

The High-Dollar Claim Question Every Self-Funded CFO Should Ask

When a small number of medical claims can move the annual benefits budget, visibility into what the plan ultimately pays becomes a financial discipline.

Executive brief

A self-funded employer bears the cost of covered medical claims, even when it contracts with an administrator to process them.[1] High-cost spending is concentrated among a relatively small share of plan members.[2] The financial consequence is straightforward: a limited number of large claims can materially affect an employer's cost experience. This does not mean those claims are improper. It means the way they are evaluated deserves executive attention.

In a 2026 employer survey, organizations projected a median 9% health-care cost trend before plan-design changes; a later survey found employers taking more action on high-cost categories.[3][4] For a CFO, the issue is not simply the rise in medical prices. It is whether the organization can see where high-dollar claims originate, what its current controls actually do, and whether the resulting payments are supported and measurable.

The real question is not “Do we have a TPA?” It is “Can we demonstrate what happens to a high-dollar claim before the plan pays it?”

Why large claims create an outsized financial exposure

High-dollar claims may arise from medically necessary, complex care. They can involve multiple facilities, services, specialists, and billing records. Even an otherwise capable claims operation may use different workflows for routine claims and exceptional cases. The opportunity for a plan sponsor is to understand which claims receive additional attention, who conducts it, and how any documented changes affect the final amount payable.

An employer should distinguish three numbers: the provider's submitted charge, the amount payable under applicable plan and provider terms before any additional intervention, and the final accepted payment. A reduction from a submitted charge is not automatically a dollar saved by the employer. A credible result measures the difference between what the plan otherwise would have paid and what it actually pays, after fees and any later reversals.

A practical oversight agenda for finance and benefits leaders

Question	What leadership should be able to see
Concentration	The number and total paid value of claims above defined thresholds, by type of service.
Controls	Which large claims are flagged before payment, and what evidence is reviewed.

Authority	Who can request records, resolve findings, and authorize payment changes.
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Results	Accepted changes to the otherwise payable amount, net of fees and reversals.
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This agenda is compatible with an existing administrator. It asks for visibility and an evidence-based improvement path, not a presumption that the administrator has failed.

The CFO's next move

Request a focused review of the organization's high-dollar claim pathway. Start with a limited historical summary and a forward-looking process map: what is flagged, when it is flagged, what documentation is available, who resolves exceptions, and how outcomes are reported. Set a reasonable threshold based on the plan's own claim distribution rather than relying on an arbitrary industry number.

If the data identifies a specific gap, test a defined cost-containment intervention on an appropriate subset of claims. Agree in advance on eligibility, timing, responsibilities, participant protections, measurement, and fees. The financial case should rest on verified net impact, not promotional percentages or assumptions about every large claim.

Where Healthcare Mitigation Solutions fits

Healthcare Mitigation Solutions (HMS) helps employers examine where high-dollar medical claims may create avoidable financial leakage and develop a targeted path to address it. We bring a finance-led perspective to the claims pathway, help frame the right questions for benefits and administrative teams, and identify appropriate solutions for opportunities the evidence supports. Our aim is a measurable improvement in the employer's claim spend that can contribute to its financial performance. Specific services, delivery partners, economics, and results are established for each engagement; no reduction is assumed or guaranteed.

A 20-minute conversation can establish whether your high-dollar claims pathway merits a closer look. Contact Healthcare Mitigation Solutions through healthcaremitigationsolutions.com.

Sources and notes

Plan sponsors should assign appropriate finance, benefits, and fiduciary personnel to oversee service providers. The U.S. Department of Labor advises fiduciaries to monitor whether providers perform agreed services.[5] This paper offers business analysis, not legal or clinical advice.

[1] HealthCare.gov, [Self-insured plan](#).

[2] Employee Benefit Research Institute, [Where Employer High-Cost Spending Often Goes](#), Oct. 2025.

[3] Business Group on Health, [2026 Employer Health Care Strategy Survey](#).

[4] Business Group on Health, [2027 Employer Healthcare Strategy Survey](#), Aug. 2026.

[5] U.S. Department of Labor, [Group Health Plan Fiduciary Responsibilities](#).