FEATURE

Consequences of Delayed Care

Written By Laura Carabello

Think back to when we were in the throes of the COVID-19 pandemic, navigating the stay-at-home orders, mandatory masking and social distancing. By June 30, 2020, the Centers for Disease Control and Prevention (CDC) estimated that 41% of U.S. adults had delayed or avoided medical care because of concerns related to the coronavirus.

While the fear of widespread disease has dissipated, multiple surveys document that waiting to receive medical care is not only detrimental to a patient's health but can also be extremely damaging financially. As conditions escalate, they can lead to more complicated surgeries, extended hospital stays, more medications, and higher costs for health plans.

There is a plethora of studies confirming this trend:

- A new survey commissioned by Imagine360 and conducted by Pollfish reveals 38% of insured Americans are still skipping care – even among the insured. They polled 2,500 adults between the ages of 18 and 64 who all had health coverage, 80% of them through an employer-sponsored plan. Researchers attribute the results to affordability concerns, including the high cost of medical care and prescription medications.

"As healthcare costs continue to rise at unaffordable rates, their impacts are far-reaching for American businesses and families," says Jeff Bak, CEO and president of Imagine360. "Businesses across the country are faced with the daunting task of either passing increasing healthcare costs to their employees or making significant cuts to other business expenses. The survey indicates that rising costs lead to Americans not accessing the care they need or leaving their place of employment to find affordable health benefits."

Jeff Bak

• A Harris Poll on behalf of the American Academy of Physician Associates (AAPA) reveals even more alarming issues: Adults in the US spend an average of 8 hours per month managing healthcare for themselves and their family/loved ones, with nearly half of those surveyed skipping or delaying care. On average, patients who cannot get an appointment in the same week wait 3.9 weeks for needed medical appointments.

- A joint study from Harvard T.H. Chan School of Public Health, the Robert Wood Johnson Foundation, and National Public Radio documented the challenges Americans faced in receiving healthcare over the past few years: 20% of U.S. adults postponed medical care or had no access to healthcare, and many said their doctor's office was too busy to see them. Others reported they didn't feel safe going to a doctor's office, and not surprisingly, 40% said financial barriers prevented them from seeking care. Some respondents simply expressed that they couldn't afford healthcare, while others struggled to find doctors who would accept their insurance.

A KFF Tracking Poll confirms all these findings: Skipping care due to costs can have notable health impacts.

- Nearly two in ten adults (18%) report that their health got worse because they skipped or delayed getting care.
- About four times as many adults under age 65 (23%) say their health got worse after skipping or postponing care.

These results further point to the cost of care as the leading reason that some adults skip or delay seeking services, with one-third (36%) of adults saying that they have skipped or postponed getting needed healthcare in the past 12 months because of the cost. Women are more likely than men to say they have skipped or postponed getting healthcare they needed because of the cost (38% vs. 32%).

And this just in from West Health–Gallup: their estimates show that nearly 70 million Americans delayed surgery or another medical treatment during the period studied. Forgoing care can allow health conditions to progress, with worsening ailments that may require more procedures, tests and medications. With increased demand for services, plan sponsors face higher premiums, and members encounter increased or out-of-pocket costs. These factors potentially lead some individuals to forgo coverage altogether and reinforce concerns that care will become less affordable without significant policy changes.

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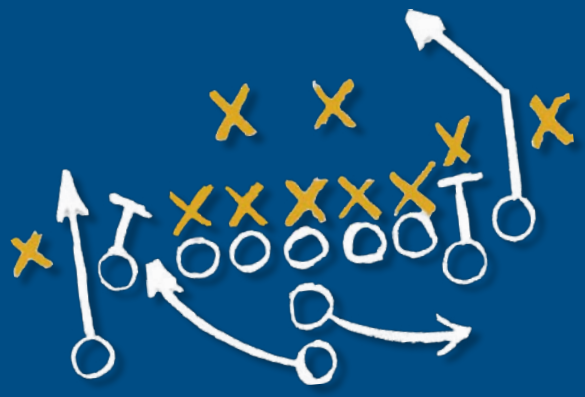

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Chris Harber

ROLE OF SELF-INSURED STAKEHOLDERS

Can employers, TPAs and brokers play a role in mitigating delayed healthcare? The answer is YES.

