The Budget Blind Spot: Why Health Tech Entrepreneurs Misread Their Customers' Financial Realities

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Abstract

This essay offers a deep investigation into the structural constraints in provider, payer, and employer budgets that health tech entrepreneurs often mis-estimate. draws on macro health expenditure forecasts, labor and wage trends, and drug spending data to ground scenario modeling of discretionary budget pools throug 2030. The essay provides:

- Mock budgets for representative provider, payer, and employer types
- Historical context from 2000 to 2020, with macro drivers
- Projections from 2025 to 2030 under best-case, base-case, and worst-case scenarios
- Discussion of which budget lines will expand, which contract
- Strategic implications for founders when sizing TAM and targeting buyers

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Introduction: The Mirage of Elastic Healthcare Budgets

Entrepreneurs in health technology often chase solutions they believe must be p for, but they habitually overestimate the accessible budget. They imagine that a provider or payer has an innovation fund or discretionary pool that can be tappe once value is demonstrated. The pitch deck shows a total addressable market calculated by multiplying the number of hospitals by some plausible spend per b the number of covered lives by a reasonable per-member-per-month fee. The ma appears sound. The need seems urgent. The ROI models project payback in mon Yet deals stall, pilots never convert, and procurement cycles stretch into years b quietly dying. The problem is not that the solution lacks merit. The problem is t the entrepreneur has fundamentally misunderstood the architecture of the custc budget.

Budgets are not neutral. They are not pools of capital waiting to be allocated to highest-value use case. They are rigid structures created by regulatory mandates labor contracts, capital depreciation schedules, clinical priorities, and actuarial models. Every line item has a manager, a historical baseline, a political constitue and a set of constraints that govern how it can be moved. The real challenge for founders is not to demonstrate value in the abstract but to engineer their solutic that it aligns with a specific budget line, one that is managed by a decision make

has authority, constrained by rules that permit the spend, and not already fully consumed by incumbent vendors or mandatory obligations. In order to do that credibly, one must understand not only the current baseline budgets but also ho they have evolved over the past two decades and how they are likely to shift unde plausible future scenarios.

This essay provides that understanding. It constructs mock budgets for hospitals physician groups, community health centers, national and regional insurers, thir party administrators, self-insured employers, and fully insured employers. It tra the evolution of these budgets from 2000 through 2020, identifying the macro dr that shaped spending patterns. It then projects forward to 2030 under three scer best case, where economic conditions and policy tailwinds create modest expans discretionary pools; base case, where current trends continue and discretionary s remains constrained; and worst case, where labor inflation, drug costs, and regul burdens collapse discretionary budgets to near zero. Finally, it offers strategic guidance for entrepreneurs on how to map their products to budget lines, discou their TAM estimates for structural access barriers, and build business models th survive the base case and thrive in the best case.

Provider Budget Dynamics: Historical a Contemporary

Hospitals and integrated delivery systems are among the most labor-intensive organizations in the economy. Labor has historically consumed between fifty and percent of a hospital's operating budget, and that share has been rising. Over the two decades, wage pressure, staff shortages, and fringe benefit inflation have progressively squeezed margins and reduced the pool of capital available for discretionary investment. In the early 2000s, information technology was a back line item, often consuming less than two percent of a hospital's operating cost. I departments were small, systems were fragmented, and most clinical documenta was still paper-based. Capital budgets were dominated by facility expansions, m equipment purchases, and debt service.

The Health Information Technology for Economic and Clinical Health Act, enac part of the American Recovery and Reinvestment Act of 2009, changed this land dramatically. HITECH provided billions of dollars in incentive payments to hosp and physicians who adopted certified electronic health record systems and demonstrated meaningful use of those systems. The result was a wave of capital investment in EHR infrastructure, data centers, networking equipment, and IT s Many hospitals saw their IT budgets climb from two percent to five or even seve percent of operating expenses over the course of the 2010s. But this growth was discretionary in any meaningful sense. It was driven by federal mandates, the ne avoid future Medicare payment penalties, and the operational imperative to mai and upgrade legacy systems. By the end of the decade, most hospital IT budgets consumed by licensing fees for core EHR platforms, annual maintenance contrac cybersecurity investments, and compliance with evolving federal regulations aro interoperability and data sharing.

Simultaneously, clinical labor costs continued to rise faster than general inflatio Bureau of Labor Statistics projects that employment in healthcare occupations v grow much faster than the average for all occupations over the 2024 to 2034 peri driven by an aging population, chronic disease prevalence, and expanded insura coverage. Registered nurses, physicians, advanced practice providers, and allied professionals all command wages that have increased at compound annual growt rates well above the consumer price index. Moreover, the supply of these worker not kept pace with demand, creating upward pressure on wages and benefits. Tr nursing, agency staffing, and retention bonuses have become structural features hospital labor markets, not temporary fixes. This wage inflation has increased th fixed cost base for provider organizations, making any non-labor line item a targ cost containment. As labor consumes an ever-larger share of the operating budg slack available for discretionary innovation shrinks correspondingly.

