February 18, 2021

Via Electronic Mail: regs.comments@federalreserve.gov

Board of Governors of the Federal Reserve System
20th Street and Constitution Avenue NW
Washington, DC 20551

**RE: Comment on Advanced Notice of Proposed Rulemaking for Regulation BB: Community Reinvestment Act, Docket No. R–1723, RIN 7100–AF94**

Dear Governors:

Webster Bank ("Webster" or the "Bank") appreciates the opportunity to comment on the Board of Governors of the Federal Reserve System's (the "Board" or "Governors") Advanced Notice of Proposed Rulemaking ("ANPR") regarding modernization of the Community Reinvestment Act ("CRA").[1] Webster is a midsize regional bank[2] with branches across the Greater New England area that has long considered its commitment to its entire community as a core value. Webster is also an institution that recognizes the critical importance of innovation within the industry through the responsible use of new products and technology. This perspective is what led the Bank to enthusiastically embrace Health Savings Accounts ("HSAs") in 2005 shortly after their introduction, eventually becoming one of the largest custodians and administrators of HSAs nationally. As such, Webster applauds the Board's efforts to modernize the CRA.

We write to you today concerning the Board's consideration of deposit-based assessment areas similar to those included in the Office of the Comptroller of the Currency's ("OCC") June 2020 final rule ("OCC Final Rule").[3] While Webster generally does not oppose the concept of deposit-based assessment areas, the Bank believes that HSA deposits should not be considered when determining whether the requirement would apply or when delineating such assessment areas. Consequently, HSAs should also be excluded from the definition of "retail domestic deposits" with respect to the Board's proposed Community Development Financing Metric. Declining to exclude HSA deposits would unnecessarily

[1] 85 Fed. Reg. 66410 (Oct. 19, 2020) [hereinafter CRA Modernization Proposal].

[2] Although Webster is supervised by the Office of the Comptroller of the Currency, the Bank has a strong interest in advocating for a consistent and fair approach to CRA regulations among all the prudential regulators. Consistency in CRA regulation across regulators will be critical to creating a level playing field for financial institutions and promoting regulatory stability and predictability for both the depositories and the communities they serve.

[3] *See* Community Reinvestment Act Regulations, 85 Fed. Reg. 34734, 34756-62 (Jun. 5, 2020) (discussing deposit-based assessment areas, exclusions for certain types of deposits, and related issues) [hereinafter "OCC Final Rule"].

lead to unfair performance expectations for certain institutions and ultimately harm the low- and moderate-income ("LMI") and underserved communities that CRA is meant to benefit.

Webster therefore strongly urges the Board to provide institutions the option to exclude HSA deposits from any determination of deposit-based assessment areas and any calculation of the Community Development Financing Metric for the following reasons:

- HSA deposits and the nature of a financial institution's relationship with underlying HSA beneficiaries (i.e., consumers) materially differ from other forms of deposits. The vast majority of HSA deposits are obtained through commercial third parties, with large groups of individual accounts flowing into and out of a bank based on a single relationship with those third- party entities. As such, HSAs should not be considered as associated with particular individuals and communities in the same way as traditional consumer or business deposit products.
- HSA beneficiaries are, in the aggregate, considerably more affluent than the average consumer and are more likely to be employed by large companies. Directing additional CRA activity to the communities in which they reside would likely exacerbate CRA deserts by allocating finite resources to higher-income and urban geographies already adequately covered by existing facilities-based assessment areas.
- HSA deposits are also a poor indicator of a bank's capacity to serve the credit and community development needs of a particular geographic area. Although each HSA is held by the custodial bank for the benefit of an individual consumer, in practical terms HSAs are aggregations of accounts associated with a commercial third-party relationship, the locus of which may have little or no relation to the geographies where the underlying HSA beneficiaries reside. It therefore cannot be said that a concentration of HSA beneficiaries in a particular area is an indication of a bank's capacity within that same area.

