THE SILENT DANGER

SELF-FUNDED HEALTH PLAN

ERISA FIDUCIARY RISK ASSESSMENT CHECKLIST

Fiduciary Exposure | ERISA Violations | Stop-Loss Claim Risks

ASSESSMENT INFORMATION

Plan Sponsor / Employer:	
Plan Year:	
Date of Assessment:	
Assessor / Advisor:	
TPA:	
Stop-Loss Carrier:	

ATTORNEY-CLIENT NOTICE: This checklist is designed for use by qualified ERISA counsel and licensed benefits advisors. Completion of this checklist does not constitute legal advice and does not create an attorney-client relationship. Findings should be reviewed with qualified ERISA counsel before acting. Plan fiduciaries retain personal liability under ERISA Section 409 for breaches of duty.

SECTION A — PLAN GOVERNANCE & FIDUCIARY STRUCTURE

	Assessment Item	Findings / Notes
☐	Plan document identifies a Named Fiduciary as required by ERISA §402(a)	
☐	Named Fiduciary is a specific person or committee — not a generic title	
☐	Named Fiduciary has accepted the role in writing	
☐	Named Fiduciary understands the scope and personal liability of the role	
☐	Plan Administrator is identified and distinguished from Named Fiduciary	
☐	A formal Fiduciary Committee has been established	
☐	Committee charter documents authority, composition, and meeting frequency	

	Assessment Item	Findings / Notes
☐	Committee meeting minutes are maintained and signed by all members	
☐	Minutes reflect documentation of the prudent decision-making process — not just outcomes	
☐	Committee reviews plan performance, vendor benchmarks, and claims data at least annually	
☐	Committee members have received fiduciary training within the past 12 months	
☐	Fiduciaries have identified co-fiduciaries (e.g., TPA, PBM, investment advisor)	
☐	Processes exist to monitor co-fiduciary performance and detect breaches	
☐	Fiduciaries understand they can be liable for co-fiduciary breaches under ERISA §405	
☐	TPA, stop-loss carrier, and other vendors have acknowledged fiduciary status (where applicable) in writing	
☐	ERISA fiduciary liability policy is in place (separate from D&O)	
☐	Coverage limits are adequate relative to plan assets and claim exposure	
☐	Policy covers both plan and individual fiduciaries for breach of duty claims	
☐	Fidelity bond meets ERISA §412 requirements (at least 10% of plan assets, min $1,000)	

SECTION B — PLAN DOCUMENT COMPLIANCE

	Assessment Item	Findings / Notes
☐	A current, fully executed Wrap Plan Document (or comprehensive Plan Document) is on file	
☐	The plan document has been updated for all legislative changes through the current plan year	
☐	Plan Year, Effective Date, and amendment procedures are clearly defined	
☐	Plan document coordinates with all underlying component documents (medical, dental, vision, EAP)	

	Assessment Item	Findings / Notes
☐	Plan document specifies the funding mechanism (self-funded, stop-loss threshold)	
☐	SPD has been provided to all participants within 90 days of eligibility	
☐	SPD contains all ERISA-required disclosures under ERISA §102	
☐	SPD has been updated and re-distributed within 210 days of the plan year in which a material modification occurred	
☐	SPD accurately reflects the current plan design, cost-sharing, and benefit exclusions	
☐	SPD includes the required statement of ERISA rights (ERISA §104(b))	
☐	SPD includes mental health parity (MHPAEA) disclosures	
☐	SPD includes Transparency in Coverage and CAA-required machine-readable file disclosures	
☐	SMM issued within 60 days of material plan modification	
☐	SBC was provided to all applicants and enrollees at open enrollment	
☐	SBC is updated annually and reflects the current plan year design	
☐	SBC includes the correct coverage examples and a uniform glossary	
☐	The HIPAA Privacy Notice (NPP) is current and distributed to all participants	
☐	Business Associate Agreements (BAAs) are executed with all PHI-handling vendors	
☐	BAAs address breach notification, permitted disclosures, and return/destruction of PHI	
☐	The plan documents include HIPAA privacy provisions separating the plan from the employer	