Supply costs have also become less stable. Medical devices, implantables, pharmaceuticals dispensed in hospital settings, and consumables like gloves and gowns all saw significant price volatility in the 2020s, exacerbated by supply cha disruptions and consolidation among manufacturers. While group purchasing

organizations and value analysis committees work to control these costs, they re substantial and growing burden. Capital depreciation schedules mean that hosp must continuously replace imaging equipment, surgical robots, and other high-c assets, further constraining the pool of funds available for new technology investments that do not directly replace or enhance clinical capability.

Physician practices have followed a similar trajectory, though on a compressed s and with regional variation. In 2000, an independent primary care or specialty practice might spend less than one percent of its revenue on information techno mostly for billing software and basic office systems. By 2020, that figure had rise three percent or more for many practices, driven by EHR adoption, quality repo requirements, prior authorization systems, and patient engagement tools. Howe physician practices also faced declining reimbursement rates, particularly from commercial payers ratcheting down fee schedules to control their own costs, and Medicare payment updates that failed to keep pace with practice cost inflation. result was margin compression that left little room for discretionary spending. M practices responded by consolidating into larger groups or affiliating with healt systems, transferring the budget decision to a corporate entity with its own constraints.

Federally qualified health centers and other safety-net providers operate under a different financial model, heavily reliant on grants, Medicaid reimbursement, an federal programs like the 330 grant funding. These organizations often have earmarked funds for specific initiatives, such as expanding access, addressing so determinants of health, or implementing value-based care models, but very little discretionary capital. Innovation budgets are typically tied to grant cycles and m align with the priorities of funding agencies. A health tech solution that does no to a specific grant opportunity or Medicaid reimbursement category will struggl find a budget home in these organizations, regardless of its intrinsic value.

Payer and Insurance Budget Dynamics

Health insurance companies and managed care organizations control enormous
of capital, but they operate under tight regulatory constraints that limit how the
deploy that capital. The Affordable Care Act imposed medical loss ratio require
mandating that insurers spend at least eighty percent of premium revenue on me
claims and quality improvement activities in the individual and small group mar
and at least eighty-five percent in the large group market. This means that only
to twenty percent of revenue can be allocated to administrative expenses, which
cover all non-clinical costs including marketing, sales, claims processing, call ce
compliance, legal, finance, human resources, facilities, and technology. The
discretionary pool within that administrative budget is a small fraction of the to

Historically, payers grew their IT allocations in response to regulatory mandates
competitive pressures. The shift from paper claims to electronic data interchang
the 1990s and early 2000s required significant investment in transaction process
systems. The rise of consumer-directed health plans and high-deductible plans i
2000s drove investment in member portals, cost transparency tools, and mobile
applications. The transition toward value-based care models in the 2010s requir
new analytics platforms, provider network management tools, and care coordina
systems. Today, large national insurers typically allocate between five and eight
percent of their administrative budget to technology, but the vast majority of tha
spend is locked into maintaining legacy core systems, refreshing claims platform
ensuring cybersecurity, and complying with state and federal reporting requiren
Innovation budgets within technology spending might represent only two to thr
percent of the total IT allocation, which translates to a tiny fraction of premium
revenue.

Regional and mid-sized payers face even tighter constraints. They lack the scale
amortize technology investments across millions of members and often operate v
older legacy systems that are expensive to maintain and difficult to replace. Thei
innovation budgets are correspondingly smaller, and their procurement processe
conservative. A regional Blue Cross Blue Shield plan with three million member
might have an innovation budget in the tens of millions of dollars, but that budg
must be spread across dozens of initiatives, each competing for attention and

resources. Moreover, payer innovation budgets are not just constrained by dollar by organizational capacity. Product managers, IT staff, compliance teams, and ve management functions are all stretched thin, which means that even when budg available, the organization may lack the bandwidth to implement new solutions.

