4sight Health Roundup Podcast
Erasing Enhanced Premium Tax Credits for ACA Health Plans
10/2/25

David Burda:
Welcome to the 4sight Health Roundup Podcast, 4sight Health's podcast series for healthcare revolutionaries, outcomes matter customers count and value rules. Hello again, everyone. This is Dave Burda, news editor at 4sight Health. It is Thursday, October 2nd, the fourth quarter of a very long year. Started yesterday. We have three months to go before we say goodbye and good riddance to 2025 a year that will live in infamy. Another thing we may be saying goodbye to are enhanced premium tax credits that help people buy health insurance over federal and state insurance exchanges. As of this taping, the enhanced tax credits are scheduled to sunset at the end of the year unless Congress renews them to tell us what's at stake for the healthcare industry. And the healthcare market are Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson, partner at Transformation Capital. Hi, Dave. Hi, Julie. How you two doing this morning, Dave?

David W. Johnson:
I'm thinking about carrots. We went to a farmer's market over the weekend. Got everything we needed except carrots. There was a kid as we were checking out and I asked if they had any carrots, he said, well, you know, we've got some big bags in the cooler. Do we want one? How big could a bag of carrots be? Right? <laugh>? So, you know, I said, sure. And we paid for it, and he came out with a, I don't know how much a weight, 25 30 pound bag of carrots. It was half as tall as I was <laugh>. And it only cost six bucks, but what are we gonna do with 25 or 30 pounds of carrots? So, I'm thinking about that.

Burda:
All right. Well, you heard that listeners Dave needs some carrot recipes, so <laugh>.

Johnson:
Exactly.

Burda:
Send them in. Thanks Dave. Julie, how are you?

Julie Murchinson:
I mean, I'm just thinking I need to move where Dave lives, because like three carrots at the Mercer Island farmer to market are like six bucks. So <laugh>, There's definitely something wrong with this equation.

Johnson:
Yeah. Well, we gotta feed the pigs or the deer or whatever. Horses up here, I guess.

Murchinson:
Oh my goodness. Wow. Well, that just sums up my week right there. It's expensive. I'm living an expensive life.

Burda:

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All right. Now, before we talk about the implications of enhanced a CA premium tax credits expiring at the end of the year, let's talk about the last three months. Flu season is upon us, it usually starts in October and starts peaking in December. Dave, have you gotten your flu shot? And I think your COVID booster is on board, right?

Johnson:
Oh, you know what, Dave? I haven't gotten either the flu shot or my COVID booster yet.

Burda:
Oh boy.

Johnson:
So this is a good re reminder, but hopefully eating lots of carrots will keep me healthy until I, until I get my shots.

Burda:
<Laugh>. Yeah. Let me know how that works out. All right. Julie, how about you? Flu shot on board along with the COVID vaccine.

Murchinson:
Yeah. Negative. No, I haven't had time for it.

Burda:
Oh, you guys, come on. I got my flu shot yesterday and my COVID booster in August. Both at, yeah, no out-of-pocket costs for me. Free vaccines that protect you from potentially deadly viruses. You wonder why more people don't get them. And I think we've talked about this before. Well, the same stable geniuses that have talked to millions out of getting vaccines are the same stable geniuses that wanna get rid of enhanced tax credits and help people buy health insurance through the ACA. And there's your transition. Let me share some tax credit basics and then implications from eliminating them and get your reaction. The ACA was signed into law in 2010, and consumers began buying ACA health over state and federal insurance exchanges in the fall of 2013, for the 2014 calendar year. Since the beginning, people below a certain income level qualified for premium tax credits to help offset their premiums for an ACA plan. The Inflation Reduction Act raised the income level, so more people could qualify for enhanced premium tax credits, so they could buy an ACA plan. It's those enhanced tax credits that expire at the end of the year, not the original premium tax credits. With the enhanced tax credits, the number of enrollees and ACA health plans more than doubled from 11.4 million in 2020 to more than 24 million this year without the enhanced tax credits. The average annual out-of-pocket premium for ACA coverage will more than double from $888 this year to $1,904 next year. According to a report from the Kaiser Family Foundation released last week, the Congressional Budget Office said 4.2 million people would become uninsured by 2034 with the expiration of the enhanced tax credits, assuming they can't find coverage from another source. An analysis released last week by the Urban Institute and the Robert Wood Johnson Foundation set that number at 4.8 million. After 7.3 million people lose their enhanced tax credits. The same analysis estimated that National health expenditures would drop by $32.1 billion next year while

