

2026 IBI FORUM

The Case for a New Prevention Strategy

The research case for a doctor-led front door to prevention.



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Prevention keeps missing the people it's built for

2024

Navigating Workplace Well-Being Programs

Employers fund preventive and wellness programs, yet a third of employees think their employer offers none, and most never engage. Prevention that exists on paper isn't reaching people.

2025

Benefits Navigation as a Barrier

Employees who want to act can't find their way to care. A quarter get no help at all, and most turn to friends, family, or guesswork instead of a clinician.

2023–25

Healthcare Access & Utilization

When prevention doesn't happen, care gets delayed. Unmet mental health care rose by a third, absenteeism climbed, and the bill lands on the employer.

Every study finds the same failure: the system offers prevention, and nothing reliably connects people to it.

The prevention issue, in numbers

32%

of employees think their employer offers no well-being programs

Navigating, 2024

1 in 4

get no help at all finding their way to care

Benefits Navigation, 2025

66%

say better benefits support would raise their job satisfaction

Benefits Navigation, 2025

+33%

rise in employees who couldn't afford needed mental health care, 2021–23

Healthcare Access

12% → 17%

high absenteeism, 2020 to 2023

Healthcare Access

\$1,021

lost wages per person for six missed workdays

Healthcare Access

Prevention is not absent from the benefits; it is absent from people's daily lives.

How we built the paper

1

Peer-reviewed clinical research

The Porter study on the clinical day, plus research on what preventive visits find and set in motion, from Sanford Health, the Medicare population, and Deloitte.

2

Federal survey and expenditure data

MEPS, the National Health Interview Survey, and Health Care Cost Institute claims, for how spending concentrates and how access has moved.

3

IBI's own research

Our published surveys on whether employees know what's offered, how people navigate benefits, and delayed care and its cost to employers.

4

Traced and tested

Every figure traces back to a primary source, and we set a standard for what a preventive entry point has to do before weighing any option against it.

Grounded in published evidence and IBI's own workforce research.

What the evidence says about the preventive visit

8%

get all recommended preventive services in a year.
Nearly 5% get none.

MEPS, adults 35+, as of 2015

+75–127%

more likely to complete mammography, colonoscopy, and vaccination after a primary care visit

Sanford Health, 1M+ patients, 2020

–5.7%

total cost after an annual wellness visit, concentrated in the highest-risk patients

Controlled Medicare ACO study

What it finds and what it triggers point the same way.

A visit with a doctor surfaces risk that would otherwise go unfound, and gets people to the next step of care.

For an employer, the benefit lies in identifying risks before they become visible today and finding a pathway to proactive care.

Why prevention keeps failing, even when employers fund it

WHAT THIS PAPER COVERS

Why the gap persists

Programs exist on paper.
Access and time stop people
before they reach care.

What it costs

Skipped prevention returns
later as absence, disability
claims, and lost wages.

What would close it

A deliberate strategy that
connects people to prevention
instead of only offering it.

THE QUESTION FOR A BENEFITS LEADER

Are your prevention efforts actually reaching your population?

If the honest answer is no, a large share of your future cost is already unaddressed.

The question isn't if you've made an effort, but if prevention actually reaches those in need.

The U.S. spends more, yet prevention and outcomes lag

The numbers point to a system optimized for treating illness after it escalates.

5% / 95%

Only a small share of U.S. health spending is directed toward prevention; the rest follows illness, procedures, hospitalizations, emergency care, and administration.

6 in 10

Americans live with at least one chronic condition, accounting for approximately 90% of U.S. health spending.

41%

of U.S. adults report medical or dental debt, showing how the financial model can penalize people after they become sick.



Where spend accelerates

The site of care, procedures, and specialty drugs can materially change the cost of care.

SITE OF CARE + SURGERY

Common surgeries can cost 2–4× more in the U.S. without consistently better quality.

~1.5M hip and knee replacements in the U.S. in 2025

Average knee replacement cost: \$38K hospital; \$28K hospital-owned outpatient center; \$21.8K

Shifting the site of care can create significant savings for common surgeries

PHARMACY SPEND

Specialty drugs are accelerating faster than most consumers can absorb.

Drug spend increased 269% since 2000

Average specialty-drug cost rose from approximately \$18K to \$52K over 10 years

The U.S. pays roughly 3× more than other countries for many drugs

Out-of-pocket medication costs rose about 25% since 2020

Implication: prevention and trusted guidance matter because cost is shaped before — and beyond — the point of treatment.

