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November 30, 2010

Via E-mail at healthinsurance@hhs.gov.

U.S. Department of Health and Human Services
Office of Consumer Information and Insurance Oversight, Office of Oversight
Attention: James Mayhew
Room 737-F-04
200 Independence Ave. SW
Washington, DC 20201

Re: Annual Limit Waiver for HRAs Administered by Discovery Benefits, Inc. and HCB Consumer Services, Inc.

Dear Mr. Mayhew:

On behalf of Discovery Benefits, Inc. ("DBI") and its wholly-owned subsidiary, HCB Consumer Services, Inc. ("HCB"), I am requesting a waiver from the restricted annual limits on the dollar value of essential health benefits under interim final regulations published on June 28, 2010 (the "Interim Final Regulations").[1]

This request applies to health reimbursement accounts ("HRAs"), as described in IRS Notice 2002-45, for which DBI serves as third party administrator, and for which benefits under the HRA are not coordinated with any major medical plan (the "DBI Stand-Alone Plans"), for the plan year beginning January 1, 2011. This request also applies to HRAs for which HCB serves as third party administrator, and for which benefits under the HRA are not coordinated with any major medical plan (the "HCB Stand-Alone Plans"), for the plan year beginning January 1, 2011. Collectively, the DBI Stand-Alone Plans and the HCB Stand-Alone Plans are referred to as the "Stand-Alone Plans". Specifically, this waiver request applies to any Stand-Alone Plans for which DBI or HCB administers the plan during the plan year beginning January 1, 2011 and ending December 31, 2011, including the plans of any employers who may transfer the administration of their Stand-Alone Plans from another administrator to DBI or HCB, as long as the applicable Stand-Alone Plan was in force prior to September 23, 2010.

[1] 26 C.F.R. § 54.9815-2719T; 29 C.F.R. § 2590.715-2719; and 45 C.F.R. § 147.126.

The Interim Final Regulations provide that when an HRA is "integrated with other coverage" that would alone satisfy the restricted annual limit requirements, the fact that the HRA itself limits the dollar value of benefits does not violate the restricted annual limit requirements of the Interim Final Regulations.[2] Because the Stand-Alone Plans are not integrated with other coverage that alone satisfies the restricted annual limit requirements, the Stand-Alone Plans may not be exempt from the restricted annual limit requirements under the Interim Final Regulations.[3] DBI and HCB are requesting waivers on behalf of the Stand-Alone Plans because the application of the restricted annual limit requirements would result in a significant decrease in the access to benefits for the affected participants of the Stand-Alone Plans.

This letter, with attachments, is intended to meet the application requirements for the waiver process set forth in the Memorandum entitled "Insurance Standards Bulletin Series --- Information" from Steve Larsen dated September 3, 2010, as supplemented on November 5, 2010 (the "Waiver Memorandum").

I. Terms of the Stand-Alone Plans

The Stand-Alone Plans are HRAs sponsored by various employers ("the Employers") for which DBI or HCB serves as third party administrator. Under the terms of the Stand-Alone Plans, the Employer annually credits a specified dollar amount to an account (the "Account") for each eligible employee. Eligible employees do not contribute to the Account pursuant to salary reduction elections or otherwise under a cafeteria plan under Section 125 of the Internal Revenue Code of 1986, as amended (the "Code").

Eligible employees may receive reimbursements for certain medical care expenses (as defined in Code § 213(d)) incurred by the eligible employee or the eligible employee's spouse and dependents (as defined in Code § 152) from their Accounts. In some cases, Stand-Alone Plans restrict eligible medical care expenses to certain categories. For example, health insurance premiums are eligible for reimbursement under some of the Stand-Alone Plans, but excluded expenses under other Stand-Alone Plans. Additionally, dental and vision expenses are eligible expenses under some of the Stand-Alone Plans but excluded expenses under other Stand-Alone Plans.

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[2] 75 Fed. Reg. 37190-91 (June 28, 2010).

