

The Value Test for Health-Care Cost Controls

How self-funded employers can judge whether current safeguards deliver measurable value on high-dollar claims.

A vendor roster is not a measure of performance

Most self-funded employers already have administrators, networks, consultants, and multiple cost controls. The relevant CFO question is whether those arrangements produce an observable result for the claims that carry the greatest financial weight. In its 2027 employer survey, Business Group on Health reported that 58% of surveyed employers were eliminating underperforming vendors and 52% were adding programs to address high-cost areas.[4]

That does not mean every employer needs another vendor. It means leaders should demand a clear description of the work performed, the claims reached, the fees charged, and the net result. The U.S. Department of Labor advises group health plan fiduciaries to monitor service providers and assess whether fees remain reasonable for the services delivered.[3]

A claimed “savings” number is useful only when the employer knows the baseline, the final outcome, and the total cost of achieving it.

Four questions for a credible value test

Question	Why it matters
What was reached?	A control cannot affect high-dollar claims it never receives, or receives only after payment.
Against what baseline?	Submitted charges alone may not reflect what the plan otherwise owed.
What was final?	A proposed change and a documented, accepted payment change are different outcomes.
What did it cost?	Fees, reversals, and administrative effort belong in the net calculation.

For example, if a provider submits \$200,000 in charges but applicable terms would have produced a \$120,000 payment, the \$80,000 difference is not automatically a new saving generated by an intervention. The proper baseline is the amount the plan otherwise would have paid. Any incremental reduction must be supported, accepted, and measured net of associated costs.

A measured path to improvement

Ask the benefits team and administrator for an anonymized, aggregate view of the last year’s large facility claims and the controls applied to them. Select a narrow test population, document the existing process, agree on the baseline and outcome measures, and specify who has authority to act on findings. Evaluate results before expanding the approach. Protect member information and follow the plan’s applicable rules throughout.

HMS works with employers to uncover where the current claims pathway may leave financial value unexamined. We help define the opportunity, align finance and benefits stakeholders, and develop an appropriate cost-containment response. The business case should stand on verified net results, not an assumed percentage reduction.

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.

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

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

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