Third-party administrators occupy a unique position in the payer ecosystem. TP manage claims and benefits on behalf of self-insured employers but do not take insurance risk. They operate on thin margins, typically charging employers a per member-per-month administrative fee that ranges from a few dollars to twenty c thirty dollars depending on the complexity of the plan and the services provided of that fee, the TPA must cover all of its operating costs, including technology. F TPA managing plans for fifty thousand lives at a fifteen dollar PMPM fee, annua revenue is nine million dollars. If technology consumes twenty percent of that, t budget is less than two million dollars, most of which goes to maintaining core c systems and regulatory compliance. Discretionary spending on innovation might one hundred thousand dollars or less, barely enough to pilot a single new solutic TPAs are extremely price-sensitive and will only invest in technology that direct improves client retention, reduces operating costs, or enhances their competitiv position. A health tech solution that requires significant integration effort or do deliver immediate, measurable value will struggle to find traction in this market

Employer Budgets in Health Tech Conte

Employers are the ultimate payers for a significant share of healthcare costs in tl United States, but their ability to directly influence or allocate budgets varies enormously depending on whether they are fully insured or self-insured. Fully insured employers purchase group health insurance from a carrier and pay a fixe premium per employee. The carrier assumes all the risk and manages all the ben The employer has virtually no discretion over how healthcare dollars are spent b choosing which plan to offer and what cost-sharing structure to impose on empl Any innovation budget is limited to small wellness programs, employee assistan programs, or voluntary benefits, typically funded out of human resources budget measured in dollars per employee per year. For a company with one thousand

employees, a wellness budget of fifty dollars per employee per year amounts to fi thousand dollars, hardly enough to support a sophisticated health tech intervent

Self-insured employers, by contrast, assume the financial risk for their employee healthcare costs and have much more visibility into and control over how those d are spent. Large employers with ten thousand or more employees often self-insu because it allows them to avoid state insurance mandates, retain surplus from favorable claims experience, and customize plan designs. However, self-insured employers still face relentless healthcare cost growth that constrains their discretionary spending. According to the Centers for Medicare and Medicaid Se private health insurance spending is projected to grow at an average annual rate about four to five percent over the next decade, driven primarily by utilization increases, provider price inflation, and especially prescription drug costs. Specia pharmaceuticals, which include biologics and high-cost drugs for conditions lik cancer, rheumatoid arthritis, and multiple sclerosis, have grown from a small fra of total drug spending in 2000 to more than half of all pharmacy costs today. CM projects that prescription drug spending will grow by more than ten percent in 2 alone, driven by new drug launches, price increases, and expanded utilization of specialty medications.

For a self-insured employer with five thousand employees and their dependents, covered lives might be twelve thousand. If annual healthcare spending averages t thousand dollars per member, total claims are one hundred forty-four million do Pharmacy might consume thirty percent of that, or about forty-three million dol with specialty drugs accounting for more than half of pharmacy spend. Employe spending on healthcare is dominated by medical claims and pharmacy costs, leav very little room for discretionary innovation. Benefits teams at self-insured empl typically allocate between one and three percent of total healthcare spend to non claims activities like wellness programs, care navigation, disease management, a technology pilots. For an employer spending one hundred fifty million dollars on healthcare, that translates to one and a half to four and a half million dollars. However, much of that budget is already committed to incumbent vendors, brok benefits consultants, and ongoing programs. The truly discretionary pool availab

new health tech solutions might be only a few hundred thousand dollars per yea even that is subject to intense internal competition and scrutiny.

Moreover, employer benefits decision-making is highly fragmented and risk-ave Benefits leaders are evaluated on their ability to control costs and avoid employe dissatisfaction, not on their willingness to take risks on unproven technologies. Procurement cycles are long, often tied to annual renewal periods, and require b from human resources, finance, legal, and sometimes the C-suite. Health tech entrepreneurs often underestimate the complexity of selling into this market an overestimate the size of the accessible budget.

Mock Budgets in Narrative Form

To make these dynamics concrete, consider a series of representative organizatic and their budget structures. Start with a five-hundred-bed community hospital t part of a regional health system. This hospital generates roughly one point two b dollars in net patient revenue annually. Labor costs, including wages, benefits, a contract staff, consume approximately seven hundred twenty million dollars, or percent of revenue. This includes registered nurses, physicians employed by the hospital, advanced practice providers, pharmacists, respiratory therapists, radio technicians, laboratory staff, environmental services, food services, and administ personnel. Clinical supplies, medical devices, implantable devices, and pharmaceuticals used in inpatient and outpatient settings account for another th hundred million dollars, or twenty-five percent of revenue. Facilities costs, inclu utilities, maintenance, and depreciation on buildings and equipment, consume s million dollars, or five percent. Information technology, including EHR licensing infrastructure, cybersecurity, telecommunications, and IT staff, accounts for sev two million dollars, or six percent. Other operating expenses, including legal, insurance, marketing, and administrative overhead, consume the remaining forty eight million dollars, or four percent.