[3] The Interim Final Regulations request comments on the application of HRAs that are not integrated with other coverage (i.e., "stand-alone" HRAs). Id. It is possible that even "stand-alone" HRAs could be exempt from the restricted annual limits provisions under the exemption for health flexible spending accounts. Treas. Reg. § 54.9815-2711T(a)(2)(ii); 29 C.F.R. § 2590.715-2711(a)(2)(ii); 45 C.F.R. § 147.26(a)(2)(ii). In this regard, IRS Notice 2002-45 states: "Assuming that the maximum amount of reimbursement which is reasonably available to a participant under an HRA is not substantially in excess of the value of coverage under the HRA, an HRA is a flexible spending arrangement (FSA) as defined in § 106(c)(2)." But because the Interim Final Regulations request comments on the application of the restricted annual limit rules to "stand-alone" HRAs, it is uncertain whether "stand-alone" HRAs that satisfy the definition of a health FSA are exempt from the restricted annual limit rules. However, DBI and HCB reserve the right to take the position that some or all of the Stand-Alone HRAs are health FSAs.

The dollar amount of reimbursements for medical care expenses received by an eligible employee are charged against the Account. The maximum dollar amount available for reimbursement at any time is limited to the dollar value of the eligible employee's Account. Depending on the design of the particular HRA, an unused portion of the Account at the end of a year may be carried forward to increase the maximum reimbursement amount in the next year.

II. Number of Individuals Covered by the Plans

DBI currently serves as third party administrator to forty-four DBI Stand-Alone Plans and estimates that there are currently (b)(4) eligible employees under the DBI Stand-Alone Plans.

HCB currently serves as third party administrator to fifty-two HCB Stand-Alone Plans and estimates that there are currently (b)(4) eligible employees under the HCB Stand-Alone Plans.

III. Annual Limits Applicable to the Plans

As noted, the maximum dollar amount of reimbursements available to an eligible participant at any time under the Stand-Alone Plans is the dollar value of his or her Account. The dollar value of the Account at any time will be the total dollar amount credited to the Account by the Employer since the eligible employee became eligible to participate in the Stand-Alone Plan, less the total dollar value of reimbursements of eligible medical expenses since the eligible employee became eligible to participate in the Stand-Alone Plan. As such, the annual limit will vary among eligible employees under a Stand-Alone Plan in 2011 based upon the extent to which the eligible employee carried over an account balance from the prior year. The annual limit will also vary among Stand-Alone Plans and among eligible employees based on the amount of the Employer credit applicable to the eligible employee for 2011 under the Stand-Alone Plan.

The minimum dollar value available for reimbursements for any eligible employee will be the amount credited by the eligible employee's Employer for 2011. The amount of Employer credits under a Stand-Alone Plan, may vary from year-to-year.

For 2010, Employer credits for the DBI Stand-Alone Plans ranged from (b)(4) per year, with an average of (b)(4) per year.

For 2010, Employer credits for the HCB Stand-Alone Plans ranged from (b)(4) per year, with an average of (b)(4) per year.

IV. Brief Description of Why Compliance with the Interim Final Regulations Would Result in a Significant Decrease or Loss of Benefits.

The Stand-Alone Plans are designed as HRAs rather than as traditional health insurance. Restricting the dollar amount eligible for reimbursement of eligible medical care expenses to the

Account balance is a fundamental component of the HRA design structure. As noted, the maximum dollar amount of reimbursements in any year is the total amount credited by the Employer for the year, plus any unused amounts in the Account carried over from prior years.

If the maximum annual limit on the dollar value of essential health benefits permitted under the Interim Final Regulations of $750,000 for the 2011 plan year applied, Employers would have to credit up to $750,000 to the Account of each eligible employee under the Stand-Alone Plans to ensure that the restricted annual limit requirements are met. While the Stand-Alone Plans do not have premiums as under a traditional health insurance plan, the additional Employer credits necessary to satisfy the restricted annual limit requirements are met would significantly increase the cost to the Employers of providing coverage under the Stand-Alone Plans.

