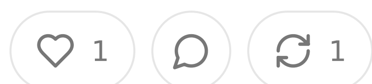
The Chargemaster Insurgency: What Steven Brill's Healthcare Exposés Me for Angel Investors in 2025

NOV 20, 2025 • PAID



Share

DISCLAIMER: The views and opinions expressed in this essay are solely my own and reflect the views, positions, or policies of my employer, Datavant, or any of its affiliate

---

If you are interested in joining my generalist healthcare angel syndicate, reach o trey@onhealthcare.tech or send me a DM. Accredited investors only.

ABSTRACT

This essay examines Steven Brill's seminal healthcare journalism, specifically his TIME magazine investigation "Bitter Pill: Why Medical Bills Are Killing Us" an 2015 book "America's Bitter Pill: Money, Politics, Backroom Deals, and the Figh Fix Our Broken Healthcare System." For healthcare technology investors and entrepreneurs, Brill's work provides critical insights into the pricing opacity, pe incentives, and regulatory capture that define American healthcare economics. T analysis extracts actionable investment theses around price transparency techno alternative payment models, and the structural arbitrage opportunities created b healthcare's broken pricing mechanisms. Key takeaways include understanding hospital chargemasters create exploitable information asymmetries, why the Affordable Care Act failed to address underlying cost drivers, and where techno companies can intervene in markets distorted by decades of regulatory and corp rent-seeking.

TABLE OF CONTENTS

Introduction: The Journalist Who Made Healthcare Pricing a National Scandal

The Bitter Pill: Deconstructing Hospital Chargemasters and Price Opacity

America's Bitter Pill: The ACA's Compromises and Their Market Consequences

Investment Thesis One: Price Transparency as Infrastructure

Investment Thesis Two: Alternative Payment Models and Risk-Bearing Entities

Investment Thesis Three: Consumer-Directed Healthcare and Decision Support

The Brill Framework: What Entrepreneurs Get Wrong About Healthcare Reforr

Conclusion: Building Businesses in Brill's Shadow

Introduction: The Journalist Who Made Healthcare Pricing a National Scandal

Steven Brill isn't a healthcare executive or a policy wonk or a venture capitalist, is precisely why his work matters so much for anyone investing in health tech. H investigative journalist who brought a fresh set of eyes to healthcare pricing and away absolutely horrified at what he found. His 2013 TIME magazine piece "Bitt Pill: Why Medical Bills Are Killing Us" clocked in at over twenty thousand word became one of the most widely read magazine articles in modern history. It did something remarkable: it made chargemasters a topic of dinner table conversati Before Brill, most Americans had never heard the term. After Brill, everyone kn that hospitals had these mystical price lists that bore no relationship to actual co market dynamics and that uninsured patients were getting completely screwed b them.

Then in 2015 Brill published "America's Bitter Pill," which took a different angl Instead of focusing purely on pricing opacity, he chronicled the backroom deals

compromises that shaped the Affordable Care Act. He had extraordinary access
Obama administration and key congressional staffers, and what emerged was a
portrait of healthcare reform as fundamentally constrained by incumbent intere
The book argues that the ACA expanded coverage but did almost nothing to add
underlying cost drivers because doing so would have required taking on hospita
pharmaceutical companies, and insurance carriers in ways that were politically
untenable.

For angel investors in healthcare, these two works provide a masterclass in
understanding the structural forces that shape our market. They explain why so
healthcare businesses that look stupid or inefficient on the surface continue to t
They illuminate the regulatory capture and rent-seeking behavior that creates b
barriers to entry and enormous arbitrage opportunities. And they show why
healthcare reform efforts consistently fail to deliver on their cost-containment
promises, which means the market opportunities Brill identified in 2013 remain
largely unaddressed in 2025.

The thing about Brill's work is that it's not prescriptive in the way policy papers
McKinsey reports are. He's not telling you what business to build or which regu
reform to advocate for. But what he does brilliantly is expose the mechanisms by
which healthcare extracts rents from patients and payers, and if you understand
mechanisms, you can build technology businesses that either exploit them or dis
them depending on your appetite for regulatory risk and your tolerance for com
business models. This essay attempts to extract the investment-relevant insights
Brill's journalism and translate them into actionable theses for healthcare angel
2025.

