

4sight Health Roundup Podcast

The Stark Reality of the Health Insurance Affordability Crisis

10/29/26

[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 29th. I'm sure you know it's open enrollment season. It's that time of year when everyone picks their health plans and their benefits for the next year. That's why you're seeing all those Medicare Advantage commercials on TV. Well, that's if you still watch TV like seniors do. Those ads are directed at us, not to mention all the junk mail in our mailboxes. If you have insurance through your employer, you're trying to figure out the best health plan option and benefits for you or for you and your family. It's if you still can afford them. Given that we're two days away from Halloween, we're gonna talk about some scary trends in employer-based health insurance today with 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:

It's October 29th, the anniversary of the 1929 stock market crash. The '89 crash also happened in October. And of course, the great 2008 recession got rolling with the collapse of Lehman Brothers in the fall of 2008. So given the current record stock market prices and the enormous

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economic uncertainty, I'm wondering as we approach Halloween whether we're headed for another major market correction.

Burda:

Way to set the tone for the podcast. <Laugh> And nobody's gonna listen. They're just gonna run and check their 401Ks. Great. Let's move that into the money market, right? That's what's gonna happen. Thanks, Dave. All right, Julie, how are you?

Julie Murchinson:

That is bright and cheerful. <Laugh> I was telling you, Burda, that the road has finally caught up with me. I'm a little under the weather, but for the most part, good. I spent the week with actually a number of pharma and med tech companies. And I'll say they are struggling with AI just as much as the health systems and health plans.

Burda:

All right. Okay. Before we talk about employer-based health insurance, thanks to the Kaiser Family Foundation's latest annual survey report, let's talk about Halloween. Dave, Halloween decorations are out everywhere and have been for weeks. Has any one decoration caught your eye as the best?

Johnson:

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Burda, I'm gonna go a little bit off script, and I'm gonna pull a Burda fact out of the air. Saturday, Halloween will be the 100th anniversary of Harry Houdini's death. They've got a tribute to him going on now at the new hand and eye magic experience in the old McCormick mansion on Ontario Street where the Lowry's Prime Rib used to be. Yeah. I bet you frequented that place. Yes, I did 39 exhibition rooms with individualized decor music, scents, and experience. It's not exactly Halloween, but as all the tech bros would say, magic and Halloween are aligned.

Burda:

<Laugh> I'll tell you that was one of the scariest movies I ever saw, ,, about Houdini, where he goes under the ice and can't find his way out. And I saw that when I was, I don't know, probably under 10, and I've never gone on ice on a pond or river ever after that, so. <Laugh> Scary stuff. Thanks for bringing that up, Dave. Stock market crashes, going through the ice. Great. Excellent. Thank you. Julie, I remember you said that you had a favorite outdoor Halloween decoration, but I can't remember what that is. What is it or do you have a new favorite?

Murchinson:

Well, my favorite has long been the things you stick in the ground that make it look like the witches are coming out of the ground that got stuck, right?

Burda:

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Right.

Murchinson:

, but my neighbor has one that has skeleton arms and legs, and it looks even better. But I was in New York last week, and on West 87th Street between Central Park and Columbus, there are, like, five or six trees in a row that have that that witch that looks like the witches run into the tree. <Laugh> It's so funny. I'm enjoying Halloween decorations too.

Burda:

Oh, that's great. Well, my favorite is around the corner from my house. One of my neighbors has a skeleton, and it's sitting nicely on the ground, and he's leaning his back up against a tree, and his hand is out like he's waving to you. He's basically saying, "Hi, yeah, I'm skeleton. We're cool. Have a nice day." It just kind of makes me crack up when I see it. And the world's a scary place, even for skeletons, and he's just trying to get through the day like everyone else. And I wonder who he's gonna vote for on Tuesday. I should ask him that when I walk by later.

Johnson:

Does, does the skeleton have a cigarette and a drink in its hands?

Burda:

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I wouldn't be surprised if that happens on Saturday. Anyway, let's talk about the results of the KFF's 2026 employer health benefits survey. I'm gonna share some of the top line findings from the report, and you tell me how afraid employees should be heading into 2027, and there's your transition. This year's report is based on a survey of 1,937 non-federal public and private employers with 10 or more employees. Here are some of the headline numbers. The total average premium cost for family coverage rose 5% this year to \$28,303. Workers paid 26.4% of that or \$7,471. That's a slightly larger share than last year when employees paid 25.4% of the premium. In terms of dollars, that's 7,471, that's a 9% increase over 2025, and 44% of large employers, or those with 200 or more workers, said they increased their worker's share of the premium this year. And here are two curious survey results, given all those numbers I just threw out. 71% of large employers said they were satisfied or very satisfied with the overall cost of care for their workers. Yet, 7% of all employers said they offer additional compensation or benefits to their workers if they don't enroll in their company's health plan and get their benefits from someone else. So to some employers, it's, "Hey, it's not my money," but to others it's, "Hey, it's my money." Dave, what's your take on some of these numbers? Is there anything else in the report that jumps out at you? And when we talk about next year's report what are we talking about?