Chris Harber, chief operating officer, Vālenz Health®, affirms, "It starts with the first step: designing their benefits strategy. Health plan designs (as determined by self-insured employers, TPAs, and brokers) can incorporate member experience features that engage early and often to encourage members to receive timely, preventive care that mitigates delayed healthcare issues."

For example, members can use cost and transparency tools to find low-cost, high-value care options — choices for which they can receive cash or digital rewards to incentivize necessary care.


Ria Shah

"At the same time, data analysis can identify potential high-risk plan members for personalized outreach, at which point care navigation can be deployed to ensure treatment adherence for chronic disease management," suggests Harber.

Underscoring this perspective, Ria Shah, co-founder and chief product officer, Handl Health, says, "The exorbitant cost of care is perhaps the biggest reason consumers delay going to the doctor. But when cost-wary consumers put off preventive care, waiting for dire circumstances before seeking medical attention, that leads to further costs."

She says that in order to break out of this endless cycle of ballooning prices, it's imperative to focus on the brokers, TPAs and other parties that design employer-sponsored healthcare.

"The only way to bend the healthcare cost curve is to support these primary points of influence and decision making," says Shah. "This, in turn, encourages informed healthcare participation from consumers. And in order to make better healthcare decisions, TPAs and brokers need access to information that helps them maximize healthcare dollars."

A PHYSICIAN'S POINT OF VIEW

"As a physician, I see firsthand how delayed care affects patients long before it shows up as a high-cost claim," says Steven Hinitt, MD, MPH, national medical director, Premise Health. "Any perceived barriers to care, be they access to quality care or financial disincentives, can delay preventive care and early treatment."

Self-insured employers and their partners are uniquely positioned to encourage their employees to keep up to date with their healthcare needs by making primary care easier to access and more engaging for employees.

"When people can see a primary care provider easily, they're far more likely to keep up with preventive visits and screenings that, if put off, can have long-term effects," he continues. "By making care easy

for their people, employers can combat the costs of emergency and urgent care, specialty referrals, and reduce overall healthcare costs for both their people and the organization."

MISSED CARE HAS SERIOUS CONSEQUENCES

Delaying medical treatment, even for ostensibly minor ailments, can lead to immediate and serious health risks. An untreated infection, for example, can quickly spread and become systemic, potentially leading to sepsis, a life-threatening condition. Injuries such as fractures or concussions, if not promptly addressed, can worsen or lead to complications that may hinder recovery or cause permanent damage.

Physician specialists warn that time-sensitive conditions like heart attacks and strokes require rapid intervention to minimize damage to the heart or brain. Every minute is precious, and wasted time can translate into a greater extent of tissue death and a higher risk of long-term disability or fatality. The staggering toll of heart disease is palpable, not only in lives lost but also in hundreds of billions of dollars in lost productivity for U.S. workers and employers.

Survivors of heart attacks or stroke typically face mounting medical expenses that are not covered by traditional insurance, although a little-used workplace benefit — critical illness insurance — is positioned to close the financial gap. When an employee is diagnosed with serious conditions such as a heart attack, stroke, or certain cancers, this coverage provides a lump-sum payment that can be used for expenses, including living costs, lost income or travel for care. For those enrolled in high-deductible health plans, it helps offset out-of-pocket costs that might otherwise create financial challenges.

The sheer magnitude of consequences of delayed medical care is not just physical but can also include missed opportunities for early detection and treatment of diseases such as cancer, where long-term prognosis often significantly improves with early intervention. Experts estimate the delays in cancer screenings could lead to 10,000 colorectal (CRC) and breast cancer deaths over the next decade. The American Cancer Society reports that disruptions in CRC screening alone are projected to result in 4000–7000 excess deaths by 2040, although there has been a rebound that is unique to CRC screening, driven by increased stool testing, which may mitigate this impact.

Yvonne Lavan, RN, CCM, MedWatch executive director of Case Management, attests, "Many of today's most expensive claims share a common thread: a missed opportunity for early intervention. Delayed care allows silent conditions to progress, turning what could have been a simple, low-cost episode of care into a more severe, expensive event. Consequently, self-insured employers, TPAs, and brokers must prioritize earlier identification and proactive outreach in an effort to prevent conditions from spiraling."