The Bitter Pill: Deconstructing Hospita Chargemasters and Price Opacity

The core contribution of Brill's TIME piece was making the chargemaster legibl
general audience. For those who somehow missed this, the chargemaster is esser
a hospital's price list. Every hospital has one. It lists the price for every service, s

item, and medication the hospital provides. And the prices are completely insan
Brill documented cases like a hospital charging five hundred and ninety-nine do
and fifty cents for a stress test that Medicare reimburses at around forty dollars.
fifteen dollars for one Tylenol pill. Or a thousand dollars for a disposable briefc
style heart monitor that Amazon sells for sixty dollars.

The key insight is that chargemaster prices are almost entirely disconnected fro
both costs and competitive market dynamics. They're not set based on what it c
provide the service plus some reasonable margin. They're not set based on what
competitors charge. They're set based on an internal logic that Brill describes as
"whatever we can get away with." And the reason hospitals can get away with it i
information asymmetry combined with the unique characteristics of healthcare
consumption. When you're having a heart attack, you don't shop around. You ca
negotiate. You often don't even know what the price is until months after you've
received the service.

What made Brill's piece powerful was the human stories. He profiled patients w
hit with six-figure bills for relatively routine care. A guy who went to the ER for
pain and left with a bill for twenty-one thousand dollars after a few hours of
observation and some tests. A woman with lung cancer whose treatment cost
hundreds of thousands of dollars, much of which represented markups on cance
drugs that the hospital bought for a fraction of what they charged her. These we
exotic cases. They were middle-class Americans who happened to be uninsured
underinsured and therefore got billed at chargemaster rates.

The investment insight here is straightforward but profound. Healthcare pricin
characterized by extreme opacity and information asymmetry. Most healthcare
transactions happen without the consumer knowing the price in advance. Even
they do know the price, they typically lack the expertise to evaluate whether it's
reasonable relative to the clinical value being delivered. This creates a massive n
failure. And market failures create startup opportunities.

But here's where it gets interesting for investors. The chargemaster problem is
actually two distinct problems. The first is price opacity, which is fundamentall

information problem. If patients knew in advance that hospital A charges three thousand dollars for an MRI while hospital B charges six hundred dollars for the scan, you'd see some price competition emerge. The second problem is the actua pricing dynamics, which reflect market power and regulatory capture. Even if pr were transparent, hospitals in many markets have oligopoly or monopoly power. can charge high prices not because of opacity but because patients have no alternatives.

This distinction matters enormously for investment strategy. Building a price transparency tool is relatively straightforward. It's mostly a data aggregation anc experience challenge. Building a business that actually drives down healthcare p requires either creating alternative delivery models or somehow constraining pr market power, which is much harder and much more capital-intensive. Brill's wo better at diagnosing the former than the latter, which is why so many companies on Brill-inspired insights have struggled to demonstrate real cost savings even w they've solved the transparency problem.

The other major theme in the TIME piece was the role of hospitals as rent-seeki entities. Brill dug into hospital finances and found that many nonprofit hospital operating with massive operating margins and paying their executives millions o dollars while simultaneously billing uninsured patients at chargemaster rates an sending them to collections when they couldn't pay. The CEO of MD Anderson Cancer Center was making nearly two million dollars a year. The CEO of Memo Sloan Kettering was making over three million. These are nonprofits that enjoy t exempt status ostensibly because they provide community benefit.

For investors, this creates interesting dynamics. Hospitals have enormous politic power and regulatory moats. They're often the largest employers in their communities. They've successfully lobbied for certificate of need laws that restr competition. They've negotiated favorable terms with commercial payers that al them to extract massive subsidies from employer-sponsored insurance to cross-subsidize Medicare and Medicaid, which reimburse below cost. Any startup tha threatens hospital revenues is going to face fierce opposition, not just in the mar but in regulatory and legislative arenas.