SECTION C — TPA AGREEMENT RISK ANALYSIS

	Assessment Item	Findings / Notes
☐	Current, fully executed ASA is on file — not expired or auto-renewing without review	
☐	TPA's fiduciary status is clearly defined — discretionary authority triggers fiduciary status under ERISA §3(21)	
☐	ASA includes performance guarantees with defined penalties for non-performance	
☐	Audit rights clause permits the plan to access and audit all claim records without restriction	
☐	ASA includes specific data ownership language confirming that the plan owns all claims data	
☐	ASA addresses data portability upon termination	
☐	Hold harmless and indemnification clauses do not inappropriately shift fiduciary liability to the plan	
☐	Error and omission provisions do not cap TPA liability below a reasonable threshold	
☐	ASA specifies initial claim determination timeframes consistent with DOL regulations	
☐	ASA defines urgent/expedited claims processing with required turnaround times	
☐	ASA requires TPA to maintain claims processing accuracy rates (target: 98%+)	
☐	ASA includes provisions for handling out-of-network claims and balance billing	
☐	TPA uses an independent repricing network — embedded repricing conflicts are disclosed and reviewed	
☐	All direct and indirect TPA compensation is disclosed — including sub-capitation, retained discounts, and spread pricing	
☐	Compensation disclosure complies with CAA 2022 Section 202 (Consolidated Appropriations Act broker/advisor fee disclosure)	
☐	Plan has benchmarked TPA compensation against the market to assess reasonableness	

	Assessment Item	Findings / Notes
☐	Revenue-sharing arrangements between TPA, stop-loss carrier, and PBM are disclosed	
☐	Network access agreements are reviewed — not just passed through from TPA without analysis	
☐	Repricing methodology is transparent — the plan is not paying the spread between the billed and the repriced amounts as hidden TPA income	
☐	Reference-based pricing (RBP) programs, if used, are documented and disclosed in the SPD	
☐	RBP balance billing risk management strategy and participant communication plan is in place	

SECTION D — STOP-LOSS POLICY STRUCTURE & KEY DEFINITIONS

	Assessment Item	Findings / Notes
☐	Policy type is confirmed as Specific Stop-Loss, Aggregate Stop-Loss, or both	
☐	Specific (Individual) Deductible (SIR) per claimant is documented and financially appropriate relative to plan cash flow	
☐	Aggregate attachment point is set at an appropriate multiple of expected claims (typically 115%-125% of expected)	
☐	Policy form is 'paid' vs. 'incurred' and plan cash flow is structured accordingly	
☐	Run-in and run-out provisions are understood and documented	
☐	Lasering of individual claimants has been reviewed and disclosed to the plan sponsor	
☐	Policy contract basis — 12/12, 15/12, 12/15 — is confirmed and understood by plan sponsor	
☐	Contract basis aligns with TPA claims payment practices and plan year	
☐	Transition year or new plan coverage handles run-in claims appropriately	
☐	Potential gap claims between policy periods have been identified and financially planned for	

	Assessment Item	Findings / Notes
☐	'Eligible Expense' or 'Covered Charge' definition in stop-loss policy matches the plan document definition	
☐	Stop-loss policy does not contain a narrower definition of covered expenses than the underlying plan	
☐	Out-of-network claim reimbursement methodology in stop-loss is consistent with the plan document	
☐	Prescription drug claims are explicitly covered under the stop-loss; PBM carve-outs are flagged	
☐	Behavioral health, substance use disorder, and mental health claims are covered consistent with MHPAEA	
☐	Specific claimant reporting thresholds and deadlines are documented (typically 50%-75% of SIR)	
☐	TPA is contractually required to report large claimants to the stop-loss carrier on schedule	
☐	Plan has verified that TPA is actually filing a timely notice — not just assuming compliance	
☐	Consequences of late reporting (claim denial, reduced reimbursement) are understood	