She says that early identification becomes even more critical

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Yvonne Lavan

when managing chronic diseases, adding, "Conditions such as chronic kidney disease can progress gradually, often without significant symptoms in early stages, and when these conditions go undetected, employers often see increased absenteeism and reduced productivity long before a formal diagnosis is made. Early detection dramatically alters the course of care. For example, diagnosing chronic kidney disease at Stage 2 or Stage 3, instead of Stage 5, can mean the difference between manageable lifestyle adjustments and the need for lifelong dialysis or a transplant."

Lavan maintains that organizations that proactively analyze claims data can identify newly diagnosed conditions earlier and intervene before complications develop. At MedWatch, claims analysis is utilized to identify emerging diagnoses and patterns that may indicate a need for outreach.

"Early engagement allows care teams to educate members, encourage appropriate follow-up care, and help patients better understand their treatment options," she continues. "When individuals seek guidance during the early stages of their condition, they are often more likely to seek timely care and follow recommended treatment plans."

When patients are identified early and provided with education and support, Lavan says there may be opportunities to slow disease progression through lifestyle changes, dietary guidance and appropriate medical care.

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"These types of early interventions not only improve quality of life for the patient but also help potentially avoid or delay more complex and costly treatments," she concludes.

DANGERS OF SKIPPING MEDICATIONS

A recent poll from KFF reveals that about one in five adults (21%) say they have not filled a prescription because of the cost, while a similar share (23%) say they have instead opted for over-the-counter alternatives. About one in seven adults says they have cut pills in half or skipped doses of medicine in the last year because of the cost. A third of all adults say they have taken at least one of these cost-saving measures in the past year, including larger shares of women and those with lower incomes.

Surescripts confirms this trend, reporting that more than half of patients experience challenges when filling prescriptions and are uncertain about who to trust for prescription medication information or costs. Their new survey found that one in four patients has abandoned a prescription because it was too expensive.

Their leadership team points to price transparency and affordability as the major pain points as patients struggle to navigate prescription pricing. They maintain that getting clearer cost information before picking up a prescription would make managing medications easier for 36% of patients. However, only 26% discuss medication costs with their provider at half or more of their visits, and just more than half believe their needs are fully met in these conversations.

As with other access issues to medical care, prior authorization (PA) also plays a significant role in obtaining medications. The Surescripts survey showed 29% of patients who have filled a prescription in the past 12 months have experienced delays because of prior authorization. This number rises to 36% when patients take two or more prescription medications a day. The impact of these delays extends beyond inconvenience, with 13% of patients reporting that their health actually worsened because of delays caused by prior authorization processes.

Throughout the marketplace, there is consensus on this issue. Gary Becker, CEO, ScriptSourcing, says, "After four decades in employee benefits, I've seen how well-intended plan design can create unintended harm. When employers raise copays for higher-cost medications, the goal is to manage spend—but too often the result is delayed care: skipped doses, delayed refills, or prescriptions never started. That's medication non-adherence, and it drives worse outcomes, lower productivity and avoidable hospitalizations."

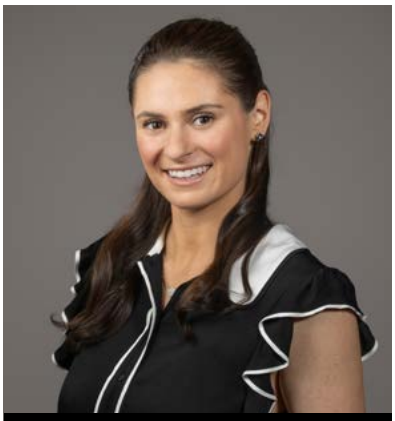
Gary Becker

Becker says delayed care often starts at the pharmacy counter as high copays turn 'take as prescribed' into 'make it last.'

"When copays rise on higher-cost meds, the plan may save on paper—but the member pays in health," he adds. "The best benefits strategy is one that protects the balance sheet and the person at the same time. Non-adherence isn't a character flaw—it's frequently a budget issue."

He says what's been most gratifying is how consistently this resonates across the organization: "HR leaders value the employee experience, CFOs appreciate the financial discipline, and benefit consultants recognize the clinical logic. Employers don't just care about dollars -- they care about people—and adherence sits right at that intersection."

Maris Becker, strategic initiatives and former member advocate, ScriptSourcing, expands, "Before I moved into strategic initiatives, I spent my first year at ScriptSourcing as a member advocate, talking every day


Maris Becker

with plan members on high-cost brand and specialty medications. Those conversations made "delayed care" feel very real. I heard people describe stretching doses, postponing refills, or trying to make a prescription last longer—not because they didn't believe in treatment, but because they were anxious about the next copay."

