

The Blind Spot in High-Dollar Claims

A CFO's guide to seeing the financial pathway between a medical claim and the payment made by a self-funded plan.

A cost center worthy of executive visibility

In 2025, 67% of workers with employer health coverage were in self-funded plans, according to KFF.[1] For these employers, the medical claim is a direct financial exposure. A third party may administer the plan, but outsourcing processing does not automatically give finance leaders a clear view of how exceptional claims are handled.

Health-care spending is concentrated: a relatively small share of people account for a disproportionate share of costs.[2] That concentration makes high-dollar claims a natural starting point for financial oversight. It does not imply that a member received unnecessary care or that a provider submitted an improper charge.

The blind spot is the distance between “the claim was processed” and “we can explain why this was the correct amount to pay.”

What a CFO should be able to trace

A useful claims narrative begins before payment and ends after any dispute or adjustment has been resolved. The finance and benefits teams should be able to trace a defined group of large claims through the following decisions:

Decision point	Evidence to request
Identification	Which claims crossed a defined threshold and who flagged them?
Evaluation	What documents and specialized expertise were available before payment?
Resolution	Were questions answered, changes accepted, or charges upheld?
Final economics	What would the plan otherwise have paid, what did it pay, and what did the intervention cost?

The submitted charge, the pre-intervention amount payable under applicable terms, and the final payment can be very different numbers. Reporting only the difference between the first and last can overstate the financial benefit. Effective oversight reconciles the actual payment difference, service fees, and any later reversals.

Turn information into an actionable decision

Begin with a 12-month distribution of high-dollar facility claims, segmented by size and service category. Then sample the pathway for a small number of claims. Ask where an exception is routed, whether review happens early enough to affect payment, and how a disputed item reaches final resolution. This exercise can confirm that existing controls are working or reveal a defined gap.

HMS helps employers frame that investigation, identify where a targeted cost-containment approach may fit, and bring the right parties together to evaluate an evidence-based solution. The goal is a defensible net financial outcome, with the member's access to necessary care and the plan's obligations respected.

Ask HMS to help you identify where your high-dollar claims process may be leaving measurable value on the table. Start the conversation at healthcaremitigationsolutions.com.

Sources and scope

Sources are linked below. Financial improvements depend on the employer's claims, existing controls, contracts, and implementation. HMS does not guarantee a reduction. Fiduciary duties depend on the plan and decision-making role; this paper is business analysis, not legal advice.

[1] KFF, [2025 Employer Health Benefits Survey](#).

[2] EBRI, [Where Employer High-Cost Spending Often Goes](#), 2025.

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