Within the seventy-two million dollar IT budget, the vast majority is committed maintaining and upgrading core systems. The EHR platform alone might cost fif

million dollars per year in licensing and support fees. Network infrastructure, d centers, and cloud hosting might consume another ten million. Cybersecurity, increasingly critical given the rise in ransomware attacks on healthcare organiza might account for eight million. IT staff salaries and benefits might be twenty m That leaves nineteen million dollars, but much of that is consumed by mandator system upgrades, compliance projects, and replacing aging hardware. The discretionary innovation budget, the pool of capital that could be allocated to a health tech solution that does not directly replace an existing system or fulfill a regulatory mandate, might be only ten to fifteen million dollars. And that budge highly contested, with dozens of internal stakeholders proposing projects rangi from patient engagement platforms to revenue cycle optimization tools to clinic decision support systems. A health tech entrepreneur targeting this hospital nee understand that they are competing not against an abstract budget constraint bu against specific projects championed by influential department heads and clinic leaders.

Now consider a large physician group practice with sixty physicians across prim care and several specialties, generating sixty million dollars in annual revenue. L costs, including physician compensation, mid-level providers, nurses, medical assistants, and administrative staff, consume about forty-two million dollars, or seventy percent of revenue. Rent, utilities, and equipment depreciation account million dollars, or ten percent. Medical supplies, vaccines, and lab services cons four point eight million dollars, or eight percent. Information technology, inclu EHR subscription, practice management software, telehealth platforms, and IT support, costs about one point eight million dollars, or three percent. Other ope expenses, including billing services, malpractice insurance, marketing, and compliance, account for the remaining five point four million dollars, or nine pe Within the IT budget, the EHR and practice management system might consum million dollars annually. Telehealth, patient portal, and e-prescribing tools migh three hundred thousand dollars. That leaves five hundred thousand dollars, mos which goes to maintaining existing systems and paying for IT support. The discretionary budget available for new health tech tools might be one hundred thousand dollars or less. For a physician practice, every dollar counts, and any n

technology must demonstrably reduce costs, increase revenue, or improve physi workflow to justify adoption.

A federally qualified health center with eighty million dollars in annual revenue serving a low-income and uninsured population, operates under a different mod Revenue comes from a combination of Medicaid and Medicare reimbursement, patient fees on a sliding scale, and federal grant funding. Labor costs are similar dominant, consuming about fifty-two million dollars, or sixty-five percent of rev Facilities and equipment account for eight million dollars, or ten percent. Medi supplies and pharmaceuticals cost six million dollars, or seven and a half percen Information technology, heavily subsidized by federal grants and programs like Health Resources and Services Administration health center program, accounts four million dollars, or five percent. Other operating expenses, including outrea transportation assistance, and social services, consume ten million dollars, or tw and a half percent. Within the IT budget, much of the spending is tied to specifi grant requirements or federal programs. The discretionary innovation budget m be only one to two million dollars, and even that is typically restricted to project align with grant objectives, such as expanding access to care or addressing socia determinants of health. A health tech solution targeting FQHCs must be framed terms of grant alignment and mission impact, not just financial ROI.

On the payer side, consider a large national health insurance company with fifty billion dollars in annual premium revenue. Under medical loss ratio rules, at lea forty billion dollars must go to medical claims and quality improvement. That le ten billion dollars for administrative expenses. Of that, sales and marketing mig consume two billion dollars, claims processing and customer service another tw billion, network management and provider relations one billion, compliance and regulatory affairs five hundred million, corporate overhead including finance, le and human resources another one and a half billion, and technology three billio Within the three billion dollar technology budget, core claims processing syste actuarial modeling platforms, and data warehouses consume about two billion. Cybersecurity, infrastructure, and telecommunications account for another five hundred million. That leaves five hundred million dollars for innovation, digital

health, member engagement, and new capabilities. However, that budget is spre
across hundreds of initiatives, each requiring business case justification, IT development resources, and ongoing support. A health tech entrepreneur hopin
sell a solution to this insurer is competing for a slice of that five hundred millio
dollar pie, and they must demonstrate not just ROI but also strategic alignment
the insurer's quality initiatives, star ratings, or cost containment goals.

A mid-sized regional health plan with eight billion dollars in premium revenue
tighter constraints. Administrative costs are capped at one point two to one poi
billion dollars, with technology consuming perhaps four to six percent of that, o
roughly sixty to ninety million dollars. Core system maintenance might consum
million, leaving ten to forty million for innovation. But this plan lacks the scale
technical sophistication of a national insurer, and its innovation budget might b
consumed by catch-up projects, replacing legacy systems, and meeting minimu
regulatory requirements. The discretionary budget available for a new vendor m
be five to ten million dollars, spread over multiple years and subject to pilot vali
and ROI demonstration.

