**2022 Joint TEGE Council Meeting**

**Health Plan Compliance Breakout**

**Questions Regarding 408(b)(2)(B) Compensation Disclosure**

1. The statutory language of 408(b)(2)(B) is very similar in many respects to the 408(b)(2) regulations for retirement plans, but in mapping over that text, does it gloss over some key distinctions between how retirement plans and group health plans operate? For example, in the vast majority of cases, it is rare for there to be an identifiable “fund” of plan assets from which service provider fees are paid in connection with group health plans.
2. What does it mean for a service provider to enter into a contract “with the covered plan”? Often with employer sponsored group health plans the contract is with the plan sponsor. Perhaps that could be viewed as the plan sponsor acting in its capacity as plan administrator and therefore entering into the contract on behalf of the plan, although that will not hold true in all cases, such as when the plan sponsor is a committee or person separately designated by the plan sponsor.
3. Is a key question for identifying a covered arrangement whether the service provider’s fees are being paid out of “plan assets,” which would include participant contributions (very common) as well as assets set aside in an identifiable fund (less common)? If so, can reasonable operating rules be established or applied to identify the sources from which fees are being paid (e.g., first out of plan sponsor funds and second out of participant contributions) or will it always be deemed proportionate?
4. Is the scope of “brokerage services” or “consulting” meant to encompass traditional third-party administration functions, such as claims processing and recordkeeping? Or are services covered only when the compensation for those services is received in connection with providing “advice, recommendations, or referrals” for identified services (per FAB 2021-03, Q4)?
5. If a bundle of services is provided under a single contract but fees are separately stated for each item in the bundle, is it reasonable to segregate the services for covered plans from the services for non-covered plans and only provide disclosures with respect to the services for covered plans?
6. By comparison, if a bundle of services (some covered and some non-covered) is provided under a single contract for a single, unallocated fee, can a reasonable allocation of the fee be made for purposes of making disclosures, or is the entirety of the compensation subject to disclosure?
7. Suppose a service provider that provides some covered services and some non-covered services uses a subcontractor that provides services only in connection with non-covered services but receives indirect compensation for those services. For example, a consultant also provides third party administration services for FSAs, HRAs, and HSAs and uses a subcontractor to provide recordkeeping and custodial services for HSAs (not a “covered plan”) for which the subcontractor receives some third-party compensation. Is the indirect compensation received by the subcontractor required to be disclosed, since it does not relate to any covered plan?
8. In disclosing compensation, when is a “reasonable and good faith estimate” of the amount of the compensation required to be provided? It does not appear to be required when the compensation can be expressed as a “formula” or “per capita charge” but rather just when generically disclosing that “additional compensation may be earned.”
9. A contract is entered into on December 1, 2020, with an initial term of 2 years and automatic evergreen annual renewals thereafter, absent affirmative renegotiation or notice of termination. Does the contract become subject to 408(b)(2)(B) on December 1, 2022, when it automatically renews, or at some future point when a “new” contract is entered into?