

4sight Health Roundup Podcast

How Can We Reduce Unnecessary Healthcare Spending? Spin the Wheel.

10/1/26

[Intro and outro music by C. Ezra Lange]

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 1st. If you love October, like I do, this is a big day. But apparently, it wasn't enough to save the October Lovers Club at the University of Illinois in Urbana-Champaign. The club was around when two of my kids went to school there, but when I checked on it this week, it turns out they disbanded in September 2025 after a nearly 20-year run. Money problems, according to what I could find online. The club lost its big financial sponsor, and college students could afford the ticket prices to attend the club's many events throughout the month. In short, the October Lovers Club became unaffordable.

Now, if we can't afford a barn dance or a hayride or apple picking, what chance do we have to afford healthcare? To tell us our chances based on two new pieces in JAMA are Dave Johnson, founder and CEO of 4sight Health, and Julie Murchinson, Partner Transformation Capital. Hi, Dave. Hi, Julie. How are you two doing this morning? Dave?

David W. Johnson:

Well, back in Chicago where the three of us happened to get together for lunch, yesterday, which was fantastic, and we're both the Cubs and White Sox qualified, for this year's baseball playoffs, what could be better?

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Burda:

Yeah. Yeah. Well, it worked out for the Sox, not so well for the Cubs last night, but, - <laugh> Right. It's always next year, right? There's always next year. You

Johnson:

You know, out my window in Streeterville, the Hancock building was alternating between blue and red for the Cubs. Gray and black for the Sox. And, I think it's just gonna be gray and black from here on out.

Burda:

I think so. I think so. That's great. Julie, how are you?

Julie Murchinson:

I am great. I'm back in Seattle after having a great lunch with you guys yesterday. It was so good to see you.

Burda:

Yeah, yeah. Feelings mutual. Okay, before we talk about healthcare spending, one of our favorite topics here on the Roundup, let's talk about October. Dave, I know fall is a close second to your favorite season, spring. What's your favorite October activity?

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Johnson:

Well, I'm, I'm gonna expand it to fall, because there are lots of things I love to - Yeah. To do, do in fall, but this actually occurs in November. It's the extra hour of sleep that we all get - <laugh>... When the, when the clock falls back. See what I did there - Yeah. To standard time. I just love that moment. And then I, I hate the darkness after that, early darkness after that, but I love that, that one day.

Burda:

Yeah, I didn't think I'd, I'd hear you say an extra hour of sleep, but that's a great answer. Thanks, Dave. <Laugh> Julie, if you were a member of the October Lovers Club, what would be your don't miss club activity?

Murchinson:

Well, as I joked with you yesterday, it's the switch from white to red wine. <Laugh> <laugh>

Burda:

I'm glad you stuck with that one. That's a good one. <Laugh> All right. For me, it's making homemade pumpkin seeds. You know, I used to throw out the guts of the pumpkin after I carved it, and not anymore. They're into the oven with lots of salt, and they're delicious. And I can afford them, and there's your transition into today's topic. Dave, that's also a lot of money out of someone else's pocket. What's your takeaways

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from these two new pieces? , What did they get right? What did they get wrong? And is any of it possible?

Johnson:

In terms of the first paper, the one, with the lead author from Brown, they did a really nice job of, getting the, macro causal factors, right, as to what's contributing to spending growth. And Dave, you went through those, so I don't need to repeat them. But their analysis doesn't really, address solutions. It's more problem identification, which, you know, you can't solve a problem until you identify what's happening. So I like that, but, it was really the second paper, from Nikhil Sani, who I know reasonably well, and, some superstar co-authors, including Zeke Emanuel and David Cutler, that identified these, six, things that could dramatically, reduce healthcare spending. And they kind of fall broadly into three buckets,, you know, technological advances , artificial intelligence, GLP-1 drugs, regulatory policies like site neutral payment, and better, payment management, you know, things like risk delegation, risk adjustment. That's how they get their savings number, and, <laugh> the scope is so wide, you know, it's kinda, and in terms of, the range of potential savings, you begin to wonder how much a handle they really have on the, incremental impact of each of these. But I would say what both studies miss is the macro shift that's required, to generate better, overall population health outcomes at reduced spending. And again, Paul, and my, conclusion in the coming healthcare revolution is that was gonna come more externally than internally. And I believe the biggest, forces that will drive this change are self-insured employers who pay premium prices for, largely commodity services just refusing to play