In light of the above, the inclusion of HSA deposits in deposit-based assessment areas or the Community Development Financing metric calculation would put institutions holding a substantial percentage of HSA deposits at an unfair disadvantage. Should the Board choose to move forward with a deposit-based assessment area for certain banks, the regulation may also cause institutions to inefficiently divert resources from geographies where they can be more effectively deployed in an effort to comply with the new CRA regime. Each of these issues are discussed more fully below.

## I. HSA Deposits Differ Substantially from Other Types of Deposits.

HSAs are custodial accounts held by banks or other qualified entities for the benefit of individual healthcare consumers. While individuals may choose to approach a bank directly to open an HSA, the overwhelming majority of HSAs are offered to consumers by employers, health insurance plans, and third-party benefits administrators who have formed partnerships with a bank custodian. In Webster's case, approximately 70% of its current HSA deposits were sourced indirectly through these third-party relationships. As such, custodians such as Webster do not have control over the geographic distribution of HSAs in the way they might over traditional bank deposit products.

Practically speaking, this also means that institutions do not maintain a strong, direct customer relationship with most HSA beneficiaries, as beneficiaries primarily interact with third parties when opening an account. The relationship becomes even more attenuated when multiple third parties are

involved. For example, an employer may offer its employees an HSA program through a third-party benefits administrator, who in turn has a relationship with a bank custodian. Thus, if a third party chooses to end its relationship with the bank custodian and form a partnership with a different custodian, nearly all of the HSA beneficiaries associated with that third party and its employer clients will allow the accounts to be automatically migrated to the new custodian.

Even consumers who do have a "direct" relationship with the custodial bank often begin as indirect relationships through a third party. As the funds in an HSA remain the property of the HSA beneficiary regardless of a change in employment or health plan,4 many beneficiaries are "orphaned" consumers who originated through a third party but subsequently became unemployed or switched to an employer or health plan that does not offer HSA benefits.

Accordingly, HSA deposits are, in effect, not associated with any individual or community and have less meaning as a metric of a bank's presence in specific geographies. In this respect, HSAs are similar to brokered deposits—one of the primary reasons the OCC chose to exclude HSA deposits from consideration for deposit-based assessment areas under its final rule.[5] Indeed, as the OCC initially explained in its proposed rule, excluding such deposits "more accurately reflect[s] the deposits a bank collects from identifiable individuals and communities."[6] For these reasons, HSA deposits should not be viewed by the Board as equivalent to other forms of deposits for the purpose of deposit-based assessment areas or performance metrics.

## II. HSA Beneficiaries Do Not Represent or Reside in the Underserved Communities That the CRA Is Intended to Assist.

HSA beneficiaries are generally not among the underserved populations that the Board seeks to benefit through CRA activities. As early as 2008, the Government Accountability Office found that tax filers who reported HSA activity "had higher incomes on average than other tax filers."[7] Indeed, HSA beneficiaries had an average adjusted gross income ("AGI") of approximately $139,000 compared to the nationwide average AGI of $57,000.[8]

Subsequent analyses have demonstrated that this trend continues: HSA beneficiaries tend to reside in higher-income households than the average American. In 2015, Health Affairs conducted a study, which found that filers in the highest income quintile were substantially more likely to contribute to an HSA than those in any other income group; this held true across all age groups.[9] The same study

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[4] *See* 26 I.R.C. § 223(d).

[5] The OCC stated in its final rule that "brokered deposits were excluded from the definition of retail domestic deposits because they are not associated with any individual or community." OCC Final Rule, *supra* note 3, 85 Fed. Reg. at 34761 n. 93. Similarly, the OCC noted that "banks do not have control over the geographic distribution of HSA deposits . . . HSAs are owned by account holders, and banks do not necessarily maintain direct relationships with these account holders." *Id.* at n. 98.

[6] Community Reinvestment Act Regulations, 85 Fed. Reg. 1204, 1218 (proposed Jan. 9, 2020).