THE PROBLEM

The structural imbalance in healthcare: the U.S. health system is acute-based



OVER

96%

of healthcare spending is on **acute-based services***

ONLY

8%

of ALL high-priority **preventive services get completed** by adults 35 years and older**

“*Our current system is designed to address medical fires, versus fire prevention.*

— Former CDC Director

*Peterson-KFF Health System Tracker and the Health Care Cost Institute both reported only 3.5% of healthcare spending in 2019 was for preventive services

**Agency for Healthcare Research and Quality (AHRQ) study published in Health Affairs (June 2018)



THE PROBLEM

This imbalance is well known. For over 20 years, most efforts to address it have focused on altering primary care

CHALLENGES TO ADOPTION



Direct Primary Care

- **Scaling** – significantly smaller patient panels
- **Capacity** – requires 3X more doctors



Virtual Primary Care

- **Complexity** – limited understanding of benefits makes choosing difficult
- **80%** of primary care still needs to be brick and mortar



Value-Based Contracting

- **Conflicting incentives** make transitions difficult

BOTTOM LINE

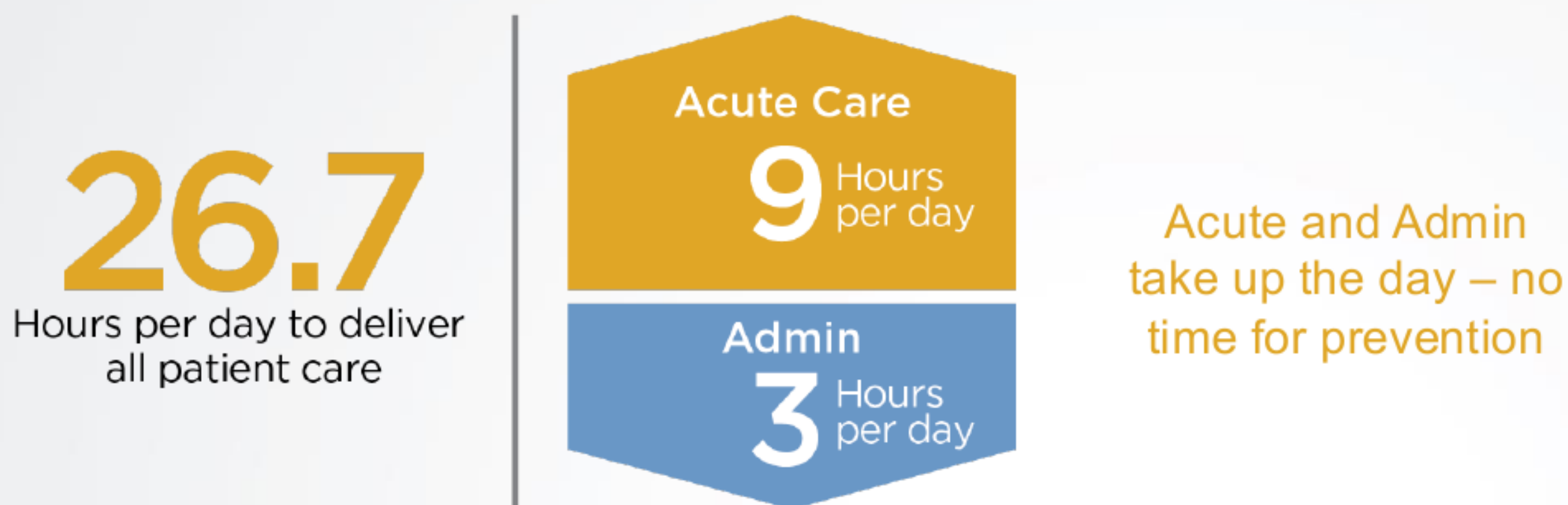
All these models have shown some positive results, and while pros and cons exist for each, the reality is that adoption is very slow and not changing any time soon.



THE PROBLEM

Insufficient time is the biggest reason for the lack of prevention

University of Chicago, Primary Care Time Study, estimated 26.7 hours/day would be required to deliver all patient care guidelines per day*



OUR REALITY

The health system and primary care do not have the time to impact prevention. The vast majority will have to be delivered outside the health system.

*2022 University of Chicago study, "Revisiting the Time Needed to Provide Adult Primary Care," published in the Journal of General Internal Medicine



THE PROBLEM

The “front door” for health is the doctor

Unfortunately, because of the urgency and demands of **acute issues** and limited time, the “front door” for **prevention** is effectively closed.



Open for acute care

These issues cannot wait.



Effectively closed for prevention

Significantly delayed access removes it from our focus and attention.



THE PROBLEM

The prevention deficit is not a philosophical, moral, or compensation issue for doctors — it is a math problem

THE AVERAGE PRIMARY CARE PRACTICE

~2,500

patient panel



~30

visits per day



~1

checkup per day,
because 96% of visits
are acute based



~6%

of the panel per year
1 checkup/day = 150/year

To reach 50% of the panel, it would take

8+ years

“It is not even close.”



