legally or not. This ended up not being included in the bill, but what was included in the bill was cuts to so-called emergency Medicaid, which is a small but really important health program. It was started when the EMTOLA [Emergency Medical Treatment and Labor Act] were passed that make it illegal for hospitals to turn away someone in life-threatening emergency or active labor. When it was passed, the hospitals, especially in immigrant neighborhoods with lots of uninsured people, went to court, so the government put a special provision in Medicaid for reimbursements just for services related to emergency room care and active labor. This meant Medicaid would cover undocumented immigrants who come to the emergency room bleeding to death or in active labor. It's a very small program, but in fact, quite important.

Cutting this also puts healthcare workers in a terrible position. I mean, no one wants to turn someone away, send a patient out to deliver a baby under a tree. Like I said, this bill is small, but important. It's probably less than one-half of 1 percent of total Medicaid spending. But it's critical for immigrants.

Similarly, the immigration raids are very scary and demoralizing for many immigrant communities and threaten the healthcare workforce, which is highly reliant on immigrant labor. I think 3.4 million immigrants work in healthcare. Maybe two-thirds of them are naturalized citizens and one-third of them are non-citizens. But everyone is threatened by what Trump has been saying, not just the undocumented folks of whom there's about almost 400,000 working in healthcare. Other workers who are non-citizens with documents, they're being threatened as well. It's likely to worsen the pre-existing workforce shortages in healthcare too. Trump is removing temporary protected status for people and it's too dangerous for them to go home. Hundreds of thousands of people are affected, including tens of thousands who work in healthcare.

KK: It seems to me that you can't separate the issue of the attacks on immigrants and on democratic rights from the issues facing the healthcare industry.

SW: Yes, I agree.

KK: Thank you for your time and comments today.