Maris says ScriptSourcing was built to solve that tension, helping employers reduce medication cost—often saving the health plan meaningfully—while giving members access at a zero copay voluntarily.

"I also heard the relief in their voices when they learned there was a path to zero-copay access for the medication their provider prescribed," she notes. "For many, removing the financial barrier didn't just improve adherence—it reduced stress and gave them confidence they could stay on therapy consistently. That's the consequence side of delayed care: it starts quietly at the pharmacy counter, and it can spiral into bigger health events that were preventable."

CONSEQUENCES BEYOND HEALTH

Glen Becker, national sales executive, ScriptSourcing, explains, "In my role, I speak daily with benefit consultants and employers—and while prescription cost control is always on the agenda, what stands out is how deeply leaders care about their people. HR executives, in particular, understand the real-world challenge of medication adherence when employees face high out-of-pocket costs. When a plan design unintentionally pushes members to delay refills or ration therapy, it doesn't just affect claims—it affects attendance, performance, and morale."


Glen Becker

Robert McCollins, chief community organizer, Employers Healthcare Alliance, emphasizes, "Delayed care is not just a healthcare issue, it is also a wage growth issue, a recruit and retain issue, a work comp issue and a culture issue," "The case is for more attention on PREVENTION than disease management -- prevention should be the focus and supported through data and the right programs for your work families."

The downside of diminished focus on preventive care or early diagnosis can have alarming results: "Stage 1 cancer becomes stage 3 or 4, prediabetes becomes diabetes, hypertension becomes a stroke or a heart attack, and minor orthopedic issues advance from physical therapy to invasive surgical cases," he explains.

McCollins stresses that early treatment translates into lower cost and more predictable spend, adding, "Delayed treatment equals catastrophic cost and claims volatility. Here's an example: Early diagnosis through colon screening costs about $1,500 - $2,500 vs. a delayed diagnosis of $250,000 - $1,000,000 expenditures. Also, stop-loss increases, lasers and declines to quote due to high-claims activity lead to increased premiums and higher frequency and severity of claims."


Robert McCollins

He points to the importance of strategic plan design to help address many of these issues:

- Prevention focus, not disease management focus.
- Direct Primary Care, On-site or near-site clinics.
- Patient advocacy and care support.
- Centers of Excellence or Providers of Excellence programs.

There is widespread agreement on these conclusions, as Chris Harber at Vālenz Health® observes, "We've seen the results in our claims data. In the last three years, Vālenz has seen a significant uptick in the volume of high-dollar claims that exceed $100,000. At the same time, we've seen an increase in distribution of those high-dollar claims across accounts, a trend that's accelerating rapidly and contributing significantly to the high costs borne by plans and the healthcare system today.

PRIORITIZING PREVENTION


Vanessa Guzman

Moving from deferment to engagement should be a strategic priority for 2026, as Vanessa Guzman, MS, ME, CPCHE, CEO & president, SmartRise Health, says, "Delayed care is the primary driver of the 9% healthcare cost increase projected for 2026. We advise viewing 'inaction' as a clinical risk. When members defer care due to cost or fragmented infrastructure, they trade low-cost prevention for catastrophic claims. Through a performance-based learning framework, we help employers identify risks early, avoiding the expensive interventions associated with advanced disease."

Guzman offers a strategic framework that includes:

- Cross-Sector Collaboration: We must leverage shared resources and competencies across healthcare, social, and private sectors. By convening these groups, we create a safety net that identifies at-risk members early.
- Empower Health Activism: Culturally resonant programs—like specialized women's health initiatives—transform passive members into proactive participants.
- Remove Barriers: We integrate precision nutrition via the Cena Health platform to treat food as a clinical intervention, improving adherence before a crisis occurs.

Dr. Hinitt fully endorses this approach, adding, "Simply put, preventive care helps people stay healthy and productive. It is critical to early detection and when people delay routine screenings or physical exams, conditions like hypertension, diabetes or cancer can progress unnoticed for years. When individuals don't receive the timely care they need, their health can worsen, increasing the risk of severe illness and leading to more complex, intensive and costly interventions later on."

He reaffirms the dedication of his organization to helping people get, stay and be well, noting, "This starts by improving access to high-quality primary care and avoiding delayed care. Through our advanced primary model that combines both in-person and virtual care, we reduce barriers caused by cost and convenience, build trusted provider relationships, and keep members engaged in their health."

