

After switching to a new claims administrator, a large East Coast multiemployer fund pursued a medical claims audit to confirm payment accuracy — securing more than \$1 million in refunds for both the plan and its members.

The challenge

Soon after onboarding a new claims administrator, an East Coast building trades fund began to see signs that something was off. Discrepancies raised red flags and prompted the question: Were medical claims being paid correctly?

Claims that should have followed clear plan rules were returning inconsistent results, creating concern about payment accuracy and operational control.

For the plan, the stakes were high. Incorrect claims payments can quietly erode plan assets, expose the fund to compliance risk and undermine member confidence — especially during a period of system change.

Plan fiduciaries needed clarity they could rely on, not assumptions.

Our solution

An audit was designed to uncover not just isolated errors, but the reason they were happening.

Segal's Benefit Audit Solutions team conducted a comprehensive medical claims audit focused on how the new administrator's system was adjudicating claims against plan provisions. The review examined both auto-adjudicated claims — where programming errors can multiply quickly — and claims requiring manual handling, where plan interpretation matters most.

Once the audit identified errors, the focus shifted from discovery to understanding. Each issue was then categorized as ineligible charges, missing or incorrect cost-sharing and system coding inaccuracies to reveal patterns, isolate system gaps and uncover root causes behind the errors.

That clarity, in turn, made resolution possible. With a clear view of how and why claims were being paid incorrectly, the path forward became less about debate and more about fixing what wasn't working.

With findings clearly established, Segal facilitated working sessions with the plan administrator and the vendor to align on results and define a clear resolution plan — promoting transparency, reinforcing accountability and ensuring corrections reflected the plan’s provisions, not just system adjustments.

The results

The findings confirmed what was suspected — and revealed the full scope of the exposure.

More than \$1 million in payment discrepancies caused by claims processing and system issues came to light. These included overpayments made by the plan as well as amounts owed back to affected members.

As part of the resolution, the vendor refunded more than \$900,000 directly to the plan and more than \$150,000 to members, ensuring members were made whole without disruption to benefits. The vendor also delivered detailed audit impact reports and updated system programming to address documented issues and strengthen ongoing controls.

In the end, every error surfaced through the audit had been fully resolved, bringing claims processing back into alignment with plan provisions and expected standards.

By pairing independent oversight with timely action, the fund protected plan assets, restored confidence in its claims operation and reaffirmed a core fiduciary priority: Accuracy matters — especially when every dollar supports members’ care.

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Contacts



Cristina De Leon
SVP, Practice Leader
cdeleon@segalco.com
312.984.8535



Jennifer Laguna
Senior Consultant, BAS
jlagua@segalco.com
602.381.4018

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