Health plans offer many programs and solutions, but low engagement* makes it virtually impossible to impact prevention

Reasons for low engagement — strategy and survey research show:

01



Self-diagnosis is required

Employees state that “self-diagnosis,” which is extremely difficult to accomplish, is essentially a requirement to engage in support and prevention programs.

Ideally, employees would only need to know about programs that apply to them.

02



There is no “front door”

There is no standard, easy entry point for prevention.

*May 2024, Integrated Benefits Institute (IBI) – Navigating Workplace Well-Being Programs, Sera-Leigh Ghouralal, PhD; December 2025 – IBI – Benefits Navigation as a Barrier, Carole Bonner, PhD, MSAS, MSAT



THE SOLUTION

Activate a new prevention strategy — you have already done the heavy lifting. Only two no-cost steps remain



1 Establish & activate a standardized, doctor-led “front door” for prevention

- Removes the requirement of “self-diagnosis” to engage
- People are familiar with seeing a doctor to identify their health issue and being guided to what is personally relevant to address it
- PathFinder Health activates the “front door” using an existing covered benefit — the “Checkup with the Doctor” — with no new incremental PMPM

2 Communicate the strategy independently

- Critical step, due to significant communication fatigue* caused by heavily marketed benefit programs that members perceive do not apply to them
- This is effectively an expansion of the network
- Use a universal, simple message:
“We are providing easy access to a no-cost, doctor-led ‘front door’ for prevention, so you can discuss and understand your potential health risks with a doctor instead of figuring it out yourself.”

*May 2024, Integrated Benefits Institute (IBI) – Navigating Workplace Well-Being Programs, Sera-Leigh Ghouralal, PhD; December 2025 – IBI – Benefits Navigation as a Barrier, Carole Bonner, PhD, MSAS, MSAT



THE SOLUTION

PathFinder creates value by uniquely carving out and optimizing the checkup with a doctor — the true “front door” of prevention



**Intentional
focus drives
significant
value**



Partnering with the entire ecosystem

Creates a non-competitive environment with primary care and prevention programs — **we don't step into their core service; we direct participants to their services**

An easier decision to start than options that require some type of self-diagnosis



Increased engagement

One-on-one conversation with a doctor allows for highly personalized guidance

Over 70% of high- and moderate-risk members identified in the checkup engaged in support programs



Increased prevention*

Checkups produce **2x** more vaccinations, **2x** more colonoscopies, **2x** more mammograms

Cancer detected by preventive screening costs **33%–50% less** within 12 months, with significantly higher survival (BCBSA)**

Annual checkups associated with a **45% lower** hazard of all-cause mortality***



Return on investment

250%+ return — independent third-party determination

All major carriers — no copay, deductible, or out-of-pocket; actuarial analysis shows high return

*Increase utilization of evidence-based preventive health measures, Hostetter et al. BMC Family Practice (2020)