Johnson:

Well, a year from now, I expect these numbers will be even worse, which is saying something because this year's figures are horrible. The

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headline is, as you mentioned, is that the cost of the average commercial family health insurance plan is now \$28,303.

\$28,303.

In 2017, which now seems like an eternity go, Zeke Emmanuel, Aaron Glickman and I published a commentary in CHAMA that introduced the affordability ratio, which is really simple. It's the relationship between the cost of a family health insurance policy, employer plus employee contribution, the \$28,303 that we just mentioned, and median household income, which is a little over \$87,000 this year. So the first year that we could calculate this ratio was 1999. That's the first year the KFF survey came out. And the ratio was 14.2%. Unfortunately, this year, that ratio has now hit a record high of 32.4%.

Burda:

Wow.

Johnson:

So almost a third of median household income. The compound growth rates, interestingly, of median household income from 1999 to today, 115%. Health insurance plans, 389%. So all things being equal, if we as an industry had been able to keep healthcare costs at 14% of GDP, which is where they are in most of the world the average family would have an

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extra \$16,000 in their pockets. That's not chicken feed, and with all the focus on affordability, it's hard not to conclude that healthcare is eating into the livelihoods of, of almost all Americans. But you know what, Dave? It's even worse than that. The individual contributions jumped to \$7,471. That in and of itself is 8.5% of median household income. It's even worse if you happen to work for, a small employer, you know, under 200 employees. Then your employee contribution's \$9,687, 11% of median household income. I mean, how many things do you spend 11% on of your household income? Just your, your deductible? But you know what? It gets even worse than that because these plans now come with larger deductibles. The average deductible now is somewhere between two and \$3,000, depending whether you work for a large employer or small employer, and often with restricted network access. So it costs more and you get less. Isn't that a winning formula? So no wonder the Kaiser Family Foundation Survey finds that six in 10 adults are worried about the affordability of healthcare. It ties with gas prices for consumers' top cost of living concern., Last week the Commonwealth Fund, issued a study that said the uninsured percentage of working adults has jumped to 11.2%. That's up from 8.9% in 2024, and that's only gonna get higher next year as the Medicaid cuts and restrictions fully kick in. Commonwealth also found that 50% of working age adults now delay or forego necessary care because of its cost, 50%. Is it really any surprise that American consumers are as concerned and angry as they are about our nation's healthcare system? It just is yet another indicator that the pressure for systemic transformation is ratcheting up. And those companies that figure out how to improve end user experience across the board, you know, cost, outcomes service

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and by end users, I mean consumers, customers, patients, whatever you wanna call them, are gonna be the ones that survive the industry's forthcoming disruptive tsunami. It, it, trends that cannot continue, won't, and we are on such an unsustainable trajectory. It's, it's, this, it's good we're talking about this on Halloween because it's truly scary.

Burda:

We're walking a tightrope and we're ready to fall off. Thanks, Dave.
Julie, any questions for Dave?

Murchinson:

So Dave, I know you're a big ICRA fan. So let's talk about the impact of, like, actually big changes. And if a meaningful slice of commercial lives moves from, you know, the group side to exchange plans, which by the way, typically pay hospitals less, who do you think notices first? The CFOs of the hospitals, the policymakers? Like, do you think anyone in Washington sees that ICRA's kind of a hospital revenue policy?

Johnson:

You know who's gonna notice first are consumers. <Laugh> The ones that are, are actually, I think you know, gonna benefit from, from more competition. But it's a really, it's a really good question. I mean, ICRAs are being pushed by policymakers, and they really haven't dented the marketplace in a big way, although I, I, I don't know if you saw this or

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not, but Centene which is a very large employer, and they, as a company, are, are pushing ICRAAs hard have st - have are now offering ICRAAs in Indiana and Michigan among other places and intend to do it for their entire workforce. So I think you're, you're onto something here where, from a policy perspective, what I would like to see is figuring out how to make it easier for large employers to offer these types of you know, defined contribution plans. And in an ideal world employees could take the contribution from their employers, let's say it's 20 th - 5,000 bucks, and go to an exchange or some other place and buy a health insurance policy, and if they can get it for \$20,000 they get to keep the difference as taxable income. So I, I think this is a way to crack the Gordian knot that we've been in where we can't get kind of price accountability from the system overall, both payers and providers because they've been so deft at sort of figuring out how to maneuver around that. But as we just talked about, and you're gonna talk about some more the costs are just getting to a point where I don't think we're gonna have an alternative, but to do these type of ICRAA-like plan designs. So they're coming, and they're gonna get bigger.

Burda:

Yeah, more competition, more consumer choice. That's sounds like a good path. Thanks, Dave. Okay, Julie, it's your turn. Any of these premium trends surprise you? What else in the report made you do a double take? And a year from now, what are we talking about from this annual survey?