Although DBI and HCB have not contacted each Employer for whom it administers a Stand-Alone Plan, many Employers have contacted DBI and HCB to state that the Employers would terminate the Stand-Alone Plans if they were required to credit $750,000 for each HRA account in 2011. The termination of the Stand-Alone Plans would result in a significant decrease in the access to benefits for the affected participants of the Stand-Alone Plans.

V. Attestation by Plan Administrator

The Waiver Memorandum requires an attestation by a plan administrator or Chief Executive Officer of the issuer of the coverage that the plan was in force prior to September 23, 2010, and that the application of restricted annual limits would result in a significant decrease in access to benefits for those currently covered by the plan or a significant increase in premiums paid by those covered by the plans. Attestations as required by the waiver process set forth in the Waiver Memorandum are attached and incorporated herein by reference.

Based on the information set forth herein, DBI respectfully requests a waiver on behalf of the DBI Stand-Alone Plans from the annual limits on the dollar value of essential health benefits for the plan year beginning January 1, 2011, including any DBI Stand-Alone Plans the administration of which may be transferred from another administrator to DBI during 2011, as long as the applicable plan was in force prior to September 23, 2010.

Further, based on the information set forth herein, HCB respectfully requests a waiver on behalf of the HCB Stand-Alone Plans from the annual limits on the dollar value of essential health benefits for the plan year beginning January 1, 2011, including any HCB Stand-Alone Plans the administrator of which may be transferred from another administrator to HCB during 2011, as long as the applicable plan was in force prior to September 23, 2010..

If you have any questions regarding this application or the Stand-Alone Plans, please feel free to contact me.

Sincerely yours,

Mark L. Stember

Mark L. Stember

Attachments
Plan Administrator Attestation for DBI Stand-Alone Plans
Plan Administrator Attestation for HCB Stand-Alone Plans

ATTESTATION
APPLICATION FOR WAIVER OF RESTRICTED ANNUAL LIMITS

HCB Consumer Services, Inc. serves as third party administrator for the HCB Stand-Alone Plans (as defined in the attached waiver application). HCB Consumer Services, Inc. has submitted the attached waiver application on behalf of the plan administrators of the HCB Stand-Alone Plans. HCB Consumer Services, Inc., hereby attests to the following:

1. The HCB Stand-Alone Plans were all in existence and in force prior to September 23, 2010; and

2. The application of the restricted annual limits to the HCB Stand-Alone Plans would result in a significant decrease in access to benefits for those covered by the HCB Stand-Alone Plans for the reasons set forth in the attached waiver application.

HCB CONSUMER SERVICES, INC.

By: _____
Name: John Biwer
Title: President

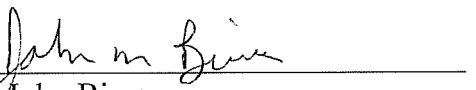
ATTESTATION
APPLICATION FOR WAIVER OF RESTRICTED ANNUAL LIMITS

Discovery Benefits, Inc. serves as third party administrator for the DBI Stand-Alone Plans (as defined in the attached waiver application). Discovery Benefits, Inc. has submitted the attached waiver application on behalf of the plan administrators of the DBI Stand-Alone Plans. Discovery Benefits, Inc., hereby attests to the following:

1. The DBI Stand-Alone Plans were all in existence and in force prior to September 23, 2010; and

2. The application of the restricted annual limits to the DBI Stand-Alone Plans would result in a significant decrease in access to benefits for those covered by the DBI Stand-Alone Plans for the reasons set forth in the attached waiver application.

DISCOVERY BENEFITS, INC.

By: 
Name: John Biwer
Title: President

From: Stember, Mark [mstember@KilpatrickStockton.com]
Sent: Thursday, December 09, 2010 12:39 PM
To: Botwinick, Alexandra (HHS/OCIIO)
Cc: Habit, Sandra (HHS/OCIIO)
Subject: RE: Discovery Benefits, Inc. Waiver of the Annual Limits Requirements of PHS Act Section 2711

Thank you for sending this update.

