



LEADING TO WIN · JULY 2026 · CRUCIBLE HEALTH

The Moat Question Every Healthcare CEO Should Answer This Quarter

AI is collapsing the cost of building healthcare software. Without a distribution, data, or labor moat, incumbents and new entrants alike are vulnerable.

OpenEvidence has fewer than 100 employees. This year, 300 million Americans will be treated by a physician who used its clinical-decision-support tool [1]. The company doubled its valuation to roughly \$12 billion after closing a \$250 million Series D in January [2]. Meanwhile, Cursor — an AI code editor — hit \$1 billion in ARR with about 300 employees, producing roughly \$3.3 million in revenue per head [3].

These are not healthcare companies in the traditional sense. But they are the template for what is coming at healthcare incumbents: small, AI-native teams that build fast, ship faster, and carry almost none of the staffing overhead that defines legacy vendors. The implications for thousands of technology and technology-enabled services companies selling to providers are severe. If you do not hold a distribution moat, a data moat, or a labor moat, your company is at risk of being displaced — not in five years, but now.

The structural vulnerability

Healthcare is a \$5.3 trillion sector, \$2.9 trillion of which is labor [4]. It is the most labor-intensive industry in the U.S. economy [5]. That concentration creates enormous surface area for AI substitution — and for the startups building the tools that enable it. In the upcoming July–August 2026 Harvard Business Review article describes what is happening as a "second great compression of entrepreneurship," in which the cost, time, and headcount required to build and test a product "have all collapsed" [6]. Small startups, the authors argue, can now enter markets "at a pace and cost structure that challenges incumbents to reimagine their operating models" [7].

Healthcare incumbents are particularly exposed. They carry legacy technical debt, legacy staffing overhead, and — critically — are often too slow to respond when customers need modifications. Epic Systems is the clearest example of what a durable moat looks like in this market: 43.7% of acute care hospitals, 56.9% of beds, and a net gain of 568 hospitals since 2021 [8]. Every large health system that made an enterprise-wide EHR decision in 2025 chose Epic [9]. That is a distribution moat so deep that even Oracle, which paid \$28.3 billion for Cerner, has watched its customer base erode for three consecutive years [10]. The lesson is not that Epic is unbeatable. The lesson is that without a moat of comparable depth — in distribution, in proprietary data, or in an embedded labor relationship — you are exposed.

The new entrants are already here

U.S. digital health startups raised \$14.2 billion in 2025, up 35% from the prior year, with AI-enabled companies capturing 54% of total funding [11]. The Y Combinator landscape alone tells the story: LunaBill automated 50,000-plus insurance-claim follow-up calls and signed partnerships with UC health systems and Mayo in its first months [12]. Prosper's AI phone agents integrate with 80-plus EHRs and go live in three weeks [13]. Voquill is building an AI-native operating system for medical labs, explicitly targeting "the billions spent on legacy management systems" [14].

These companies are lean by design. Sapphire Ventures projects that by the end of 2026, at least 50 AI-native businesses will reach \$250 million in ARR [15]. Many will do it with headcounts that legacy vendors would staff in a single department. For context, Draper Associates partner Andy Tang told Fortune that the startups he spoke with last month are reducing engineering teams by a third, finding that investing in AI tokens produces three to five times the code for a fraction of the cost [16].

Health systems, meanwhile, are beginning to formalize how they manage the resulting vendor sprawl. Mount Sinai just deployed Signal 1's AI Management Platform to centralize governance and performance monitoring across its growing portfolio of clinical, operational, and administrative AI tools [17]. When a buyer starts building infrastructure to manage its AI vendor portfolio, the market is no longer experimental. It is operational — and the vendors that cannot prove ROI will be the first cut.

The CEO problem

Here is where the argument sharpens into a leadership question. The teams that will displace incumbents — and survive the wave of new entrants competing for the same contracts — will be the ones with the best people,

the sharpest strategy, and the most disciplined execution. Healthcare is unforgiving. The regulatory thicket, the payer complexity, the 18-month sales cycles — none of that goes away just because your product was built with a smaller team.

First-time founders face an 18% success rate, compared to 30% for serial entrepreneurs [18]. In healthcare technology specifically, the failure rate runs as high as 80% [19]. First-time CEOs and founder CEOs do not have time to learn on the job. Neither do their investors. Sutter Health CEO Warner Thomas made this point implicitly when discussing the planned Allina Health merger: his integration philosophy draws directly on his prior experience at Ochsner Health, where he learned how to combine cultures, retain clinical talent, and build operational credibility across state lines [20]. That kind of pattern recognition — knowing what breaks during an integration, knowing which executive hires matter in month three versus month twelve — is not something you read about. You earn it.

The honest tension

The counter-argument deserves airtime. Healthcare Dive reported in January that entrenched EHR vendors integrating AI into their existing offerings could pose a competitive threat to startups, precisely because EHRs are already critical to care delivery and represent "the path of least resistance" for health systems [21]. Not every AI-native entrant will win. Many will crash into the same walls that have always defined this market: long procurement cycles, clinician skepticism, and the sheer friction of changing workflows in a regulated environment. Seventy-six percent of healthcare leaders say their organizations are not prepared to implement AI at the speed required [22]. That gap is real, and it protects incumbents — for now.

But protection by inertia is not a strategy. It is a countdown.

What this means for operators

If you are running a healthcare technology or services company, the moat question is no longer academic. Can a team of 30 engineers replicate your core product in a few months using AI-assisted development? If the answer is yes — or even maybe — your competitive position depends entirely on your distribution relationships, your proprietary data assets, or the embedded nature of your labor force. Product alone will not save you.

And if you are a first-time CEO leading one of these companies — whether incumbent or insurgent — the most consequential hire you can make is not your next engineer. It is the operator who has done this before. There is a wealth of expertise among entrepreneurs who have already navigated healthcare's regulatory maze, survived its sales cycles, and built the teams that held together under pressure. They want to give back to the next generation. The question is whether the next generation is humble enough to ask.

The moat question does not wait for your next board meeting. Ask it now, and answer honestly.

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