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along anymore. You may have seen that Bloomberg, is no longer offering commercial insurance to its employees. They're just giving them a lump sum payment, and they gotta go out and get their own health insurance starting next year. Imagine if that trend continued in a meaningful way, you wouldn't have the cross subsidy that props the whole system up. The other thing is, and the site neutral payment is indicative of this, the government is, really going after some of these buckets of excessive expenditure that are propping up the system. And I think it's a lot more vulnerable than, than people realize, but maybe the biggest one is, we need to shift the emphasis from how much we're spending on healthcare to, investing more in health promotion, chronic disease management, population health, the things that will enable most people, to lead healthier lives, longer health spans. So, you know, I like where they're going. Both papers are short. You really can't expect them <laugh> to solve everything. I mean, Paul, in my book, was, 300 and something pages, right? So, but I like the thinking, I would just personally like to see more emphasis on how we become a nation that cares as much about, promoting health, as we do about treating disease.

Burda:

Yeah. Yeah. Need that 180 degree shift. I hear you. Yeah. Thanks, Dave. Julie any questions for Dave?

Murchinson:

Yeah, Dave, so looking abroad, one of the articles talked about other countries, Germany, the Netherlands, and Switzerland, and how they

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pair competition with pricing guardrails. You know, Indiana has a, a 260% of Medicare cap in place. Is something like that moving us towards, you know, an all-payer rate setting environment? Would you support that kind of model?

Johnson:3

Yeah, Maryland also has a hard cap on expenditure that begins to look like some of the European models. And Indiana's moving in that direction too. You know I'm old enough to remember the Nixon administration. So, we had this thing called stagflation, right, which was slow growth and inflation happening at the same time post the spike in oil prices, and the excesses, generated by the Vietnam War and the Great Society program spending. So, Nixon administration instituted wage and price controls in different phases, phase one, phase two, phase three, and then ultimately phase four. And I remember a political cartoon from that era that, showed, President Nixon on the sidelines as a football coach, and you had the down marker that said phase four, and the caption underneath read, "Punt." <laugh> And, I guess I look at what the European countries do, what Indiana's doing, what, Maryland does as the equivalent of punting. We've given up then on the fact that we can unleash, the forces of American innovation in the marketplace to generate the desired outcomes we all want and believe are achievable, and basically resort to, these hard cap, expenditure controls, and they work, but they don't optimize. So <laugh> I don't not support them, I guess, because I think, you know, absent anything else, that is a way to slow the train down. But I would much rather see us trying to figure out

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how we can get the ultimate buyers of healthcare services to become much more effective purchasers.

Burda:

I think California's phasing in per capita spending increases, right.

Through 2029, and they wanna get that down to 3%. So, that's not a lot of room to innovate, right? So, - Yeah. We'll see what happens there.

Thanks, Dave. Okay, Julie, you're up. Are these two pieces destined for the desk bin of history, or is there some there, there? Give us a reality check on these answers to runaway healthcare spending.

Murchinson:

Yeah, there's some there, there, but not exactly where the headline number points, I guess. You know, if you start with that, the savings piece, more than half of that 844 billion to 1.3 trillion depends upon one assumption, which is widespread AI adoption. Yeah. So that's, that's feat, right? The other piece, you know, published the same day, same journal, talks about redistributing, you know, spending as much as reducing it and the money flowing to vendors and investors, by the way, and data infrastructure. And I saw Eric Larson speak this week. He's, of course, doing his stump thing on his healthcare Oppenheimer moment. <Laugh> uh-huh. He, of course, set the stage for how we are the most susceptible sector to AI. We have, catch this, 50 zetabytes of health data. We have one third of all global data, 90% of which is unstructured. These are the numbers he threw out. So, you know, we're the, also the only industrial vertical that with negative productivity growth over the last generation.