increasing uncompensated care by $7.7 billion. Now, you know what I know now, I wanna know what you know. Dave, what do you make of all this? Should these enhanced tax credits expire? Why or why not? And what are the long-term policy implications either way?

Johnson:
It's certainly a hot button issue around here, west Michigan, which is red country. I drove down the highway yesterday and saw a billboard that said MAGA and Mike Huezinga, he's our Congress person, voted to take away your healthcare <laugh> called this number. Who knows how that's gonna turn out. But assuming they don't get renewed the, the enhanced tax credit, it's gonna hurt low income workers the most. Those that are seeing these average premiums of under a hundred bucks a month, and they're gonna more than double As you point out these are really, really low income people. So it's gonna cause some pain. Should the enhanced tax credits expire is a much trickier question from; expire from a, is it a good policy perspective is a much trickier question. Even though my friend Zeke Emanuel would disagree, the ACA at its core really worked just to increase access not to control costs. We essentially bought access through these various subsidy programs. The way this works reminds me a little bit of something that happened to me, geez, at least 15 years ago. I went, as you all know or regularly know, I went to Colgate University in upstate New York, and they approached me again long time ago about potentially becoming a board member. And it didn't go very far. But I had a conversation with the committee and I told them I could get very excited about being a board member at Colgate if we became the first elite liberal arts college in the country, to figure out how to provide an, an elite liberal arts education for $30,000 a year instead of $60,000 a year. That tells you how long ago it was, because Colgate is now over $90,000 a year. Well, anyway, they left skid marks, right? I mean, they had no interest in, in that conversation.

Burda:
Cutting tuition, right?

Johnson:
Yeah. So the ACA became the law of the land in large measure because it enabled the current volume based system to continue functioning as it always had. The incumbents went along with it, and it essentially buys access for lower income people at increasingly high prices. It's really the same as Colgate and other colleges and universities that ask their alumni to make donations to fund financial aid. Doesn't change the ATE business model. It just lowers the after subsidy costs of the program. And you know, anybody who listens to us knows that our opinion is the US healthcare system requires major structural reform that is revolutionary, not evolutionary in character. That brings exponential, not incremental change. I believe that revolutionary change is coming to US healthcare, that it's more outside in than inside out, and that it's gonna be messy and cause significant harm, particularly to vulnerable populations. But ultimately, we get to a better place. Reducing A CA subsidies, I fear, is just part of that messiness. And we'll have, as we're talking about negative real world consequences. It will also, however ratchet up financial pressure on the overall system to become more productive. Some incumbents will and have responded proactively to this increased pressure. Most won't. And so the battle for better outcomes, lower costs and superior customer service drags on.

Burda:
You take the money away and you figure out a better way to do things. Right. I think yeah. Interesting, thanks Dave. Julie, any questions for Dave?

Murchinson:
Such a hard topic because it's just the people suffer, but Dave, who exactly is supposed to pick up the slack, the states and employers safety net providers? And I mean, for me, it's always coming back to this little, you know, taboo phrase, health equity. Like, how's that impacted?