A third-party administrator with twelve million dollars in annual revenue, servi
fifty thousand covered lives at a twenty dollar PMPM fee, operates on razor-thin
margins. Technology costs might be two to three million dollars, with core clai
systems consuming one point five to two million. Discretionary spending on innovation might be only one hundred thousand to five hundred thousand dolla
This TPA cannot afford to take risks on unproven technology and will only cons
solutions that are plug-and-play, require minimal integration, and deliver imme
cost savings or revenue enhancement. The health tech entrepreneur selling to T
must offer a highly standardized, low-touch product with transparent pricing an
clear value.

Finally, consider a self-insured employer with ten thousand employees, generati
two billion dollars in annual payroll and spending two hundred million dollars p
year on healthcare benefits. Medical and pharmacy claims consume one hundred
ninety million dollars, leaving ten million dollars for stop-loss insurance, TPA fe
wellness programs, care navigation, disease management, and innovation. Of tha

million, the TPA might charge three million, stop-loss another two million, leavi five million for discretionary programs. But that five million is already allocated incumbent wellness vendors, EAP providers, and consultants. The budget availa for a new health tech solution might be only a few hundred thousand dollars, an employer will expect to see measurable results within twelve months. A fully ins employer with three thousand employees paying ten million dollars in annual premiums to a carrier has almost no discretionary budget at all. They might allo one hundred thousand dollars to a voluntary wellness program or employee assis but that is the ceiling. The carrier controls all other spending, and the employer no direct influence.

Macro Trends and Forecasts (2024–203

Understanding current budget structures is necessary but not sufficient. Health entrepreneurs must also anticipate how these budgets will evolve over the next f ten years. The Centers for Medicare and Medicaid Services Office of the Actuary publishes detailed national health expenditure projections that provide a macro framework for this analysis. According to the most recent projections, national l spending is expected to grow at an average annual rate of five point eight percen 2024 through 2033, reaching seven point seven trillion dollars and accounting fo twenty point three percent of GDP by the end of the period. This growth is drive several factors: an aging population that consumes more healthcare services, inc prevalence of chronic diseases, expanded insurance coverage, and continued med innovation that introduces new and expensive therapies.

Within this overall growth, different categories of spending are projected to gro different rates. Hospital spending is expected to grow at an average annual rate o point five percent, driven by inpatient and outpatient utilization, wage growth, a technology adoption. Physician and clinical services are projected to grow at five one percent annually, reflecting volume growth and modest price increases. Prescription drug spending, however, is projected to grow at a significantly faste with double-digit growth expected in the near term driven by new drug launches particularly in specialty categories, and price increases that outpace general infl

By 2030, specialty drugs are projected to account for more than seventy percent total pharmacy spending, up from about fifty-five percent today. This shift has profound implications for employer and payer budgets, as pharmacy costs crowd discretionary spending on other categories.

Labor costs are expected to continue rising faster than general inflation. The Bu of Labor Statistics projects that healthcare employment will grow from about tw two million jobs in 2024 to more than twenty-six million by 2034, an increase of roughly eighteen percent. Much of this growth will be in high-wage occupations registered nurses, nurse practitioners, and physician assistants. Moreover, workf shortages in nursing and allied health professions are expected to persist, puttin upward pressure on wages. Hospitals and health systems are already responding increasing base wages, offering retention bonuses, and relying more heavily on contract and travel staff, all of which increase labor costs. By 2030, labor costs ar likely to account for sixty-five percent or more of hospital operating budgets, up sixty percent today. This increase comes at the expense of other budget categorie including discretionary capital for technology and innovation.

Regulatory and compliance costs are also expected to rise. While specific manda difficult to forecast, the trend over the past two decades has been toward increas complexity and reporting requirements. Interoperability regulations, prior authorization reforms, transparency rules, and cybersecurity standards all impos costs on providers and payers. Each new regulation requires system changes, sta training, and ongoing compliance monitoring, further consuming IT budgets tha might otherwise be available for innovation.

Capital costs for providers are also rising. Interest rates, which were historically for much of the 2010s, have increased significantly, making it more expensive fo hospitals to finance capital projects through debt. Construction costs have risen to labor shortages and supply chain constraints. Medical equipment, from imagi devices to surgical robots, continues to become more sophisticated and more expensive. Hospitals face a constant need to replace aging infrastructure and up clinical technology to remain competitive and meet quality standards. These cap demands reduce the pool of funds available for discretionary IT spending.