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We talked about this, I don't know, a few months ago. So when one in six workers in the US is a healthcare worker, like, we are so primed for this. And the sequence he described was first, AI makes healthcare super inflationary, which a lot of other people have said as well, as, you know, providers focus it on revenue and all the things we know are happening right now in RCM, basically. But then the payer and provider capabilities reach some sort of equilibrium, and eventually, you know, really automating the, the guts of our system, the workflows, and the, like, reduces the labor need. And it's just the, it's just the reality. So the issue, of course, is that deflationary means fewer people. And when are we gonna be ready for that? And, and how does that actually happen? So, the crux of his argument was really about, "Yeah, of course it's gonna be inflationary, but it has to be deflationary. And we need to set ourselves up for what that means for the, for every single local economy in this country." And I think when you start to think about it that way, we're getting... Even articles like this are getting very hyped up about a, a phase, but, you know, that phase is important. I also looked at the GLP-1s, which I thought was interesting. Like, you know, getting into the 2030s when these things go on off patent, there could be real savings, but right now, it's cost additive, right, three to five billion a year. So that's not great in the short term. But there, you know, the things that can be bankable, like the site neutral payments and fixing MA risk adjustment, like, that's real money. And that flip could be switched very quickly with just a policy change. So it seems like, I don't know. The problem with what's happening, which we've talked about in the last couple weeks around consumer satisfaction with the industry, is that our growth has not been outrageous in the last decade, but because we've shifted so much cost to the consumer, everyone feels it in a really

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different way. And this, all the savings piece that is talked about here, I don't know that you're gonna see any of that savings show up for those consumers. As a matter of fact, I don't think you will. I'm not so sure that it's a lot of what was talked about in the savings article is some, you know, amazing solution.

Burda:

Yeah. Yeah. Will we feel it? The answer is probably not. That's interesting. Thanks, Julie. Dave, any questions for Julie? Yeah.

Johnson:

I know Eric Larson pretty well. I've helped him write a couple of things, and, I really like how he thinks about, about these kind of macro trends. One of the things Eric talks about is, the John Maynard cadence concept. Julie, I don't know if this came up in your, conference, but this idea of a post-scarcity society, right, that we create so much productivity improvement and wealth to go along with it that we can, redistribute so that there can be an average, annual income for, for everyone in the country. And so the real question, I think is who gets the benefits of these productivity improvements, which you touched on. I'm gonna let you go a little deeper on it. So the second JAMA paper, that Nikhil Sani was the lead author, suggests that over half of the potential savings, 810 billion out of the 1.3 trillion dollar number will come from widespread adoption of artificial intelligence. And the first paper with the brown lead author, has this quote, "It is not assured that the productivity gains from AI will automatically translate into lower healthcare spending." So

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here's my question. What can or should governments do to translate AI's enormous potential, which you were starting to, circle around, into actual reductions in healthcare expenditure that really do, push healthcare as a segment of the economy to a lower overall percentage rather than a higher percentage?

Murchinson:

Gosh, it's such a big question. I know. I mean, when you look at the fact that Washington controls Medicare prices, I mean, just from a CMS lens, right? And all this AI-driven price inflation is showing up in the commercial markets where feds and states, by the way, their abilities are quite piecemeal, you end up back in the, you know, the first article's conclusion that structural reform is kind of the way to go, right?