Chris Harber at Vālenz Health® calls attention to the value of a comprehensive suite of Utilization Management, Case Management, and Disease Management solutions, engaging clients early and often to identify and guide high-risk members through their care journeys.

"Through personalized, intuitive care navigation support, our clinical teams empower members to make smarter decisions, which reduce unnecessary expenses and improve healthcare outcomes, especially for those with chronic conditions," he states. "With this proactive preventive support, Vālenz delivers a significant return on investment for our clients, minimizing the high costs associated with advanced disease and chronic conditions while protecting member access to high-quality care options."

THE AFFORDABILITY CRISIS

It appears that Americans are more worried about healthcare costs than gas or groceries, as the newest polling data from health policy research firm KFF raises the red flag even higher on the affordability crisis.

The report shows that more than four in 10 voters intend to cast their ballots with their health insurance bills top-of-mind this November, as financial strains caused by the tax credits' expiration are compounded by the rising price of insurance. Premiums for private insurance, like those offered by employers, have also been on the rise, increasing 6% or more for families during the last three years.

Further confirmation from KFF polling on the public's experiences with healthcare costs shows that just under half of U.S. adults say it is difficult to afford healthcare costs, and about three in ten say they or a family member in their household had problems paying for healthcare in the past 12 months. Additional findings include:

- Healthcare debt is a burden for a large share of Americans. In 2022, about four in ten adults (41%) reported having debt due to medical or dental bills, including debts owed to credit cards, collections agencies, family and friends, banks, and other lenders to pay for their healthcare costs.

- Those who are covered by health insurance are not immune to the burden of healthcare costs. Almost four in ten insured adults under the age of 65 (38%) worry about affording their monthly health insurance premium, and large shares of adults with employer-sponsored insurance (ESI) and those with Marketplace coverage rate their insurance as "fair" or "poor" when it comes to their monthly premium and to out-of-pocket costs to see a doctor.

The cost of care is clearly a primary driver of delayed care, but there are also other factors, as Chris Harber explains, "It's not just concerns over high costs that are driving delayed care; it's also member access to affordable care options in the first place. To remove these obstacles preventing many members from seeking timely, necessary care, Vālenz offers several proactive solutions that engage members early and often in their care journeys."

For example, he points to the launch of a Variable Copay solution that combines the comprehensive price transparency of the Vālenz Bluebook platform with easy-to-understand variable copay pricing. This guides

members toward lower-cost providers and facilities that have been proven to deliver higher-quality care — securing lower out-of-pocket costs for initial care and minimizing future costs caused by traditional fee-for-service-based care models.

Dr. Hinitt concurs, adding, "Cost concerns are an increasing barrier to timely care, including out-of-pocket expenses such as deductibles and copays, and financial personal costs associated with lab and imaging fees. When people are uncertain of the costs they will incur, they are more likely to put it off, even when symptoms are present."

Employers can remove financial obstacles by offering primary care that is low- or no-cost and designed around prevention and routine health maintenance services.

"When care is affordable and easy to access, members are more likely to seek it earlier, leading to better health outcomes and preventing avoidable high-cost events down the road," he emphasizes. "At Premise, we work with large employers and unions to deliver advanced primary care that removes barriers to access and cost concerns and encourages preventive services to help members seek care before it necessitates an emergency room visit or hospital admission."

He also explains the value of direct contracting in providing more affordable care: "What we see is that aligning the incentives between self-insured organizations and their healthcare partners leads to more affordable care for both the self-insured payor and the members seeking services."

Dr. Hinitt clarifies that many healthcare providers in the community are paid based on the number of patients they see, not the quality of care they provide, which negatively impacts patient experiences and outcomes.