Johnson:
<Laugh>? Well, it doesn't help health equity <laugh> in terms of who's gonna pick up the slack. We just saw that commercial rate increases had their highest jump in 15 years. There's not gonna be any more flex there. Uncompensated care will surely increase even more than it already has with the cuts in Medicaid funding. That will fall on the backs of, of providers, particularly providers, that, that that serve pop low income populations. Some states more affluent blue states will try to mitigate the impact. Most states won't. And we know from decades of experience what happens when the number of uninsured increase. It's not pretty. We, we see more visits to the emergency room when people are desperate and haven't done the routine things they could do to prevent the, the need to go to the emergency room. People die earlier. And this burden, Julie, as you're mentioning falls on the backs of those who can least afford it. But that burden increasingly is creeping into the middle class and as that happens, our national health status will continue to underperform the health status of, of other advanced economies. In essence, our Hobbs-ian healthcare world will continue to operate the way it has, and it's gonna look a lot more like it did pre-Obamacare than than it has since.

Burda:
Yeah. I guess my takeaway is invest in emergency room innovation. Right?

Johnson:
Primary care.

Burda:
Yeah. Primary care. There you go. Thanks Dave. Julie, it's your turn. What's your reaction to what's happening should these enhanced tax credits expire? Why or why not? And what are the long-term market implications either way?

Murchinson:
Well, I mean, I think similar to Dave, there are plenty of reasons why lawmakers not only wanna reduce, you know, federal spending here, which I'm sure is of course a big part of it. But whether it's the program designs behind this and really looking at how to use this money best for those who most need it, or whether it's, you know, just the political calculus of using this as a negotiation chip, which of course is what's happening in people's lives. Lots of reasons why, you know, these probably should be left to expire. But it's gonna, as Dave said, we're gonna see market destabilization and affordability shock. And, you know, I just met with a board member of a blues plan this week who said, people are reeling. It worries the institutions, that's for sure.

A lot of providers strain out there from the world. I see day to day, I think there's gonna be an uneven impact across digital health. Yeah. And all the novel care delivery, like less coverage means fewer people paying for things in the system. Right. So that's gonna affect digital solutions and, you know, adoption. I can see how, you know, virtual care, behavioral health some of the direct to consumer solutions might face some pretty big pressures. And any kind of payer dependent solution maybe in chronic disease management or remote patient monitoring or something that is looking at providing longer term outcomes. There could be some pressure there. I don't know, smaller insure base means more pressure. I think if I were in the shoes leading one of these companies today, I'd be thinking really hard. Again, I think, I feel like I say this every half a dozen shows, 'cause we talk about something like this, but what's, what value am I providing and how quickly can I get it there? And payers are gonna care about, Burda, reduceed visits and mm-hmm <affirmative>. You know, hospitalizations. They're gonna care about anything that reduces the cost model. So I've been thinking a lot about that. And, you know it'll be interesting to see whether payers try to more actively get in the game of controlling access through digital or other means. Like they did, I think more during the COVID days. There could be some opportunity out there. Maybe, maybe there's demand for lower cost alternatives and hence some of the solutions that we talk about all the time could fill the gap. Maybe we could see more uptake of employer driven solutions. Maybe. I'm not quite sure. I think the reality is on the market side, I'd be running scenarios with the reality that if they are extended this year that they might not be extended next year, we're gonna see it at some point. This is just like a thread that's gonna be pulled eventually. So I'd be just doubling down on my ROI and figuring out how to diversify.

Burda:
Yep. Yeah. Prepare now because it's an eventuality. Thanks Julie. Dave, any questions for Julie?

Johnson:
Julie, the study Burda referenced by the Robert Wood Johnson Foundation projects that national health expenditures will drop by 32 billion in 2026 as a result of the cuts to the a CA subsidies, enhanced subsidies. That seems like a big number, 32 billion, but it's a mere one half of 1% of the projected 5.64 trillion national health expenditure in 2026. Given that fiscal reality are these subsidy reductions really that big a deal? Couldn't we simply figure out how to overcome them with some really marginal tinkering within the system?