Someone does have to be responsible for turning productivity gains into public benefit, and right now no one is. So, <laugh> you know, I guess the government's job could be less about funding or regulating AI and more about making sure that dividends captured somewhere before the payers and, you know, before it reaches all the other, the parties. I guess some countries, you know, use a health technology assessment to decide what gets covered and at what price, and the US could do the same for AI tools, right? Tie coverage to evidence of better outcomes and lower costs with these tools. You know, not billing codes <laugh> necessarily. <Laugh> so I guess I'm thinking more short-term and long-term, Dave, because the long-term, like, redistributing wealth in mass ways, is a bigger discussion. In the short term, like, are there ways that they could neutralize, you know, the impact of some of this? Yeah, absolutely.

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Burda:

Thanks, Julie. You know, like I said, I think that \$1.3 trillion has to come from someone else's pocket, and that's what's gonna make doing this stuff really hard, like you both said. But if people can't afford healthcare anymore, what choice do we have, right? So, thanks, Dave, and thanks, Julie. Now, let's talk about other big healthcare news that happened this week. Julie, what else happened that we should know about?

Murchinson:

Well, I think a lot of people who are following this kind of stuff probably know about this, so it's not new news, but when Ora pulled its IPO this week, you know, or the ring - uh-huh. Citing market weakness, and, you know, if you dig into a little bit of what was happening there, apparently there were some diligence concerns about their health claims, and, you know, it seems like, it's actually kinda good, right? Maybe Wall Street's looking as much at the clinical validation as they are at, at growth projection. So I look at that as a positive. But for anyone who hasn't been following what's in the S1, ORA's engagement is amazing. Like, members wear that ring, 23 hours a day, it's a median number. They open the app more than three and a half times per day on average, and the retention of members after 12 months is about 85%. Like, what else in the world has those kinds of numbers beside I mean, not even your phone, right? You don't have that kind of engagement with your phone or really data flowing in that same way. It's amazing.

Burda:

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Yeah, continuously monitoring your, vital signs, right? Dave, are you still wearing yours or are you part of the...?

Johnson:

In fact, I was, as Julie was going through this, I stopped my Oura Ring after two years and, my big lesson was I need to sleep more so I don't set an alarm unless I have to, like this morning I had to. I wonder what their engagement numbers are after two years?

Murchinson:

Yeah, it's a great question.

Johnson:

Yeah. anyway, my news for the week is not new news, it's old news. Illinois, has some of the lowest, Medicaid payment rates in the country and particularly for joint replacements. And there's this Illinois based company called Genesis Orthopedics that I just found out about that has re-engineered itself to make money at these very low reimbursement rates for joint replacements. So I looked the company up, yesterday and here's what they say about themselves. "Our National capacity for medical care is remarkable and our current system is underestimating it. We need a new orthopedic model, one where we value human beings regardless of economic status, where pricing is ethical, not exploitive, where recovery is expedited and surgery is a last resort, not a preferential revenue source. If we're going to push healthcare forward,

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we need to cut loose from the old model that just doesn't work anymore. We don't need more high cost orthopedic care. We need something new, high quality, ethically priced orthopedic care. " And it kind of goes on about their, their re-engineering model and so on, and how it took hundreds of hours to re-engineer what they're doing., But I guess I wanted to highlight this story just based on everything else that we talked about today and how frustrating it is to see real improvement. The more companies like this company that are using their creativity, their ingenuity, their blood, sweat, and tears to figure out how to improve healthcare outcomes at lower costs, the greater percentage of the overall ecosystem with companies like this, I believe that's what from the bottom up will transform the company. So I'm actually almost tired by reading these economic analysis reports. I'd much rather, engage, I guess, Julie, like you do with companies like this Genesis, and I gotta meet them since they're right here, but, that are doing the hard work of delivering better health outcomes at lower costs with better customer experience ethically.

Burda:

That's the leadership thing we talked about a few weeks ago, right? They fit that category and they've had enough and it took somebody with the guts to do it. So, yeah, look forward to hearing more about that. That's great, Dave. Thanks. 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 at 4sighthealth.com. You also can subscribe to the Roundup on Spotify, Apple Podcast, YouTube, or

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