But hospitals also have genuine cost problems that create vendor opportunities. They're operationally inefficient. They have terrible data infrastructure. Their ca coordination is abysmal. Their supply chains are riddled with waste. Their staffi models are inflexible. So there's this tension where hospitals are simultaneously extracting rents from the system and hemorrhaging money on operational inefficiencies. The successful health tech companies figure out how to help hosp reduce costs in ways that don't threaten their core revenue streams. The unsucce ones try to disintermediate hospitals or redirect volume away from them withou adequate defensive moats.

America's Bitter Pill: The ACA's Compromises and Their Market Consequences

Brill's book takes a different approach than the TIME piece. Instead of focusing pricing and bills, it's a narrative history of the ACA's passage. The central argum that the ACA was designed around preserving incumbent interests rather than f underlying cost drivers. Obama and his team made a strategic decision early on t trying to move to a single-payer system or even a public option was politically infeasible, so they instead pursued an expansion of coverage within the existing private insurance framework. This meant cutting deals with hospitals, pharmace companies, and insurers to secure their acquiescence.

The hospital deal was particularly important. The American Hospital Associatio agreed not to oppose the ACA in exchange for a promise that the law would brin them millions of newly insured patients. The logic was that expanding coverage reduce uncompensated care, which would offset any Medicare payment cuts. Hospitals came out ahead. The pharmaceutical industry got a similar deal. They agreed to some modest cost concessions in exchange for the individual mandate, which would expand the market for their products. The insurance industry got guaranteed customers via the individual mandate and subsidies.

What didn't happen was any serious attempt to address pricing dynamics, mono power, or the fee-for-service payment model that incentivizes volume over value. documents how proposals to include a public option or to allow Medicare to neg drug prices were killed off early in the process. The White House was focused or getting something passed, and that meant not picking fights with powerful indu lobbies.

For investors, the key takeaway is that healthcare reform in America happens th market-preserving rather than market-disrupting mechanisms. The ACA didn't up the private insurance market or impose price controls or create a government healthcare system. It built on top of existing structures. This is important becau suggests that future reforms will likely follow similar patterns. When you're bui a healthcare business, you need to be thinking about how it aligns with incumbe interests, not just with theoretical policy goals or consumer preferences.

Brill also spends a lot of time on the exchange rollout fiasco. The [HealthCare.gc (http://HealthCare.gov) website was an embarrassing disaster at launch. He attril this partly to government procurement dysfunction and partly to poor project management. But the deeper issue was that the exchanges were trying to create a market infrastructure for individual insurance in a context where individual insurance had historically been a dysfunctional high-risk pool characterized by adverse selection and administrative waste.

This has real implications for digital health businesses. The individual insuranc market remains challenging. Penetration rates are low outside of subsidy-eligibl populations. Risk pools are unstable. Provider networks are narrow. Any busine: model that depends on selling into the individual market needs to be eyes-wide- about these structural challenges. The ACA improved the individual market but didn't fix it, and Brill's book explains why.

Another important thread in the book is the role of lobbying and revolving door dynamics. Brill shows how former congressional staffers and administration offi moved seamlessly into lobbying roles representing healthcare industry interests. Fowler, who was a key Senate staffer working on the ACA, went to work for Wel

before joining the Obama administration and then went back to industry after tl passed. This isn't corruption in any illegal sense but it does mean that policy get made by people who are deeply embedded in industry networks and incentivizec preserve those networks.

For entrepreneurs, this is both sobering and clarifying. It's sobering because it n that regulatory change is going to be slow and incremental and shaped by incum interests. But it's clarifying because it tells you where to look for opportunities. gaps in the ACA, the things it didn't address, are still sitting there as unsolved problems. Price transparency. Drug pricing. Monopoly hospital markets. Fragme data infrastructure. Fee-for-service payment misalignment. These are all areas w Brill shows the ACA either failed to act or acted in ways that were politically expedient but economically insufficient.