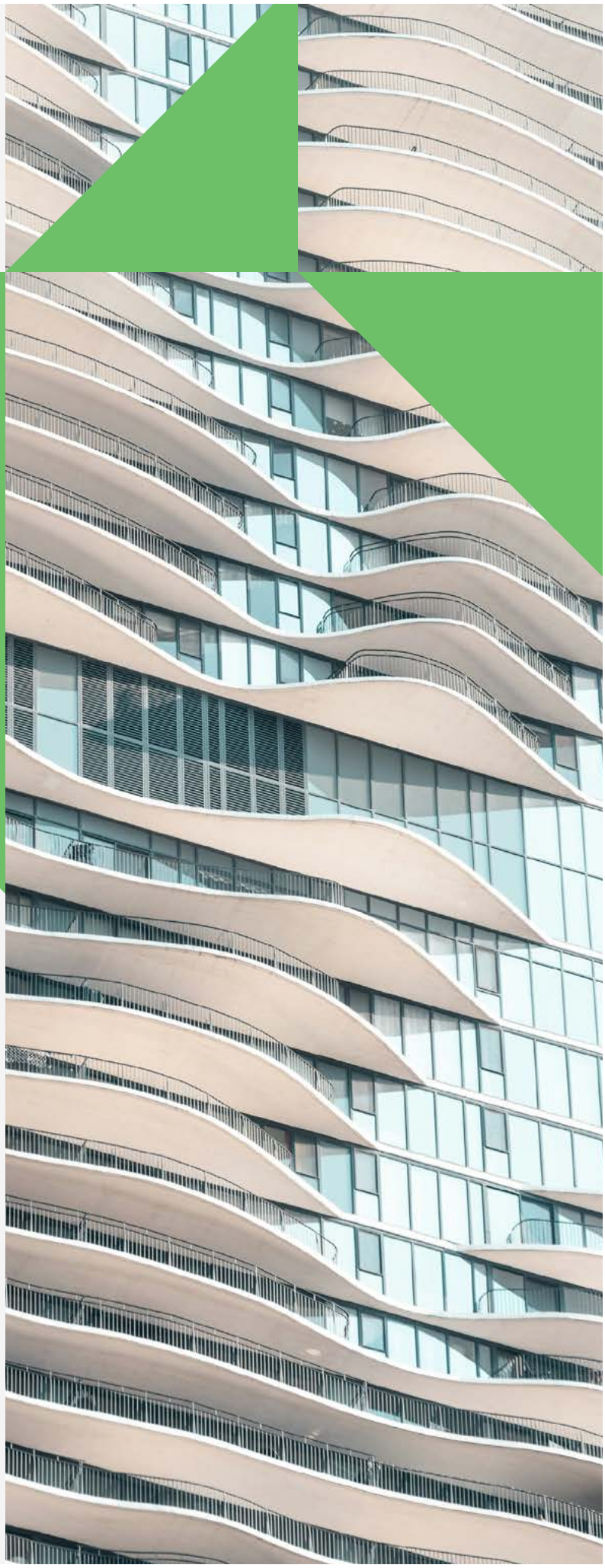
"Because Premise Health partners directly with employers, our providers can spend more time with members and build relationships, which means our members are more likely to seek care at an appropriate time, leading to fewer complications down the line and a decrease in potential ER visits and hospital admissions," he stresses.

In 2024, Premise Health completed a study of claims data for more than 207,000 members attributed to Premise, using methodology validated by Milliman. Those members saw less overall out-of-pocket spend as a result of better health, putting an average of $290 back in their pockets each year. They also spent 17% less time in the ER and 52% less time in the hospital, contributing to a lower total cost of care and improved productivity for employers.

ELIMINATING PRICE FRICTION

"In the United States, healthcare spending is projected to reach $5.6 trillion in 2026, yet 36% of adults report delaying essential care due to costs," reports Leonardo Pires Seib Corso, MBA, BSIE, CSM, SSGB, Operations Manager, BeniComp Health Solutions. "This 'prevention and care gap' is catastrophic for self-insured plans. Research indicates that 20% of those who delay care see conditions worsen, driving the 8.5% medical cost trend currently squeezing employer budgets."

Leonardo Pires Seib Corso



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Corso confirms that BeniComp IncentiCare disrupts this downward trajectory by eliminating the primary barrier to early intervention: financial friction.

"While traditional wellness programs struggle with 20-30% engagement, IncentiCare achieves an industry-leading 96% average participation rate through annual health screenings," he explains. "We accomplish this through high-value, outcome-based deductible incentives that empower members to lower their personal out-of-pocket costs by thousands of dollars.

He indicates that BeniComp is unique in the nation for the depth of data captured in a single population, integrating real-time biometric data with comprehensive claims (CPT, IC, etc.) and utilization review, allowing a full picture of the member's health journey.