SECTION E — STOP-LOSS COMMON CLAIM DENIAL TRIGGERS

	Assessment Item	Findings / Notes
☐	All claimants were eligible under the plan at the time services were rendered	
☐	Dependent eligibility verification is current — overage dependents, divorce, loss of student status	
☐	Enrollment changes and terminations are processed timely — no retroactive enrollment without carrier notification	
☐	Late enrollees are properly categorized per the plan document and stop-loss policy	
☐	COBRA participants are correctly administered, including the election period, premium payment, and termination	
☐	Domestic partners are covered only if the plan document and stop-loss policy explicitly permit	
☐	Prior authorization requirements in the stop-loss policy are tracked and met by TPA	

	Assessment Item	Findings / Notes
☐	Pre-existing condition definitions in the stop-loss policy are reviewed for consistency with the plan	
☐	High-cost claimant treatment plans (e.g., transplants, CAR-T therapy, gene therapy) require advance review with the stop-loss carrier	
☐	Case management referrals for high-cost cases are documented and timely	
☐	Medical necessity criteria used by TPA are consistent with the criteria referenced in the stop-loss policy	
☐	Experimental, investigational, or unproven treatment exclusions are clearly defined in both the plan and stop-loss policy	
☐	Discrepancies in coverage decisions between the plan and the stop-loss carrier are identified and escalated	
☐	Specialty pharmacy, gene therapy, and cell therapy claims are reviewed in advance with the stop-loss carrier	
☐	Stop-loss claim submissions include complete itemized bills, EOBs, and medical records as required	
☐	Claims are submitted within the stop-loss carrier's required filing deadline	
☐	TPA has not changed claim coding, bundling, or repricing methodology in a way that inflates submitted charges	
☐	Proof of payment is provided for each claim submitted to the stop-loss carrier	
☐	Coordination of Benefits (COB) determinations are properly documented, and primary coverage is billed first	
☐	Specific deductible accumulation is calculated consistently with policy definitions (paid vs. incurred)	
☐	No cross-accumulation of claims between plan years without explicit carrier approval	
☐	Reimbursements, refunds, or claw-backs from providers reduce the SIR accumulation correctly	
☐	Subrogation recoveries are reported and applied per stop-loss policy requirements	

SECTION F — STOP-LOSS POLICY EXCLUSIONS & LIMITATIONS

	Assessment Item	Findings / Notes
☐	Self-inflicted injury exclusion reviewed — does the plan document contain the same exclusion?	
☐	Acts of war exclusion reviewed — plan document is consistent	
☐	Workers' compensation-covered conditions — coordination and exclusion properly documented	
☐	Medicare/Medicaid coordination — plan document and stop-loss policy are aligned on primary/secondary payer rules	
☐	Automobile accident medical payments exclusion reviewed for consistency with plan document	
☐	Specialty pharmacy exclusions or dollar caps in stop-loss policy are identified and compared to plan benefits	
☐	Gene therapy and CAR-T cell therapy claims: carrier position is documented before treatment authorization	
☐	Compounded medications exclusion is present or absent in both the stop-loss and plan document — consistent treatment	
☐	The weight-loss medication (GLP-1) coverage position is documented in both the plan and the stop-loss policy	
☐	Biosimilar substitution requirements — stop-loss position is reviewed and aligned with the plan document	
☐	Residential treatment facility (RTF) coverage — stop-loss policy limitations are consistent with plan and MHPAEA requirements	
☐	Substance use disorder (SUD) treatment day/visit limits — stop-loss policy is reviewed for MHPAEA compliance	
☐	Applied Behavior Analysis (ABA) therapy for autism — coverage and stop-loss position are documented	
☐	Eating disorder treatment — stop-loss covers to the same extent as the underlying plan	
☐	Lifetime maximum and annual benefit caps in stop-loss policy are identified (prohibited in the underlying plan under ACA)	