Murchinson:Oh, yeah. I mean, I think <laugh>,

Johnson:
<laugh>, <laugh>, I can't decide if this is a hard ball or a softball question, but

Murchinson:
Like, couldn't we tinker? So I mean, the reality is like, okay, if, if you're looking at like big numbers, like it's, it's not as big a number as our really big number, but who absorbs the, these shifts is really who's impacted at the end of the day. And yeah, in distributional terms, it's a super big deal because the cost don't disappear, right? They just shift from the federal treasury to households and providers and states, and it's going trigger second order effects for sure.

Coverage loss, financial stress, to your point, like care avoidance. So, I mean, we could tinker all day. <Laugh>, what do you wanna do? <Laugh>

Johnson:
Revolution, baby. That's what I wanna, yeah.

Burda:
The thinking here by the stable geniuses isn't that deep. I mean, it was Biden who signed the law that put the enhanced tax credits in place. So we must erase them from history, right? I mean, you just have to look at those fortress of the presidents, right? He put in the White House, I don't think it's any more complicated than that. Thank you for your attention to this matter, <laugh>, <laugh>. It might be the first time I've ever said that, but promise not to say it again. All right. Let's talk about other big healthcare news that happened this week, Julie. What else happened this week that we should know about?

Murchinson:
Well, I'll let Dave take the, sending the generals to Canyon Ranch, all expenses, paid story <laugh>. But did you happen to see they snuck in white House Trump Rx drug buying site that they and Pfizer are working on? Do you see this?

Burda:
Yes.

Murchinson:
They say they're gonna, I mean, they're, this, whatever this thing is is getting a three year grace period to exempt it for the national security related tariffs. <Laugh>, really? I mean, it's just grifting like crazy.

Johnson:
Well, you know, that Trump signed the stimulus checks that Congress passed. Like he was personally paying them out to people, and Biden didn't. And there's one theory that part of the reason people voted for Trump this last time around on, on the Economy, is that he wrote out those checks. So he's gonna be writing out your prescriptions too, <laugh>.

Burda:
Oh, great.

Johnson:
Anyway, I spoke at a leadership meeting at LabCorp this week in North Carolina. And when I got off the plane in Charlotte I saw that American Airlines had painted several of their planes with the standup to cancer banner. That program's going on, inundated the airwaves. And you know, kudos to American for doing that. It's good cause, but I, I found myself wondering why doesn't American or other companies put forward the same kind of effort to stand up for public health? And kind of two things brought that into focus for me this week on the negative side. And it was in North Carolina Mandy Cohen's Health Opportunity Pilot which has been going on

for the last five years, focused on rural healthcare enrollees 13,000 of 'em. And it saved an average of a thousand bucks a year each of the five years. But the, the benefits were far beyond that in terms of stabilizing life and so on. I mean, true investment in social determinants of health. And that's now going away as the Republican legislature in North Carolina decided to stop funding it. On the other hand New York State has a program that got written about this week that tries to identify potential school shooters and turn them around before the tragic event happens. And the New York Times wrote this piece about how 106 people got together to stop a school shooting in Madison County, happens to be where Colgate University is before it happened. And most times, when we identify a problem student, you know, someone who's threatening or making gun motions and being bullied and all those things, we go to their home and check whether or not they have access to guns. And that's sort of the end of it. This was a full on program to engage the family and the shooter and the school, and to try to turn this all around. And it looks like it worked. Of course, you can never prove a negative, right? Did it prevent a shooting? Who knows? But why aren't we doing this everywhere? Why aren't we doing this everywhere?

Burda:
Yeah, no, couldn't agree more. Couldn't agree more. Well, yeah, classic. Good news, bad news there, Dave. Thanks.

Johnson:
Yeah.

Burda:
And thank you, Julie. That is all the time we have for today. If you'd like to learn more about the topics we discussed on today's show, please visit our website@4sighthealth.com. You also can subscribe to the roundup on Spotify, apple Podcast, YouTube, or wherever you listen to your favorite podcasts. Don't miss another segment of the best 20 minutes in healthcare. Thanks for listening. I'm Dave Burda for 4sight Health.