"This enables our prevention health management teams to identify silent risks like hypertension early and intervene at the root cause," he continues. "This proactive approach protects both the member's long-term health and the plan sponsor's bottom line from the avoidable, high-cost consequences of delayed care."

PSYCHOLOGICAL IMPACT OF NOT SEEKING TIMELY MEDICAL HELP

The decision to delay medical care can also take a toll on mental health. The stress and anxiety of living with an untreated or worsening condition can lead to depression, anxiety and a sense of helplessness. This can create a vicious cycle where the psychological burden intensifies the physical health issue, further

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deterring the individual from seeking care.

Moreover, the regret of not acting sooner when symptoms first appeared can be a source of significant emotional distress. People may struggle with feelings of guilt or self-blame, which can impede their recovery and overall well-being.

Speaking from the perspective of a Managed Behavioral Healthcare Organization (MBHO) that operates alongside a TPA, often sharing or interacting with a shared technology platform, Myron Unruh, LPC, chief operating officer, MINES and Associates, Inc., says, "Our network access and supportive care navigation team work to schedule behavioral health appointments quickly by monitoring provider availability and closely connecting members with services. By focusing on these connection points, we often prevent the need for higher levels of care and ensure members see the right network provider. This is a central focal point of our care navigation team and reduces the dependence on acute care services in behavioral health."


Myron Unruh

Regarding affordability, he attests, "We advocate for low copayments and discourage high-deductible plans, acknowledging that healthcare can be unaffordable for many. Without accessible outpatient behavioral health services, clients are at risk for costly acute care or emergency room visits due to behavioral health needs. There is a strong correlation between behavioral and medical-surgical services, with costs escalating when behavioral health treatment is not affordable. Health insurance must be financially accessible for individuals to bring true value."

Unruh maintains that direct contracting results in more affordable care -- especially for behavioral health: "Direct contracting and MBHO carveouts can significantly reduce delays in access to care. Certain preventive services, such as employee assistance programs (EAPs), already provide low-cost, confidential access to mental health support without requiring employees to use their medical plan. This model shows how direct-to-provider contracting outside the health plan can remove financial and administrative barriers that often delay treatment."

Likewise, he believes that a carved-out MBHO operating within the health plan structure can further mitigate access delays by offering a dedicated behavioral health network, more focused care management, and faster appointment availability.

"Because MBHOs are solely concentrated on behavioral health, they typically maintain broader provider panels, shorter wait times, and more proactive outreach, all of which reduce the likelihood of delayed or unmet care," he says.

Unruh's team is focusing on preventive health measures that can help identify issues early, avoiding the high costs associated with advanced conditions.

"As a carveout MBHO, our work centers on prevention and early intervention, and that focus shapes every interaction we have with members," he explains. "Each contact becomes a meaningful moment in time, a chance to identify concerns early and guide individuals toward the right support before issues grow more complex or disruptive. When we are involved at the earliest stages of a member's behavioral health journey, the impact is clear: care becomes less expensive, outcomes improve, and people experience a higher quality of life."

This improvement extends into the workplace as well, where employees who receive timely behavioral health support are more present, more engaged, and better able to perform at their full potential.

"By concentrating exclusively on behavioral health and removing the barriers that often slow access, a carveout MBHO makes it easier for members to get the help they need at the moment they need it, benefiting both the individual and the employer," concludes Unruh.

DANGEROUS SLOPE FOR CHRONIC CONDITIONS

Even people with chronic conditions experience delays in receiving care. Almost six in 10 commercially insured patients in the US had at least one chronic condition in 2024, according to a new report from FAIR Health.

Experts advise that allowing conditions like diabetes, hypertension and cholesterol to go unchecked for a year is extremely dangerous. They estimate the delays in screenings could lead to 10,000 colorectal and breast cancer deaths over the next decade.

It is now becoming even more evident that missed physicals, routine checkups to major surgeries, the impact of delaying care is now coming to light.