For payers, the macro environment is similarly challenging. Medical loss ratio requirements remain in place, capping administrative spending. Competition, b from traditional insurers and from new entrants like managed Medicaid plans a Medicare Advantage plans, puts pressure on premium pricing and margins. Regulatory uncertainty, particularly around the future of the Affordable Care A Medicaid expansion, makes long-term planning difficult. Payers are responding investing heavily in value-based care models, provider network management, an analytics to control costs and improve quality. But these investments are strateg necessities, not discretionary choices, and they consume the budget that might otherwise be available for unproven health tech solutions.

Employers face a similar squeeze. Healthcare cost growth continues to outpace v growth and general inflation, forcing employers to shift more costs to employees through higher deductibles and out-of-pocket maximums or to reduce benefits. Political and regulatory pressures, including state and federal efforts to increase transparency and regulate pharmacy benefit managers, add complexity and uncertainty. The shift toward high-deductible health plans and consumer-direct models has increased employee dissatisfaction, putting pressure on benefits tea find solutions that improve the employee experience without increasing costs. B discretionary budget to fund those solutions remains constrained.

Scenario Modeling Through 2030

Given these macro trends, it is useful to construct three scenarios for how provi payer, and employer budgets might evolve between now and 2030. These scenari not predictions but rather plausible futures that bound the range of possibilitie help entrepreneurs stress-test their business models.

In the best-case scenario, economic growth remains robust, healthcare policy stabilizes, and productivity gains from automation and artificial intelligence beg offset labor cost inflation. Hospitals successfully implement staffing models that reduce reliance on high-cost contract labor, and wage growth moderates to roug match general inflation. Drug spending growth slows as biosimilars gain market

and value-based pricing models take hold. Employers see healthcare cost growth moderate to three to four percent annually, and payers achieve margin improven through better risk adjustment and care management. In this scenario, discretio IT budgets expand modestly. For a five-hundred-bed hospital, discretionary IT spending might grow from fifteen million dollars in 2025 to twenty-five or thirty million by 2030, representing two to two and a half percent of revenue. For a physician group, discretionary spending might grow from half a million to one o million. For an FQHC, federal appropriations for health center innovation and technology might increase, raising discretionary budgets to three or four million a large national insurer, innovation budgets might expand from five hundred mi to one billion or more. For a regional payer, discretionary IT spending might rea one hundred to one hundred fifty million. For a TPA, strong growth in client bas efficiency gains might allow discretionary spending to reach one to three million a self-insured employer, moderating healthcare cost growth might free up five to million for innovation. For a fully insured employer, wellness and voluntary ben budgets might expand to two or three million.

In the base-case scenario, current trends continue without major disruption. Lab costs continue to grow faster than revenue, consuming sixty-five percent of hosp budgets by 2030. Drug spending growth remains elevated, driven by specialty pharmaceuticals. Employers and payers continue to face four to five percent ann healthcare cost inflation. Discretionary budgets remain flat or grow modestly in nominal terms but shrink as a percentage of total spend. For a five-hundred-bed hospital, discretionary IT spending remains around fifteen to twenty million, rou one to one and a half percent of revenue. For a physician group, discretionary spending remains at half a million to one million. For an FQHC, discretionary budgets remain flat at two to three million, tied to federal grant cycles. For a lar national insurer, innovation budgets remain in the five hundred million to seven hundred million range. For a regional payer, discretionary spending remains at s to one hundred million. For a TPA, tight margins keep discretionary spending u one million. For a self-insured employer, discretionary budgets remain at three t million. For a fully insured employer, discretionary spending remains under one million. In this scenario, health tech entrepreneurs face intense competition for

limited dollars, and only solutions that clearly reduce costs, increase revenue, or regulatory requirements gain traction.

In the worst-case scenario, labor shortages worsen, wage inflation accelerates, ar drug spending growth continues unchecked. Hospitals see labor costs rise to sev percent of operating budgets, leaving little room for anything else. Drug spendi employers and payers grows at double-digit rates, crowding out all other categor Regulatory burdens increase, consuming more IT budget. Economic recession or policy changes reduce reimbursement rates for providers and squeeze payer mar In this scenario, discretionary budgets collapse. For a five-hundred-bed hospital discretionary IT spending might fall to five to ten million, less than one percent revenue. For a physician group, discretionary spending might disappear entirely all IT spending locked into maintaining core systems. For an FQHC, federal bud cuts might reduce discretionary innovation funding to under one million. For a l national insurer, innovation budgets might shrink to two to three hundred milli focused only on regulatory compliance and cost reduction. For a regional payer, discretionary spending might fall to thirty to fifty million. For a TPA, discretion spending might effectively reach zero. For a self-insured employer, discretionary budgets might shrink to one to two million, with all focus on cost containment. fully insured employer, discretionary spending might fall to under five hundred thousand dollars. In this scenario, only health tech solutions that are absolutely essential, that directly replace more expensive alternatives, or that are required l regulation will find buyers.