	Assessment Item	Findings / Notes
☐	Per-diagnosis sub-limits in the stop-loss policy are compared against the plan document — conflicts are documented	
☐	The stop-loss policy does not contain a maximum reimbursement that conflicts with the plan's unlimited maximum	
☐	Organ transplant sub-limits, or exclusions in the stop-loss policy, are documented and disclosed to the plan sponsor	
☐	All lasered individuals are identified on a separate schedule, and the plan sponsor has acknowledged	
☐	Laser amounts and conditions are reviewed for accuracy at each policy renewal	
☐	Financial plan accounts for the potential stop-loss gap on all lasered participants	
☐	Lasered participants are informed of any plan limitation changes that may affect their benefits (with ERISA-compliant notice)	

SECTION G — CAA 2022 & CAA 2026 COMPLIANCE

	Assessment Item	Findings / Notes
☐	All direct and indirect compensation paid to the broker/advisor is disclosed in writing to the plan fiduciary	
☐	Compensation disclosure is made prior to or upon engagement — not retroactively	
☐	Disclosure covers all forms of compensation: commissions, overrides, contingent payments, bonuses, non-cash	
☐	Broker/advisor has provided updated disclosure upon any change in compensation arrangement	
☐	Plan fiduciary has reviewed compensation for reasonableness and documented the analysis in committee minutes	
☐	Machine-readable files (MRFs) for in-network rates and out-of-network allowed amounts are posted publicly	
☐	MRFs are updated monthly as required	

	Assessment Item	Findings / Notes
☐	TPA or vendor responsible for MRF production is identified and compliance is verified	
☐	Plan confirms MRF URLs are active, accessible, and not broken	
☐	Plan has implemented NSA cost-sharing protections for emergency services and non-emergency services at in-network facilities	
☐	TPA is sending the required Advanced Explanation of Benefits (AEOB) when triggered	
☐	The Independent Dispute Resolution (IDR) process is understood and used appropriately	
☐	Good Faith Estimates are being processed per NSA requirements	
☐	Non-quantitative treatment limit (NQTL) comparative analysis has been completed and is on file	
☐	NQTL analysis covers all six classifications required by MHPAEA	
☐	NQTL analysis is updated at each plan year with any benefit design changes	
☐	Analysis documents both the evidentiary standards and the actual application of NQTLs — not just a template	
☐	Plan is prepared to provide the NQTL analysis to DOL upon request (now required under CAA 2021)	
☐	The RxDC report has been submitted for all applicable reporting years	
☐	Data collection from PBM, TPA, and stop-loss carrier has been coordinated for accuracy	
☐	Plan sponsor has confirmed the accuracy of the submitted data — not simply delegated without oversight	
☐	Gag Clause Prohibition Compliance Attestation (GCPCA) has been filed with CMS	
☐	All TPA, network, and PBM agreements have been reviewed for prohibited gag clauses	
☐	Any identified gag clauses have been renegotiated or removed	

SECTION H — VENDOR OVERSIGHT & PRUDENT EXPERT STANDARD

	Assessment Item	Findings / Notes
☐	TPA was selected through a documented RFP or competitive bidding process	
☐	Stop-loss carrier was selected through a competitive marketing process with documented criteria	
☐	PBM was selected with a documented analysis of rebate pass-through, spread pricing, and formulary management	
☐	Selection criteria and final decision rationale are documented in committee minutes	
☐	TPA performance is reviewed annually against contract benchmarks	
☐	Claims repricing effectiveness is benchmarked against independent market data	
☐	PBM rebate pass-through is audited or benchmarked at least every two years	
☐	Stop-loss carrier's claims reimbursement accuracy and turnaround time are monitored	
☐	Vendor conflicts of interest are identified and documented annually	
☐	Plan has exercised audit rights on TPA claims data within the past 3 years	
☐	An independent claims audit has been conducted or commissioned	
☐	A pharmacy audit of PBM billing has been conducted within the past 2 years	
☐	Audit findings have been reported to the Fiduciary Committee and documented in minutes	