We understand the OCIIO has issued annual limit waivers to other third party administrators who administer health reimbursement arrangements for numerous plans. We understand these waivers have been applied to all current and future clients who may open an HRA during the year. From that perspective, it is unclear how the spreadsheet is to be completed. If we completed for each of the current HRAs administered by Discovery, there would be over 1,000 different plans and would be cost prohibitive to complete such a spreadsheet. Therefore, are we to complete the spreadsheet using aggregate information for all separate plans combined?

Mark L. Stember
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mstember@kilpatrickstockton.com | My Profile

From: Botwinick, Alexandra (HHS/OCIIO) [mailto:Alexandra.Botwinick@hhs.gov]
Sent: Thursday, December 09, 2010 12:24 PM
To: Stember, Mark
Cc: Habit, Sandra (HHS/OCIIO)
Subject: Discovery Benefits, Inc. Waiver of the Annual Limits Requirements of PHS Act Section 2711
Importance: High

Dear Applicant:

Thank you for your application for the Waiver of the Annual Limits Requirements of the Public Health Service Act (PHS Act) Section 2711. In order to expedite your application, please provide the following information:

I. Please complete the entire annual limits spreadsheet, [attached to the email] [and available at: http://www.hhs.gov/ociio/regulations/annual_limit_waivers.html]. Please return the completed spreadsheet to this email address as an attachment. We will only be able to process spreadsheets that are fully complete (i.e., every cell should contain the information requested). If a cell on the spreadsheet does not pertain to your plan, please write "None," and/or provide an explanation regarding why you are unable to complete that particular cell in a separate document.

II. In addition, please provide the following information:

- Confirm whether the plan was in existence prior to March 23, 2010. If so, is the plan in compliance with grandfathering provisions, pursuant to 45 CFR 147.140?

- In your application, your plan(s) or policy(ies) provide a lifetime limit. Pursuant to Section 2711 of the PHS Act, you may not have any lifetime limit on your plan as of September 23, 2010, except in the case of non-essential benefits that are permitted under Federal or State law. Plans that previously had a lifetime limit may add an annual limit not less than the lifetime limit without affecting the grandfather status of the plan. Please confirm whether this lifetime limit will be eliminated from your plan.

- Confirm whether the plan was created pursuant to the Taft-Hartley Act.

In order to complete your application, please provide this information as soon as possible. Once this information is received and the application is complete, it will be processed by the Department of Health and Human Services (HHS). As stated in our September 3, 2010 Sub-Regulatory Guidance, HHS will issue a decision within 30 days of receiving a complete application. You will receive an e-mail from HHS notifying you of the waiver decision.

Thank you.

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

From: Stember, Mark [mstember@KilpatrickStockton.com]
Sent: Tuesday, November 30, 2010 10:50 AM
To: HHS HealthInsurance (HHS)
Subject: waiver

Attachments: [Unsaved]WSHCPR1021A_SCANTODESKTOP_11302010-103626.pdf; Attestations Application for Waiver - DBI and HCB.pdf
Please see attached an annual limit waiver request along with the required attestations.

Mark L. Stember
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From: Stember, Mark [mstember@KilpatrickStockton.com]
Sent: Thursday, December 09, 2010 12:49 PM
To: Botwinick, Alexandra (HHS/OCIIO)
Cc: Habit, Sandra (HHS/OCIIO)
Subject: RE: Discovery Benefits, Inc. Waiver of the Annual Limits Requirements of PHS Act Section 2711

Thanks for the quick update. No apology is necessary. I appreciate the quick turn around time, and if you need any additional information, please let me know. Thanks, Mark

Mark L. Stember
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Sent: Thursday, December 09, 2010 12:47 PM
To: Stember, Mark
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Mr. Stember,

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I am in the process of reviewing your application and will let you know if I have any further questions.

Please let me know if I can be of further assistance.

