Turning Insight Into Impact: How Payers Can Close Care Gaps and Bend the Cost Curve

The Challenge

Health care costs in the U.S. continue to outpace economic growth, rising more than 8% in 2024 and now accounting for 18% of GDP, a figure projected to exceed 20% within a decade. This trend exerts pressure on everybody, driving higher insurance premiums, increased out-of-pocket costs, and growing financial strain for individuals and families. Despite cost-containment efforts, affordability remains a major barrier to equitable access and quality care. Rising medication costs, especially for specialty drugs, further strain budgets for families and payers. For 2026, over one-third of insurer filings (125 of 312) request premium increases of at least 20%, underscoring the urgency of addressing affordability and care efficiency.

Traditional efforts to identify and close care gaps have failed to reverse worsening health outcomes. Preventable deaths are rising, and chronic conditions like diabetes and obesity are increasing across all populations. Meanwhile, 97% of healthcare data goes unused. Providers are drowning in data but starving for actionable insights. Despite significant payer investments in analytics and care management, Medical Loss Ratios (MLRs) continue to climb. The core issue? **Critical information still isn't reaching the right people at the right moment when decisions are made, and care is delivered.**

Primary care physicians often fly blind. They see only what's in their own EMR and can miss critical data like overdue screenings, unresolved referrals, and social barriers. While payers may have valuable data, it's often delivered in fragmented formats outside the clinical workflow or buried in the EMR, making it hard for PCPs to access, trust, and/or act on at the point of care. The result? Persistent gaps, rising costs, and frustrated members.

What Is Happening Today

Health plans generate enormous amounts of data. Much of this data can identify clinical gaps and sometimes social care gaps. Yet these insights rarely reach the doctor during a member visit. Care managers may see the data, but they cannot act in real time.

Despite the growing availability of payer-generated insights on clinical care gaps, unmet social needs, and open referral loops, PCPs often struggle to use this information because of how and where it is delivered. Data is frequently housed in fragmented reports sent outside the clinical workflow through portals, faxes, or spreadsheets, making it hard to reconcile with the member's record at the point of care. Even when integrated into the EMR, care gap alerts are often buried, surfaced inconsistently, or lack actionable next steps. As a result, PCPs and specialists frequently distrust the accuracy or timeliness of this data, especially when it conflicts with the chart. Combined with alert fatigue and time pressure, many providers see these interventions as administrative noise rather than clinical support, which undermines their effectiveness and contributes to persistent gaps in care.

Plans often respond with incentive or outreach programs, but these initiatives are typically evaluated in silos and fail to reach the high-cost, high-risk members who need them most. Treating care gaps as separate tasks rather than connected health priorities limits both effectiveness and return on investment.

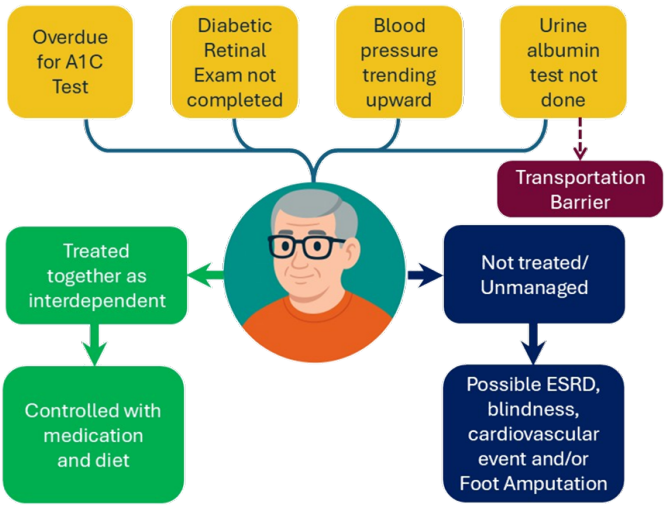
The best moment to address these gaps is when the member is sitting in the exam room. If the doctor does not know the member missed a diabetes check, for example, or needs help getting to appointments, the opportunity is lost.

What is Needed?

Real-time visibility so PCPs can act during the visit to close care gaps faster and more completely, close referral loops more reliably, get the member themselves involved in their own care plan, and improve satisfaction. This includes:

- **Clear, concise summaries** of open care gaps, missed referrals, and unmet social needs put at the PCP's fingertips within the EMR workflow (also surface to the payer's care manager).
- **One-click actions** to order tests, schedule follow-ups, or connect members to community resources.
- **Ongoing status monitoring of open care gaps and referral loops** done by the care manager between member visits with the PCP.