Growth and Contraction of Budget Line

Within these scenarios, certain budget lines will grow while others contract. On growth side, cybersecurity spending will continue to increase, driven by the esca threat of ransomware and data breaches and by regulatory requirements around protection. Artificial intelligence and automation tools that demonstrably reduc administrative burden, improve clinical decision-making, or optimize revenue cy will see increased investment, particularly if they can be shown to reduce labor c or improve productivity. Patient engagement and experience platforms that are t

reimbursement incentives, such as those that improve star ratings for Medicare Advantage plans or patient satisfaction scores for hospitals, will attract budget. management and population health tools that support value-based care contract continue to grow, as these contracts become more prevalent. Telehealth and rem monitoring, which saw explosive growth during the pandemic, will stabilize at h baseline levels than pre-pandemic, though growth rates will moderate.

On the contraction side, wellness programs and employee engagement tools that not demonstrate measurable ROI will face budget cuts, particularly among empl Generic, off-the-shelf solutions that do not integrate with core systems or that r significant manual effort to use will struggle. Analytics and reporting tools that produce insights without actionable workflows will lose favor. Pilots and proofs concept that do not convert to enterprise contracts will find it harder to secure i funding, as organizations become more disciplined about opportunity costs. Poi solutions that address narrow problems without fitting into a broader strategic initiative will face consolidation pressure, as buyers seek to reduce vendor sprav administrative complexity.

Importantly, the line between growth and contraction is not always about the int value of the solution but about how it is positioned and priced. A solution that c framed as reducing labor costs, improving compliance, or enhancing revenue wi access to larger and more stable budget pools than one that must compete for discretionary innovation dollars. A solution that integrates seamlessly with exist workflows and core systems will be more attractive than one that requires signif change management. A solution that can be piloted cheaply and scaled incremer will be more viable than one that requires large upfront investment. Health tech entrepreneurs must design their products and go-to-market strategies with thes realities in mind.

Strategic Lessons for Health Tech Entrepreneurs

The implications for health tech entrepreneurs are profound. First, TAM calcul must be discounted for structural access barriers. It is not enough to multiply th number of hospitals by a plausible spend per bed or the number of covered lives reasonable PMPM. Entrepreneurs must estimate how many of those potential customers actually have budget authority, discretionary capital, and organizatio capacity to buy and implement a new solution. In many cases, the accessible mar an order of magnitude smaller than the theoretical market. A more realistic app is to segment potential customers by size, ownership structure, financial health, strategic priorities, and then estimate penetration rates and average contract val for each segment. This requires deep customer discovery and a willingness to ac that the addressable market may be smaller than initially hoped.

Second, business models must be designed to survive the base case and thrive in best case, not to depend on the best case materializing. This means conservative revenue projections, lean cost structures, and contingency plans for slower adop and lower pricing than the pitch deck assumes. It also means designing product can be sold into non-discretionary budget lines. Solutions that reduce labor cost improve regulatory compliance, enhance reimbursement, or replace more expen incumbents have access to larger and more stable budgets than solutions that de on innovation funds or strategic initiatives. Entrepreneurs should map their valu proposition to specific budget lines and decision-makers within their target customers, rather than assuming that demonstrated ROI will automatically tran to purchase authority.

Third, entrepreneurs must develop fluency in the language and logic of their customers' budgets. This means understanding not just the total dollars but the constraints, the stakeholders, the approval processes, and the political dynamics means asking questions like: Which budget line would this come out of? Who controls that budget? What is already committed? What would need to be cut or deferred to make room? What are the approval thresholds? What is the buying c What are the competing priorities? This level of budget literacy is rare among h tech founders, but it is essential for navigating complex sales processes and avoi the trap of endless pilots.

Fourth, pricing strategies must be calibrated to the realities of constrained budg and long approval cycles. Health tech entrepreneurs often price their solutions b on the value delivered rather than the customer's ability to pay, leading to propo that exceed available budget pools regardless of ROI. A more effective approach understand the customer's budget constraints first and then design pricing mod that fit within those constraints while still delivering meaningful value. This mig mean offering modular solutions that can be implemented incrementally, subscr models that spread costs over multiple budget cycles, or risk-sharing arrangeme that tie payments to measurable outcomes. For customers with severely constrai discretionary budgets, entrepreneurs might need to position their solutions as replacements for existing spend rather than additions to it.

Fifth, entrepreneurs must be realistic about implementation timelines and organizational capacity. Even when budget is available, healthcare organizations lack the internal resources to implement new technologies quickly or effectively departments are stretched thin, clinical staff are resistant to workflow changes, a compliance teams are overwhelmed with regulatory requirements. A health tech solution that requires significant integration, training, or change management w face delays and resistance regardless of its intrinsic merit. Entrepreneurs should design their products to minimize implementation burden, provide extensive su during rollout, and demonstrate quick wins that build internal momentum for broader adoption.