Investment Thesis One: Price Transparency as Infrastructure

The most direct investment thesis coming out of Brill's work is that price transparency tools represent genuine infrastructure opportunities in healthcare. Before Brill's TIME piece, transparency was mostly a niche concern. After Brill, became a federal regulatory priority. The Trump administration's hospital price transparency rule, which requires hospitals to publish payer-negotiated rates, w direct response to the public outrage that Brill helped generate. The transparen coverage rule, which requires insurers to publish machine-readable files of nego rates, followed the same logic.

Now we're in an environment where pricing data is theoretically available but practically unusable for most consumers. The machine-readable files are massive poorly structured, and inconsistent across payers. Hospital chargemaster files ar published but not linked to quality metrics or consumer-friendly descriptions. T creates an opportunity for technology companies that can aggregate, clean, norm and present this data in ways that actually enable consumer decision-making.

But here's the challenge, and it's one that Brill doesn't fully address. Price transparency only matters if it changes behavior. And changing consumer behav healthcare is incredibly difficult. Most people don't shop for healthcare even wh price information is available. They rely on their doctor's recommendations. The to the closest hospital. They prioritize access and perceived quality over price. S can build the world's best price transparency tool and still struggle to demonstr ROI to payers or employers who are footing the bill.

The companies that have found traction in this space have typically done so by embedding transparency tools into decision points where consumers are already engaged. Like in the insurance plan selection process or in scheduling workflow prescription fulfillment. Standalone transparency apps that ask consumers to proactively shop for care have mostly failed to achieve meaningful utilization. T lesson for investors is that distribution and user experience matter as much as d quality. You need to meet consumers where they already are rather than asking t to develop new shopping behaviors.

There's also a business model question. Who pays for transparency? Self-insurec employers are the obvious answer because they have direct financial incentives t reduce spending. But selling into employers means long sales cycles and a fragm market. Insurers are another potential customer but they have mixed incentives around transparency since it can reduce their negotiating leverage with provider Direct-to-consumer models struggle with the classic healthcare challenge that t person consuming the service isn't the one paying for most of it.

What Brill's work suggests is that transparency is necessary but not sufficient. T real value comes from coupling transparency with navigation and care managem Telling someone that hospital A charges half what hospital B charges is useful, b helping them understand whether the quality is comparable and whether their d has privileges at hospital A and whether the timing works with their schedule is where the actual behavior change happens. This is why companies like Castlight Health pivoted from pure transparency plays to broader employee engagement platforms. The data is table stakes. The value is in the actionable guidance.

Investment Thesis Two: Alternative Payment Models and Risk-Bearing Entities

Brill's critique of fee-for-service payment is implicit throughout both the TIME and the book. The chargemaster madness he documents is partly a function of hospitals being paid for volume rather than value. Every test, every drug, every procedure generates revenue. There's no financial incentive to provide less care or cheaper care, only more care. And because price signals are broken, there's no m mechanism to constrain this behavior.

The ACA included some gestures toward alternative payment models, most nota the Medicare Shared Savings Program and the Center for Medicare and Medicai Innovation, which got broad authority to test new payment approaches. But as B documents, these were add-ons rather than fundamental reforms. Fee-for-servic remained dominant. The hope was that demonstration projects would prove out based models that could then be scaled, but more than a decade later we're still world where the vast majority of healthcare reimbursement is fee-for-service.

For investors, this creates interesting opportunities around building risk-bearin entities. If you believe that fee-for-service creates bad incentives and that capita or value-based payment creates better incentives, then you want to invest in organizations that can successfully take on risk. This could be value-based prim care companies like Oak Street Health or ChenMed. It could be specialized risk-bearing providers in areas like oncology or musculoskeletal. It could be technolo platforms that enable traditional providers to manage risk more effectively.

The challenge is that taking on risk is capital-intensive and operationally compl You need actuarial sophistication to price risk accurately. You need care manage infrastructure to control costs. You need provider networks that are aligned wit cost-containment goals. You need data systems that can track utilization and ide high-risk patients. Most early-stage startups don't have these capabilities, which

means alternative payment model businesses tend to be better suited for growth equity or even buyout strategies rather than early-stage venture.