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Murchinson:

Well, you know, the 9% is what was in the headlines, and I don't know, numbers not entirely surprising, but underneath it. When you really step back and look at it, it's probably some of the cleanest cost shifting we've seen in a long time. Like, it looks like employees absorb nearly half the increase. And what I looked at was the single coverage, like, worker contribution jumped 16% or so in a single year, and that's hitting our younger, healthier, lower wage workers the hardest, and they're exactly the people you want in the risk pool.

Burda:

Right.

Murchinson:

So it's becoming super unsustainable. And then, you know, the... I work for a small firm, right? We're actually having a pretty big overhaul of our health plan approach now, and small firms are getting hit hard. Like, if you look at their workers pay about 9,600, \$9,700 for family coverage, that's about 37% of the premium versus 25% of large employers. And this has always been the way, you know, large versus small employers sort of behave, but that difference is getting, you know, larger and larger. I'd love to look at that with the trends of how companies are shifting in company size too. Like, these are a lot of, a lot of people are getting hit harder. Two things maybe do a double take. Only about half the large employers say they get enough information about the rebates that their

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PBM collects from drug makers. And I know we talked about this for... We've talked about it for a long time, but these are fiduciaries writing eight-figure checks without seeing the money flows. And there was something that came out yesterday, actually, on this. I think we're gonna start to see some, you know, movement on this again. There's an article about drug movement. Middlemen will soon have to share details on how they're paid. So, you know, we'll see. There's constantly some PBM activity happening. The other thing was that, you know employers are really shifting how they're getting drugs, and about a third are starting to really lean into the more innovative models, but 9% of employers now buy their maintenance drugs from outside the US, which is not a super high percentage, but it's definitely an interesting trend to watch. I'll be excited to see if that, if that moves the needle at all. And then, you know, among the biggest employers with 5,000 or more workers it looks like GLP-1 coverage is starting to fall. So I think it's... We're, we're... I think we're gonna go through a dip in GLP-1s and then come back up the other side, but it's gonna take a number of years. So a year from now, I think we're just gonna be talking about more double digits, honestly. I don't, I don't know that anything's really gonna change on that. And I don't know, the question's gonna be how much premiums rose?

Burda:

Buying drugs from outside the U.S. directly, that, that is one to watch. That, that was a great pickup. Thank you. Dave, any questions for Julie?

Johnson:

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Well Julie, I'm gonna give you a chance to bite out of the ICRA apple too, because some of those trends that you mentioned while small you know, like the one we just talked about buying drugs outside the US, are starting to tell a story that employers are really looking for alternative channels to deliver healthcare. So put it in an ICRA, <laugh> wrapping if you'd like, but where do you think these sort of price-driven direct contribution models go? Do they get bigger the way I think they will? What do you think?

Murchinson:

I don't know. We studied this pretty closely a couple years ago, and I don't, I don't know, I don't look at Centene as evidence that ICRA is gonna replace group coverage at large employers. It's, it's an ICRA seller using its own workforce as a demonstration. So I treat it like market signal, but I mean, the scale is tiny. What they're really doing is moving, what, 700 employees in Indiana this year, and then I guess more in Ohio and Oklahoma next year, but 700 means it's - <laugh>... It's not a lot. And it's really... I mean, yeah, it's the next step in cost shifting, but to your point, Dave, I think it's the competition it could spin off would be amazing. <Laugh> you know, the thing to watch, I guess, is when a non-insurer from the Fortune 500 moves its salaried workforce fully onto ICRA. Like, if that happens, then I think it becomes more real. But until then, the small group market is, you know, it's what's actually at risk.

Burda:

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Yeah, who's gonna really go first, right? That's, that's always the always the issue. Thanks, Julie. W- well, to me, you know, you, you found that 9% of companies buying drugs offshore, that 7% of companies paying you not to join their health plan, right? <Laugh> I mean, that, that tells you something seriously wrong with the system, so, -

Johnson:

Yeah.

Burda:

Yeah, here's some cash, go, go somewhere else. But great discussion. Thanks, Dave, and thank you, 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'm sure you probably saw this actually happened last week that Epic launched their app connector for AI agents, and I've seen all sorts of coverage about how this could actually be good breathing life into some of the digital health companies, or bad it's gonna actually really, like, now shape the market entirely. So lot of, lot of chatter out there in the Epic world.

Burda:

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Mm. Yeah, like a plumbing connection, right, when you go to the hardware store <laugh> - Yeah. Does it work with everybody else's pipes? Interesting. Dave, what's your big healthcare news of the week?

Johnson:

Well, Epic also announced that they're stopping their training with a bridge to bring in, you know, into the Epic system, so win some, you lose some. Well, Terry and I have been watching the BBC series, Doc Martin, about a famous surgeon turned rural GP who has a blood phobia. They, they've made a U.S. version of this out called Best Medicine. And it's just fantastic. And outside of the Panorama British eccentricity on display, it's remarkable to witness how well universal access to primary care services works, even maybe especially in small communities. So given what we were talking about getting back to basics really has potential.

Burda:

All right. What we can learn from Doc Martin, huh? Okay. I'm gonna have to watch. That's great. Thanks, Dave. 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 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.