Why It Matters to Address Gaps in an Integrated Manner Together



Consider a 62-year-old male health plan member with type 2 diabetes who is overdue for an A1C test, has not completed a diabetic retinal exam, and has skipped a urine albumin test despite early signs of chronic kidney disease (CKD). Recently, his blood pressure readings have also been trending upward, suggesting possible hypertension. Within payer workflows, these appear as four separate care gaps tied to distinct quality measures. In reality, they are clinically interconnected: poor glycemic control accelerates kidney damage, which heightens cardiovascular risk; uncontrolled blood pressure compounds renal decline; and undetected retinopathy can lead to vision loss, impairing medication adherence and self-care.

Adding another layer, the reason he missed the urine albumin test wasn't clinical, it was social. He lacks reliable transportation, a common Social Determinants of Health (SDoH) barrier that prevents timely lab visits. If this need goes unaddressed, the clinical gaps will compound, pushing him toward end-stage renal disease, blindness, or even a cardiovascular event. Conversely, if his physician can connect him to a community-based organization that provides transportation assistance, that single intervention could unlock access to all referrals and pending tests stopping the downward spiral before it begins.

By surfacing these clinical and social gaps together in a coordinated view, payers enable whole-person care rather than fragmented encounters. Physicians intuitively recognize these relationships, but payer systems rarely capture them, resulting in missed opportunities for preventive action. Treating care gaps as part of an integrated continuum, including SDoH, improves quality scores, reduces downstream costs, and strengthens member engagement, turning clinical insight into strategic advantage.

Make Data Actionable at the Point of Care

To truly bend the cost curve, payers must do more than collect data. They must make it actionable for doctors *inside* their workflow. This means giving PCPs a clear summary of open gaps, missed referrals, and social needs, along with one-click options to order tests, send referrals, or connect members to community resources together all in a summarized view and in the EMR workflow. These tools should work during the visit, not later, and should not require searching through multiple systems.

New technology makes this possible. Standards such as FHIR (Fast Healthcare Interoperability Resources) allow payers to share data securely with EMRs. Smart applications can display concise, prioritized actions right in the doctor's screen. Artificial intelligence can summarize complex information and suggest next steps. When doctors and care managers see the same information and can act immediately, gaps close faster, and outcomes can improve drastically.

The Financial Opportunity

Closing care gaps isn't just about improving member health, it's a financial imperative. As an example, for a health plan with 4 million members, addressing care gaps and referral loops in this manner could conservatively unlock over $300 million in savings annually (see figure 2). For large national payers, the opportunity scales to $ billions. These savings won't materialize overnight, but they also won't take as long as many payers might think. The business imperative is clear: **organizations that prioritize long-term value over short-term stock performance and financial results will reverse the current cost trend and gain a decisive first-mover advantage.** Acting now enables payor leadership teams and boards of directors to achieve measurable results sooner than expected, positioning themselves as market leaders in health outcomes and long-term financial performance.

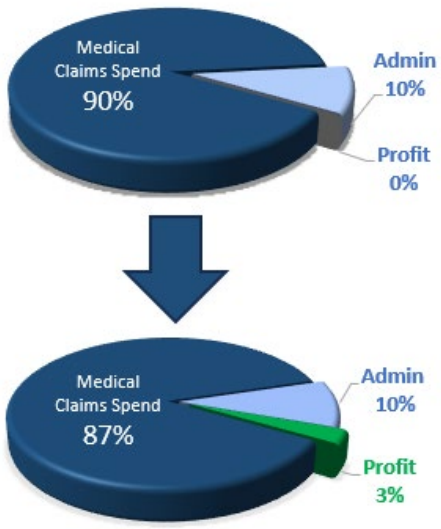


Figure 1: What improved patient outcomes translate to reduced medical spend and increased profit for payers

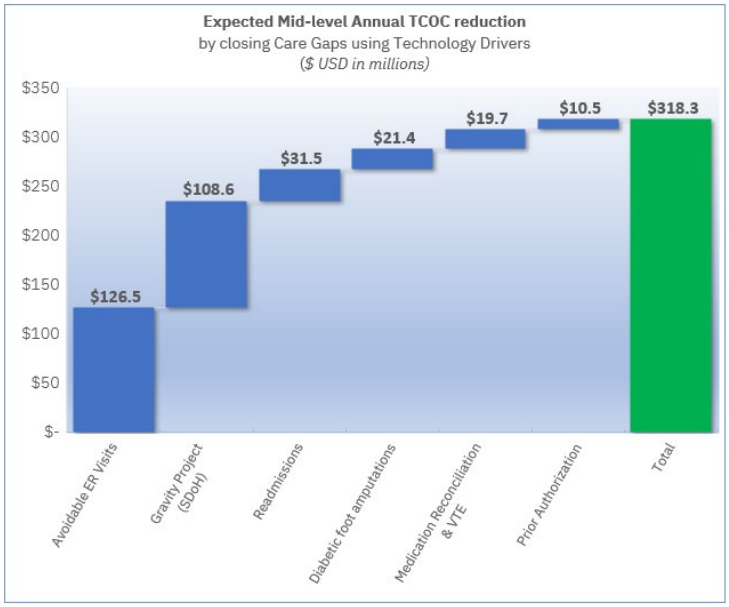


Figure 2: Example of modeled annual savings for mid-sized payer with assumed four million members

Figure 1 illustrates this bending of the cost curve when both health and social care gaps are integrated to drive better overall outcomes while reducing MLR. Figure 2 shows the financial modeling completed with data and input from industry experts to reflect the types of cost reductions that can be realized by closing health and social care gaps and referral loops, for this example mid-sized payer.