Sixth, the timing of market entry matters enormously in healthcare, where budg cycles are rigid and decision-making is seasonal. Hospitals typically finalize thei capital budgets in the fall for the following fiscal year, which often begins in July October. Payers set their technology priorities during annual strategic planning that vary by organization but often occur in the fourth quarter. Employers make benefits decisions during open enrollment periods that typically happen in the f health tech startup that misses these windows may have to wait an entire year fo next opportunity, regardless of the urgency of the problem they solve. Entrepren must map their sales cycles to their customers' budget cycles and plan their fundraising and product development accordingly.

Finally, entrepreneurs must build relationships and credibility over time rather expecting immediate adoption. Healthcare is a relationship-driven industry whe trust and reputation matter more than in many other sectors. A startup with no healthcare experience, no clinical advisors, and no reference customers will stru to gain traction regardless of how innovative their technology. Building credibil requires investing in industry relationships, hiring experienced healthcare execu engaging with clinical thought leaders, and demonstrating domain expertise thr thought leadership and conference participation. This relationship-building tak time and resources, but it is essential for breaking into an industry where buyer risk-averse and skeptical of unproven vendors.

Conclusion: Toward Budget-Fluent Innovation

Health tech innovation will succeed only when entrepreneurs speak the languag budgets. The total addressable market may be measured in hundreds of billions dollars, but the accessible market is constrained by structural realities that most founders fail to appreciate. Labor inflation, drug cost escalation, regulatory compliance, and capital depreciation consume the vast majority of healthcare spending, leaving discretionary pools that are smaller, more volatile, and more contested than entrepreneurs typically assume. These constraints are not tempo obstacles to be overcome through better sales execution or more compelling valu propositions. They are permanent features of the healthcare landscape that will persist regardless of technological innovation or policy reform.

The entrepreneurs who will succeed in this environment are those who design th products, business models, and go-to-market strategies around these constraints rather than despite them. They understand that healthcare budgets are not neut pools of capital but complex political and regulatory constructs with their own l and limitations. They map their solutions to specific budget lines managed by identifiable decision-makers with clear authority and available funds. They price products to fit within existing budget constraints rather than requiring custome find new money. They time their sales cycles to align with customer budget cycle

plan their own fundraising and development accordingly. Most importantly, they build their businesses to survive the base case scenario while positioning to capture upside in the best case.

This budget fluency is not optional for health tech entrepreneurs. It is the foundational requirement for achieving scale and impact in an industry where the largest pools of capital are already committed and the smallest pools are fiercely contested. The entrepreneurs who master this discipline will find themselves with sustainable competitive advantages that are difficult for competitors to replicate. Those who continue to chase theoretical markets and mythical innovation budgets will find themselves trapped in pilot purgatory, burning cash while waiting for customers who will never materialize. In healthcare, as in few other industries, understanding the money is not just helpful for business success. It is the prerequisite for making any meaningful difference at all.

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Stuart Miller Haverin about... Sep 29

I riffed on your article in this post I dropped today. I cited you and backlinked to y article. Thanks for the inspiration :-)

https://haverin.substack.com/p/beyond-the-knights-who-say-no-the?r=2vmx1l

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Stuart Miller Haverin about... Sep 28

Trey, spot on. Your piece nails the core miss: founders sell to the theoretical budg the accessible one (TAM needs to be spelled out for many early-stage companies! the beast, even in well-resourced systems, discretionary pools of funding are tiny, political, and mostly already spoken for.

More so than this, they also underestimate the “Knights who like to say No!” (thar Monty Python!).

https://open.substack.com/pub/haverin/p/the-knights-who-say-no?r=2vmx1l&utm_campaign=post&utm_medium=web&showWelcomeOnShare=fal

Even with an enthusiastic clinician sponsor, an institutional sale still has to clear:

Procurement → IT architecture → InfoSec → Compliance → P&T → IRB

And those last two are often chaired by the most conservative clinical/research le These checkpoints rarely appear in startup closing plans because many teams do know they exist.

Your budget-fluency message matches that go-to-market reality. Evidence and pre
ROI aren’t enough if you don’t map to the right budget line item and address whe
work actually happens.

Hospitals will pick “good enough + integrated” over “best-in-class + standalone”
day. As you so clearly state, labor and drug inflation simply crowd out everything

Bottom line: budget literacy + distribution + workflow integration > sizzle and ab
ROI potential.

Great debate!

LIKE REPLY