[7] U.S. GOV'T ACCOUNTABILITY OFF., GAO-08-474R, HEALTH SAVINGS ACCOUNTS: PARTICIPATION INCREASED AND WAS MORE COMMON AMONG INDIVIDUALS WITH HIGHER INCOMES 3 (2008).

[8] *See id.*

[9] Lorens A. Helmchen et al., *Health Savings Accounts: Growth Concentrated Among High-Income Households and Large Employers*, 34 HEALTH AFFS. 1594, 1595 (2015), https://www.healthaffairs.org/doi/pdf/10.1377/

also found that HSA beneficiaries tended to receive their HSA benefits through employment with large companies.[10] Moreover, high-income households were both considerably more likely than low-income households to contribute to HSAs and were substantially more likely to fund their HSAs fully than filers in the lowest-income quintile.[11] As recently as 2018, Benefitfocus, a benefits technology and services firm, found that employees enrolled in a high-deductible plan (a prerequisite for making HSA contributions), earned 7% more than employees enrolled in other types of health care plans.[12] That same year, the Employee Benefit Research Institute ("EBRI") found that both individual and employer HSA contributions were higher among account owners residing in counties with higher median household income.[13] EBRI has continued to report that HSAs tend to have higher-income beneficiaries—their 2020 report found that "[HSA] accountholders in higher-income ZIP codes had average account balances that were more than two times the size of those in lower-income ZIP codes."[14]

Using HSA deposits to delineate assessment areas would therefore inject finite CRA dollars and activity into more affluent areas or urban centers that are already well-served by depository institutions. This is precisely the result the Board wished to avoid when it acknowledged that deposit-based assessment areas could "exacerbate CRA hot spots and deserts."

## III. HSAs Are Not Reliable Indicators of a Bank's Capacity.

HSAs also do not fairly represent an institution's capacity to engage in qualified activities in a particular geography or market. Whereas a concentration of ordinary consumer or business deposit account balances within a particular geographic area implies that an institution should have the resources and ability to serve the credit and community development needs of that geographic area, HSA deposits

hlthaff.2015.0480 ("In each age group, filers in the highest income quintile were substantially more likely to contribute to an HSA than those in any other income group (Exhibit 2). For example, 8.9 percent of filers at midlife (ages 45–49) in the highest income quintile contributed to an HSA, compared to 0.8 percent of those in the lowest quintile.").

[10] *See id.* at 1597.

[11] *See id.* ("We found that high-income households were considerably more likely than low-income households to contribute to HSAs, even though disease prevalence is inversely associated with income. Moreover, the highest-income filers at all ages were substantially more likely to fund their HSAs fully than filers in the lowest-income quintile.").

[12] Stephen Miller, *High-Deductible Plans More Common, but So Are Choices*, SOC'Y FOR HUM. RES. MGMT. (Feb. 9, 2018), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/high-deductible-plans-more-common-but-so-are-choices.aspx (discussing Benefitfocus study that showed employees who elected an HDHP earn on average a salary roughly $4,700, or 7 percent, higher than that of employees enrolled in a PPO).

[13] Paul Fronstin, Ph.D., *Trends in Health Savings Account Balances, Contributions, Distributions, and Investments, 2011–2017: Estimates From the EBRI HSA Database*, EMP. BENEFIT RSCH. INST., 10 (Oct. 29, 2018), https://www.ebri.org/docs/default-source/ebri-issue-brief/ebri_ib_463_hsa_long-29oct18.pdf?sfvrsn=31783e2f_2 ("Similarly, in all years, individual contributions were higher among account owners residing in counties with higher median household income. Employer contributions also increased with median household income by county, which may have reflected higher overall compensation in higher-income areas of the country.").

[14] *Fast Facts: Higher-Income HSA Owners Save More, Spend More*, EMP. BENEFIT RSCH. INST. 1 (Jan. 16, 2020), https://www.ebri.org/docs/default-source/fast-facts/ff-343-hsaincome-16jan20.pdf?sfvrsn=62043d2f_4.

are not reflective of such capacity. This is because, as discussed above, HSAs operate as aggregations of accounts under the umbrella of a commercial third-party relationship.