Key Steps for Payers

To make this happen, payers need a coordinated approach built on seven essential actions that work together to improve outcomes and reduce costs. Each step tackles a key barrier in today's healthcare system and enables PCPs to deliver whole-person care more effectively. While many organizations are implementing parts of what's needed to address whole person care, all seven components are essential to achieving better outcomes and meaningful cost reductions.

1. Aggregate Member Data (Longitudinal Patient Record)

Bring together claims, clinical records, and social needs into one comprehensive view. This unified data helps PCPs understand the full context of a member's health and make informed decisions during the visit.

2. Identify and Monitor Gaps in Care and Open Referral Loops

Track missed screenings, chronic care gaps, and open referrals in real time. This ensures that no opportunity for preventive or follow-up care is missed.

3. Use Predictive Analytics to Stay Ahead of Risks

Combine clinical and social data to identify members at risk before problems escalate. Early identification allows for proactive care and reduces costly emergency interventions. It helps to suggest potential care gaps that haven't been formally identified yet.

4. Put Actionable Information at the Primary Care Physician's Fingertips

The introduction of AI into the member ecosystem provides the ability to consolidate multiple data inputs and deliver a concise summary directly in the EMR workflow, not buried in dashboards, so the doctor can act during the visit. This enables timely interventions and improves care efficiency. The Smart on FHIR application in the EMR workflow will be accessible from within the respective EMR marketplaces.

5. Equip Care Managers with the Same Insights as the PCP

Ensure payer care managers see the same prioritized gaps to support follow-up and care coordination. The Care Manager can monitor and act between PCP visits to make sure the doctor's care plan is followed and referrals are completed. This creates a unified care team working toward the same goals.

6. Seamlessly Connect Members to Community Resources

Address SDoH like food, housing, and transportation through trusted local organizations. This helps remove barriers to care and supports long-term health outcomes.

7. Align Incentives to Drive Action

Reward providers for closing gaps and completing referrals, not just for volume of services. Reward them now for closing the care gap and not have it tied to downstream savings that may occur one or more years down the road. Incentivize them to do the right thing now to ensure that the downstream benefits accrue to the payer. This encourages value-based care and ensures providers are motivated to improve outcomes. Rewriting value-based care contracts would not be required.

The Bottom Line

The United States has the highest medical cost per citizen of any country in the world. Despite breakthroughs in detection and treatment, the health of our population is not improving, and medical costs continue to rise. Data alone doesn't change outcomes. Action does. Action happens in the exam room. Until payers put actionable insights at the physician's fingertips, Medical Loss Ratios will stay flat or continue to rise, and members will keep falling through the cracks.

IBM, in collaboration with Infor and Unite Us, has introduced a next-generation model designed to solve all these challenges at scale. This integrated approach connects clinical care with social and behavioral health needs, creating a unified pathway that addresses the root causes of poor outcomes. For payers, the implications are significant: measurable improvements in quality scores, stronger member engagement, and potentially billions in savings through avoided complications and high-cost interventions. This is not incremental change, it's a strategic shift that positions payers to lead in delivering whole-person care, while driving sustainable financial performance.

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References

Avoidable Mortality Is Increasing Despite High Spending

- A March 2025 *JAMA Internal Medicine* study found that **avoidable mortality increased across all U.S. states between 2009 and 2021**, while comparable high-income countries saw improvements. The U.S. spends more but does not achieve better outcomes, suggesting systemic inefficiencies. [jamanetwork.com]

Premature Death and Chronic Conditions Are Worsening

- *America's Health Rankings* (April 2025) reported that the long-term decline in premature death reversed in the last decade, with a **22% increase between 2012 and 2022**. Chronic conditions like diabetes and obesity also worsened, rising to **11.5% and 34.3% prevalence in adults**, respectively. [https://www.americashealthrankings.org/learn/news/key-trends-provide-insights-into-americas-health-and-well-being-over-35-years]

What's Behind Rising Health Insurance Costs?

- Ortaliza, J., McGough, M., Vu, K., Telesford, I., Rakshit, S., Wager, E., Cotter, L., & Cox, C. (2025, August 6). *How much and why ACA Marketplace premiums are going up in 2026*. Peterson-KFF Health System Tracker. https://www.healthsystemtracker.org/brief/how-much-and-why-aca-marketplace-premiums-are-going-up-in-2026/