But there are technology enablement opportunities. Building software that help: providers manage capitated populations. Building analytics tools that predict ris identify care gaps. Building patient engagement platforms that improve medicat adherence and reduce avoidable utilization. These are all venture-backable busi that sit adjacent to the alternative payment model opportunity without requirin company itself to bear insurance risk.

What Brill's work underscores is that payment model innovation has to contend incumbent resistance. Hospitals make money from fee-for-service. Specialists m money from procedures. Device manufacturers and pharmaceutical companies n money from volume. Any shift toward value-based payment threatens these reve streams, which means you're going to face opposition from powerful lobbies. Th successful companies navigate this by aligning with payer incentives and demonstrating clear cost savings while somehow not pissing off providers so mu that they refuse to participate in your network. It's a narrow path and most com fail to walk it successfully.

Investment Thesis Three: Consumer-Directed Healthcare and Decision Support

One of the implicit themes in Brill's chargemaster exposé is that consumers are getting screwed because they lack agency in healthcare transactions. They don't prices. They can't evaluate quality. They're dealing with acute medical situation where their bargaining power is essentially zero. This suggests a need for consu directed healthcare tools that empower patients to make better decisions and ad for themselves.

But consumer-directed healthcare has a mixed track record. High-deductible he plans coupled with health savings accounts were supposed to make consumers n

price-sensitive and drive down costs through competition. The evidence suggest hasn't really worked. Consumers don't shop. They just delay care or skip it entir which can lead to worse health outcomes and higher downstream costs. So simpl giving consumers more skin in the game doesn't solve the problem Brill identifi

What might work better is decision support tools that help consumers navigate complexity. Apps that help you find the right specialist for your condition based quality data and cost data and network status. Platforms that help you understa your insurance coverage and what you'll actually owe out of pocket before you re care. Chatbots or nurse lines that provide triage and care coordination. These ar about making consumers more price-sensitive and more about reducing informa asymmetry and helping consumers avoid low-value care.

The challenge is that consumer-facing digital health tools have famously struggl achieve sustained engagement. People don't wake up in the morning excited to interact with their healthcare app. They engage episodically when they have an immediate need and then churn. This makes it hard to build defensible business with strong unit economics. The companies that have succeeded tend to be emb in employer or health plan workflows or they're attached to a high-engagement s like primary care or chronic disease management.

What Brill's work suggests is that consumer empowerment in healthcare require addressing both information asymmetry and power asymmetry. Giving consume pricing data is helpful but insufficient if they're dealing with providers who hav market power and no incentive to compete on price. Giving consumers quality d helpful but insufficient if quality is difficult to measure and communicate in wa that are actionable for lay consumers. The real opportunity is in building end-to platforms that combine information, decision support, and access to alternative delivery models that are actually lower-cost and higher-quality than incumbents

The Brill Framework: What Entreprene Get Wrong About Healthcare Reform

Here's what I think a lot of healthcare entrepreneurs misunderstand when they r
Brill's work. They see the dysfunction he documents and they think the solution
obvious. Build a transparent marketplace. Enable direct contracting. Cut out the
middlemen. Use technology to route patients to high-value providers. These all s
great on a pitch deck. The problem is that they underestimate the structural bar
and incumbent resistance that Brill's work actually reveals.

The lesson from America's Bitter Pill is that healthcare reform happens through
compromise and accommodation with incumbents, not by blowing up incumben
business models. The ACA preserved and even strengthened the role of private
insurers. It brought more revenue to hospitals. It avoided price controls on drug
This wasn't because Obama and his team were stupid or captured. It was becaus
achieving consensus for any reform required not threatening the core economic
interests of powerful stakeholders.

This doesn't mean disruptive business models are impossible. But it does mean t
require either massive capital and long time horizons or else they need to find w
align with rather than oppose incumbent interests. Amazon's healthcare moves a
interesting partly because Amazon has the capital and patience to play a long ga
and the market power to credibly threaten incumbents. Most startups don't have
those luxuries. So they need to be more surgical about where they intervene and
they position themselves.