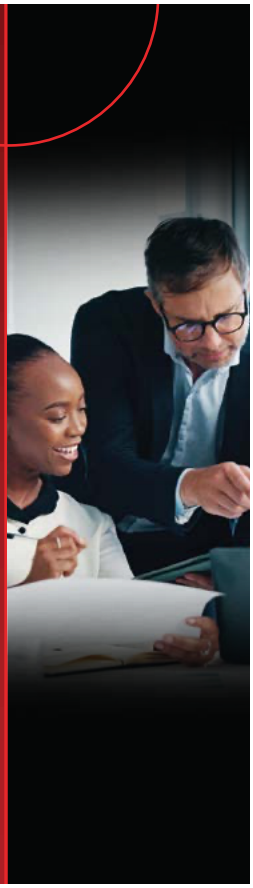
Another national poll, U.S. Employee Perspectives on Managing Chronic Conditions in the Workplace, found that three-fourths (76%) of those with chronic conditions—such as hypertension, heart disease, diabetes, and asthma—need to manage their conditions during work hours, and most have not formally disclosed their conditions to their employers.

- More than one-third of employees with chronic conditions (36%) say they have skipped medical appointments or delayed getting care to avoid interfering with work in the past year.
- About half of those with chronic conditions say, in the past year, they felt they could not take time off work (49%) or take a break while at work (49%), even though they needed to because of their conditions.

WOMEN ON SPECIAL ALERT FOR HEART DISEASE

Experts at the Centers for Disease Control and Prevention (CDC) warn that only 56% of women are aware of the risks of heart disease, a top healthcare threat that supersedes cancer, leading to one in five female deaths.

Media commentators decry, "Women never see it coming," emphasizing that it is the leading killer of women at all ages and starting at the age of 18, more women will die of heart disease than breast cancer.



While most people expect a heart attack to come on suddenly, research suggests that women experience symptoms for several weeks before a heart attack. Physicians advise it's important to encourage women to seek medical care when they have symptoms. Heart problems -- even a heart attack -- can occur without chest pain, a situation that is particularly common among women.

A study in the Journal of the American Heart Association stated that despite women having more symptomatic chest pain than men, they are less likely to have timely and appropriate care. On average, researchers affirmed that women have an 11-minute longer wait time when seeking emergency care for a heart attack, a delay that has a direct impact on heart attack outcomes.

DON'T DELAY!

The popular saying, "Don't put off until tomorrow what you can do today," is widely attributed to Benjamin Franklin. But this advice has special meaning in today's delayed care environment.

The upshot of delayed care is multi-dimensional -- whether because of cost, access barriers, insurance issues, long wait times or administrative hurdles. Delaying medical care has significant impacts on health outcomes, costs and mortality.

Beyond identification, hands-on support from nurse case managers plays a vital role in helping members navigate the healthcare system and access appropriate care. Through a comprehensive assessment, nurse case managers can identify barriers that may contribute to delayed treatment.

Lavan emphasizes, "These barriers often include social determinants of health such as transportation challenges, financial concerns, limited understanding of treatment plans, or lack of access to local resources. However, clinical collaboration is only one piece of the puzzle. A multidisciplinary approach can strengthen these efforts."

At MedWatch, Lavan substantiates that collaboration with professions such as social workers and dieticians allows care teams to address both medical and nonmedical factors that influence health access and outcomes.

"When care teams work together to support the whole patient, they are better positioned to help members stay engaged in their care and follow through with recommended treatment," she confirms. "In addition to improving access to care, opportunities may arise to manage access and costs through strategic provider arrangements. For example, single case agreements or direct contracting with high-quality providers and facilities can help ensure members receive timely care while managing the plan's financial impact."

She stresses that as healthcare costs continue to rise, proactive strategies that focus on early identification, coordinated case management, and thoughtful provider collaboration are essential to ensuring members receive the right care at the right time.

Lavan underlines the need for supporting timely intervention and addressing barriers that prevent patients from accessing treatment, noting, "Organizations like MedWatch can help improve health outcomes and reduce the frequency of complex, high-cost claims."

Clearly, timely access to care is critical for individual health and healthcare system stability, as April Gill, CCO, Smart Data Solutions, says, "Delayed care is often driven by operational friction, not clinical

intent. Fragmented data and workflows across eligibility, prior authorization, medical records and claims processing slow decisions and delay access to care."

She suggests that self-insured employers, TPAs, and brokers can help mitigate these barriers when supported by intelligent automation and real-time data orchestration.

"Without it, manual processes, disconnected systems and cost pressure compound delays, often leading to worsening conditions and higher-cost claims," she continues. "Our approach consistently sees better outcomes when healthcare organizations accelerate intake, normalize data, and streamline decision workflows, enabling earlier intervention, improved member experiences, and more efficient care delivery. Reducing administrative friction is a critical step towards improving affordability, access, and long-term health outcomes." ■

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