Thank you for your patience and cooperation.

Sincerely,

Alexandra Botwinick

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Dear Applicant:

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Attachments: Application for Waiver of the Annual Limits Requirements of PHS Act Section 2711.xls
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Thank you.

Alexandra Botwinick

Office of Oversight
HHS/OCIIO
alexandra.botwinick@hhs.gov

From: Stember, Mark [mstember@kilpatricktownsend.com]
Sent: Monday, January 03, 2011 9:47 AM
To: Habit, Sandra (HHS/OCIIO)
Subject: RE: Discovery Benefits Approval Letter for a Waiver of the Annual Limits Requirements 12-30-2010

Sandra-

Thank you. This confirms receipt.

Mark L. Stember
Kilpatrick Townsend & Stockton LLP
Suite 900 | 607 14th Street, NW | Washington, DC 20005-2018
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mstember@kilpatricktownsend.com | My Profile | VCard

From: Habit, Sandra (HHS/OCIIO) [mailto:Sandra.Habit@hhs.gov]
Sent: Thursday, December 30, 2010 5:33 PM
To: Stember, Mark
Subject: Discovery Benefits Approval Letter for a Waiver of the Annual Limits Requirements 12-30-2010
Importance: High

Good Afternoon,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for **Discovery Benefits.** HHS has reviewed your application and made its determination. Please see the attached letter.

Please confirm receipt of this letter by replying to this e-mail.

Please let me know if I can be of further assistance.

Sincerely,

Sandy Habit
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
301-492-4175
Sandra.Habit@hhs.gov

From: Habit, Sandra (HHS/OCIIO)
Sent: Thursday, December 30, 2010 5:33 PM
To: 'mstember@kilpatrickstockton.com'
Subject: Discovery Benefits Approval Letter for a Waiver of the Annual Limits Requirements 12-30-2010

Importance: High

Attachments: Updated Jan 1 Approval Letter .pdf
Good Afternoon,

Thank you for submitting an application for a Waiver of the Annual Limits Requirements of the PHS Act Section 2711 for **Discovery Benefits.** HHS has reviewed your application and made its determination. Please see the attached letter.

Please confirm receipt of this letter by replying to this e-mail.

Please let me know if I can be of further assistance.

Sincerely,

Sandy Habit
Department of Health and Human Services
Office of Consumer Information and Insurance Oversight
301-492-4175
Sandra.Habit@hhs.gov

Annual Limit Waiver Request Applicant Name	**Policy Name (use a new row for each policy application)**	**Applicant (Plan/ Policy Situs) City**	**Applicant (Plan/ Policy Situs) State**	**Plan/ Policy Effective Date (mm/dd/yyyy)**	**Contact Name**	**Street Address**	**City**	**State**
Applicant ABC	Plan 1	Washington	DC	########	Jane Doe	100 ABC Drive	Washington	DC

Zip Code	**Phone Number (including area code) (xxx-xxx-xxx)**	**Email Address**	**Type of Coverage (e.g., Limited Benefit, HRA, Rx only, Other)**	**Self-Insured**	**Individual or Group Policy**	**Total Number of Individuals Covered by Policy (include all dependents covered)**	**Current Plan Annual Limit (in dollars)**	**Ambulatory**
20201	1-800-ABC-1234	abc@abchealthplan.com	Limited Benefit	Yes	Group	4,000	$100,000	None

Current Essential Benefits Annual Limits (Annual Limit for Each Essential Benefit)

Emergency	Hospitalization	Laboratory	Pediatric	Maternity / Newborn	Mental Health/ Substance Abuse	Rehabilitative/ Devices	Preventive/ Wellness
None	None	None	None	None	None	None	None

		Office Visit Copays/Coinsurance		Hospital Inpatient Copay/Coinsurance		Emergency Room Copay/Coinsurance	
Prescription	**Plan Deductible**	**Copay (if applicable)**	**Coinsurance (if applicable)**	**Copay (if applicable)**	**Coinsurance (if applicable)**	**Copay (if applicable)**	**Coinsurance (if applicable)**
$3,000.00	$500.00	$15.00	50.00%	$100.00	50.00%	$100.00	50.00%