The companies that have scaled in healthcare are often the ones that solved
operational problems for incumbents rather than trying to replace incumbents.
built software for pharmaceutical companies. Flatiron built oncology data
infrastructure for providers and life sciences companies. Commure is building
horizontal infrastructure for health systems. These businesses succeed by makin
incumbents more efficient or more profitable, not by cutting them out of the val
chain.

Brill's work also shows why policy entrepreneurship matters. The price transpar
regulations that now exist are partly a result of public outcry that Brill's journal
helped generate. The No Surprises Act, which protects patients from surprise m

bills, was likewise a response to the kinds of stories Brill told. Entrepreneurs wh
understand policy dynamics and actively engage in advocacy can shape the regul
environment in ways that create tailwinds for their businesses. This is table stak
healthcare in a way that it isn't in consumer software or enterprise SaaS.

The other thing entrepreneurs get wrong is underestimating how long change ta
healthcare. Brill's TIME piece came out in 2013. It's been over a decade.
Chargemasters still exist. Hospital pricing is still opaque for most consumers.
Uninsured patients still get hit with catastrophic bills. The structural problems
identified remain largely unaddressed. This is frustrating if you're a patient or a
policy advocate. But if you're an investor, it means the market opportunity is du
You don't need to rush. You need to build something sustainable that can comp
over time as regulatory and market conditions slowly evolve.

Conclusion: Building Businesses in Bril Shadow

Steven Brill's healthcare journalism matters for angel investors because it provic
rigorous diagnostic framework for understanding why American healthcare is so
expensive and dysfunctional. The chargemaster investigation exposes pricing op
and information asymmetry as core market failures. The ACA chronicle reveals
incumbent capture constrains reform and preserves rent-seeking behavior. Toge
these works explain why healthcare represents both enormous market opportun
and enormous execution risk.

The investment theses that emerge from Brill's work are straightforward but dif
to execute. Price transparency is necessary infrastructure but requires creative
business models to monetize. Alternative payment models create better incentiv
require operational excellence and capital intensity that make them challenging
early-stage companies. Consumer empowerment tools can reduce information
asymmetry but need to be embedded in high-engagement workflows to achieve
utilization. All of these opportunities remain relevant in 2025 because the under
structural problems Brill diagnosed have not been solved.

What makes Brill's work enduringly valuable is that it refuses to accept healthca
dysfunction as inevitable or natural. The chargemaster prices he exposed aren't
result of market forces or clinical necessity. They're the result of regulatory capt
market power, and opacity. The ACA's compromises weren't the only possible
approach to expanding coverage. They were the politically expedient approach g
the lobbying power of hospitals, insurers, and pharmaceutical companies.
Understanding these dynamics is essential for any entrepreneur or investor tryir
build businesses in healthcare.

The companies that will succeed in this space are the ones that understand both
opportunity and the constraints. They see the market failures Brill documented
they build technology to address them. But they also understand the political
economy of healthcare reform and they navigate incumbent interests rather thar
simply opposing them. They have realistic timelines and they build sustainable
businesses that can compound over years or decades as the regulatory environme
slowly evolves. They're simultaneously idealistic about the change they want to c
and pragmatic about the path to get there.

Brill showed us that healthcare pricing is broken. He showed us that reform is
constrained by incumbent power. He showed us that the dysfunction is not accic
but is instead the predictable result of how our healthcare system is structured a
regulated. For investors willing to take the time to understand these dynamics, t
opportunities are enormous. But they require patience, sophistication, and a
willingness to engage with the messy reality of how change actually happens in
American healthcare. The companies built in Brill's shadow will be the ones tha
real problems for real customers while navigating the complex political economy
thoroughly documented.

1 Like • 1 Restack

Previous

Nex

Discussion about this post

Comments Restacks

Write a comment...

© 2026 Thoughts on Healthcare · Privacy • Terms • Collection notice
Substack is the home for great culture