SECTION I — CLAIMS, APPEALS & ERISA PROCEDURES

	Assessment Item	Findings / Notes
☐	Plan's claims procedures comply with DOL Claims Regulation (29 CFR §2560.503-1)	
☐	Initial claim determination timeframes are met: 15 days (pre-service), 72 hours (urgent), 30 days (post-service)	
☐	Denial notices include all required content: specific reason, plan provision, and description of appeal rights	
☐	Claimants are notified of their right to request and receive documents relevant to their claim at no charge	
☐	Internal appeal rights are provided, and timeframes comply with ACA and DOL regulations	
☐	Appeals are reviewed by a person different from the initial claim reviewer, no deference to the original denial	
☐	Urgent appeal response time: 72 hours (not to exceed)	
☐	Non-urgent appeal response time: 60 days (pre-service), 60 days (post-service)	
☐	External review process complies with ACA requirements — plan uses URAC-accredited IRO	
☐	Plan follows applicable state external review law or federal default process	
☐	Participants are notified of external review rights in all internal appeal denial notices	
☐	Subrogation provisions in the plan document are ERISA-compliant and enforceable under US Airways v. McCutchen (2013)	
☐	Plan document includes a 'make whole' doctrine override if permitted under plan terms	
☐	Subrogation recoveries are being actively pursued and documented	
☐	Stop-loss carrier is notified of subrogation recoveries that may reduce stop-loss claims	

SECTION J — PROHIBITED TRANSACTIONS & CONFLICTS OF INTEREST

	Assessment Item	Findings / Notes
☐	No plan assets have been transferred to or used for the benefit of a party in interest without an exemption	
☐	Plan fiduciaries have not received any direct or indirect benefit from plan vendors beyond reasonable compensation	
☐	The employer has not used plan assets to fund its own general operating expenses	
☐	Employer's contribution of plan assets has been timely — no late deposits that create a prohibited loan	
☐	Captive insurance arrangements have been reviewed for ERISA prohibited transaction risk	
☐	Employer's investment in stop-loss carrier, TPA, or PBM is disclosed and reviewed for conflict	
☐	Related-party vendor contracts have been reviewed for market reasonableness and exemption qualification	
☐	Fiduciaries have disclosed all potential conflicts of interest to the plan committee in writing	

SECTION K — REPORTING & DISCLOSURE OBLIGATIONS

	Assessment Item	Findings / Notes
☐	Form 5500 (or 5500-SF) has been filed timely for all applicable plan years	
☐	Schedule A (Insurance Information) and/or Schedule C (Service Provider Compensation) are complete and accurate	
☐	Large plan filers (100+ participants) have obtained an independent qualified accountant audit	
☐	Form M-1 filed for Multiple Employer Welfare Arrangements (MEWAs), if applicable	
☐	CHIPRA notice provided annually at open enrollment (for states with premium assistance programs)	
☐	WHCRA (Women's Health & Cancer Rights Act) notice provided annually	
☐	Newborns' & Mothers' Health Protection Act notice provided in SPD	

	Assessment Item	Findings / Notes
☐	Annual HIPAA Special Enrollment Rights notice provided	
☐	Medicare Part D Creditable Coverage notice sent by October 15 each year to Medicare-eligible participants	
☐	PCORI fee paid by July 31 each year (if applicable to plan type)	
☐	Transparency in Coverage / Price Comparison Tool link published and accessible to participants	
☐	Plan maintains a complete plan document file: plan document, SPD, all amendments, 5500s (6-year retention)	
☐	Claims records, denial notices, and appeal decisions are maintained for minimum of 6 years	
☐	Fiduciary committee minutes and vendor selection documentation are maintained and organized	
☐	HIPAA breach log is maintained — all incidents documented, investigated, and reported as required	
☐	Plan has a written DOL audit response protocol — who to contact, what to produce, legal counsel is designated	

ASSESSMENT COMPLETE — NEXT STEPS

1. Present Critical and High findings to the Fiduciary Committee within 30 days.
2. Engage ERISA counsel to review and remediate Critical findings immediately.
3. Document all remediation steps in Fiduciary Committee minutes.
4. Retain completed assessment as part of fiduciary records — minimum 6-year retention.