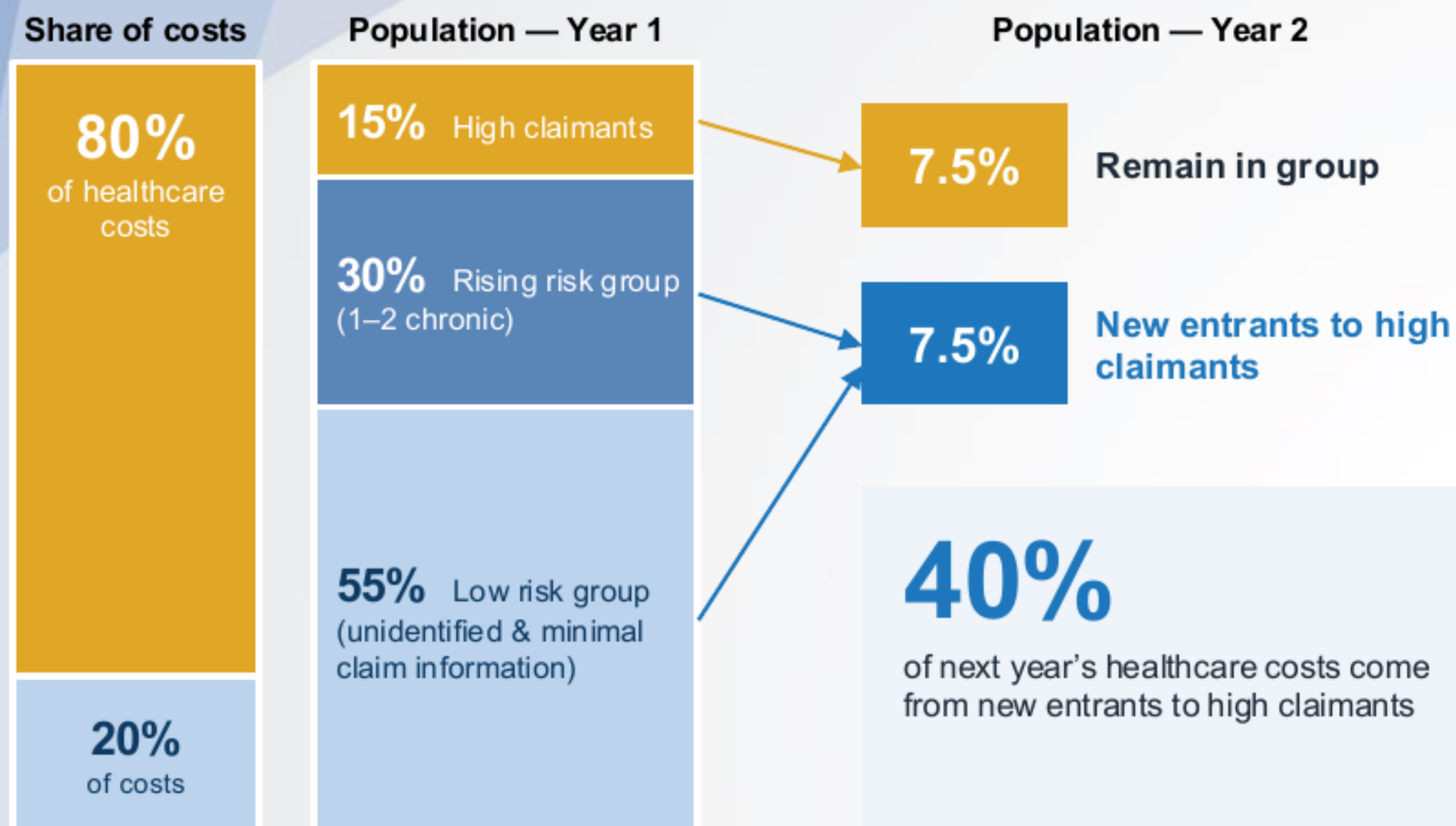
**Improving Clinical Outcomes Through Access to Timely Cancer Screening: Evidence from Blue Cross and Blue Shield Members, January 2026

***A meta-analysis of annual physical examination and all-cause mortality, Pathak et al. Prev Med. 2022 August 161:107130



THE IMPACT

A new prevention strategy matters because it attacks 40% of next year's healthcare costs



CURRENT STRATEGIES TO ATTACK RISING & LOW RISK GROUPS

- **Disease management (DM)** — targeted at rising risk
- **Preventive programs** (e.g., MSK, EAP, coaching) — offered to all

THESE STRATEGIES FACE SIGNIFICANT CHALLENGES AND BARRIERS

- **DM engages only 1–2%** because of its telemarketing outreach and perception as an intrusion of privacy
- **Prevention programs struggle with low engagement** because employees perceive them as out of context and require self-diagnosis



THE IMPACT

This new prevention strategy overcomes the current barriers and challenges

OLD BARRIERS

Impersonal outreach

Self-diagnosis required

Communication fatigue



NEW PREVENTION STRATEGY

Covered members choose the checkup — an easy, high-value decision

Talking with the doctor eliminates the self-diagnosis requirement

The doctor personalizes and simplifies the messaging

This strategy opens the door to prevention and returns to a familiar process — the way it is supposed to be.



IMPLEMENTATION

Because of its simplicity, you can turn this strategy on practically tomorrow



No new point solution

Just an expansion of your health network

No new PMPM spend

No start-up costs



Open the “front door” to prevention

Simply activate your current, existing programs, and platforms in a new way.



Checkups on their schedule

Beneficiaries complete their preventive “Checkup with the Doctor” virtually — no waiting for an appointment in the current system.



Guided to funded services

The doctor guides them to the right preventive health services you have already funded, and drives personalized engagement into follow-up care.



Safe. Simple. Funded.



COMING SOON

Read the full research

IBI's white paper, "A New Prevention Strategy," will be published after the 2026 Forum.

It lays out the evidence behind today's discussion and what a working prevention strategy actually requires of an employer.

Find it at ibiweb.org



INTEGRATED BENEFITS INSTITUTE

WHITE PAPER

A New Prevention Strategy

Why preventive care doesn't reach most employees, and what would change that

Sera-Leigh Ghouraiat, PhD
Director of Research

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