Rx Copay/Coninsurance			Current Monthly Premium Rates or Premium Equivalent Rates (in dollars)*:			Renewal Monthly Premium R Premium Equivalent Rates if Granted (in dollars)*	
Copay (if applicable)	Coinsurance (if applicable)	Individual/ Employee Tier*	Employee contribution	Employer contribution	Total	Employee contribution	Employer contribution
$10.00	None	Employee	$100.00	$600.00	$700.00	$110.00	$650.00

ates or Waiver	Projected Rate Increase that would result from compliance with $750,000 Annual Limit Restriction (in dollars) (Average Premium by Individual)*					
Total	Employee contribution	Employer contribution	Total	Projected Rate Increase that would result from compliance with $750,000 Annual Limit Restriction (in dollars)(Average Premium by Individual) (Difference of Column AV and AS divided by Column AS)	Decrease in Access to Benefits that would result from compliance with $750,000 Annual Limit Restriction (describe briefly)	Plan Administrator / CEO of Health Insurance Issuer Name
$760.00	$125.00	$800.00	$925.00	21.71%	None	Jane Doe

Title of Individual Providing Attestation
Plan Administrator

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Consumer Information and
Insurance Oversight
Washington, DC 20201

Date: October 2010

From: Steve Larsen, Director, Office of Oversight

Subject: Application for Waiver of the Annual Limits Requirements of PHS Act Section 2711

Dear Waiver Applicant:

Section 2711(a)(2) of the Public Health Service Act (PHS Act), as added by the Patient Protection and Affordable Care Act (Affordable Care Act), requires the Secretary to impose restrictions on the imposition of annual limits on the dollar value of essential health benefits (as defined in section 1302(b) of the Affordable Care Act) for any participant or beneficiary in a new or existing group health plan or a new policy in the individual market for plan or policy years beginning on or after September 23, 2010 and prior to January 1, 2014. Specifically, the Secretary is granted the authority to determine what constitutes a "restricted annual limit" that can still be imposed under such plans or policies prior to January 1, 2014.

The interim final regulations published on June 28, 2010 (codified at 26 CFR § 54.9815-2719T; 29 CFR § 2590.715-2719; and 45 CFR §147.126) established such restricted annual limits. The regulations also provided that these restricted annual limits may be waived by the Secretary of Health and Human Services (HHS) if compliance with the interim final regulations would result in a significant decrease in access to benefits or a significant increase in premiums. Pursuant to the regulation, HHS issued guidance on September 3 regarding the scope and process for applying for a waiver.

The Office of Consumer Information and Insurance Oversight, Office of Insurance Oversight received and processed your application for the plan(s) or policy(ies) year beginning January 1, 2011. We have determined that your application has met the criteria to obtain a waiver of the restricted annual limits requirements because compliance with the interim final regulations would result in a significant decrease in access to benefits for those currently covered by such plans or policies, or a significant increase in premiums paid by those covered by such plans or policies. To the extent you make any change to your benefit package after March 23, 2010, you must determine whether the change(s) will trigger loss of grandfathering status pursuant to 45 CFR §147.140(g)(1).

An approval of your request for waiver of the restricted annual limits requirements granted under this process applies only to the annual limit(s) provided in your application for the plan or policy year beginning between September 23, 2010 and September 23, 2011. This waiver only applies to the annual limits requirements in Section 2711 of the ACA and does not apply to any other requirement of the Affordable Care Act, ERISA, the IRS Code or the PHS Act. Further, a group

health plan or health insurance issuer must reapply for any subsequent plan or policy year prior to January 1, 2014 when this waiver expires in accordance with future guidance from HHS. HHS may modify this waiver approval process memorandum and other relevant information.

If you have any questions regarding this letter, please email OCIIOOversight@hhs.gov.