For example, while an institution may partner with a third-party benefits administrator in New York, the underlying HSAs may be concentrated in California and Texas. The fact that the custodial bank has a commercial relationship in New York does not provide an indication of the bank's capacity to engage in qualified activities benefiting consumers and small businesses in the other two states. Further, the underlying HSAs associated with the New York relationship operate as a single unit despite their geographic dispersion. Thus, when banks accept HSA deposits, they cannot be said to have affirmatively sought to service the areas where the individual HSA beneficiaries reside or developed the infrastructure to do so.

## IV. The Consideration of HSAs Would Skew the Playing Field and May Adversely Affect the Quality of CRA Activities.

Due to the issues described above, the failure to exclude HSA deposits from any determination of whether a bank's deposits sit outside its facility-based assessment area would have several unintended but foreseeable consequences. Specifically, it would (1) create an uneven playing field for banks with significant HSA deposit volumes; (2) cause inefficient allocations of CRA resources; and (3) potentially deter banks from expanding the availability of HSAs, limiting the growth of a government-sponsored healthcare tool that serves an important societal purpose.

### *a. Institutions Holding Large Amounts of HSA Deposits Would Be Unfairly Disadvantaged.*

As discussed throughout this comment, HSA deposits are not, in practical terms, associated with any particular individual or community, yet would have the potential to affect the number and geographic dispersion of deposit-based assessment areas, as well as the Community Development Financing Metric[15] used to evaluate the impact of an institution's CRA activities. Including HSA deposits as a factor in delineating deposit-based assessment areas would also be inconsistent with the approach taken by the OCC. This would create an uneven and unfair playing field for banks with significant HSA volumes relative to those that do not, as well as between institutions supervised by the Board and those under the OCC's purview.

### *b. Institutions Would Be Incentivized to Engage in Inefficient Allocations of CRA Resources.*

A bank's resources are limited, and institutions that take their CRA obligations seriously carefully allocate their resources to where they will have the most impact for both the communities served and in meeting regulatory expectations. Further, once resources have been allocated and commitments made, those allocations and commitments cannot be quickly undone without jeopardizing community relationships, breaching contractual obligations, or undermining effectiveness. Failing to account for HSAs in assessing whether a bank's deposits fall outside its facility-based assessment area could make that balancing act extremely difficult for some institutions and may encourage rapid and inefficient shifts in resource deployment.

[15] CRA Modernization Proposal, *supra* note 1, at 66439 (describing calculation of Community Development Financing metric with first option to use FDIC SOD data and second option to use dollar amount of retail domestic deposits held on behalf of depositors residing within each assessment area).

As previously mentioned, HSAs are frequently placed with an institution in groups that ultimately will leave the institution as a group if the third-party relationship ends. For third parties such as health plans or third-party benefits administrators, geographic concentrations of deposits may also come into and out of a bank as the third party acquires or loses commercial clients (i.e., employers) of its own. This means that geographic concentrations of HSA deposits may suddenly materialize or disappear, potentially leading to greater variability in deposit-based assessment area delineations from examination to examination. This could force institutions such as Webster to invest resources in one geographic area, only to find that it must quickly reallocate those resources elsewhere in time to meet regulatory expectations before its next examination.

*c. Institutions May Be De-Incentivized to Offer HSAs or Pursue Innovative CRA Strategies, Harming Consumers.*

These potential problems may discourage institutions from expanding their involvement in HSAs. HSAs are an important, government-sponsored healthcare tool for consumers to help manage rising medical costs and proliferation of high-deductible health insurance plans. The availability of HSAs is dependent on banks that act as HSA custodians.

Moreover, certain banks may be discouraged from pursuing new or innovative CRA strategies that require longer-term investments and commitments to maintain the flexibility needed to serve shifting assessment area delineations. As HSA deposits are largely placed by third parties *en masse*, they also can be removed from a bank *en masse* and relocated to another institution. Given that reality, banks will likely shy away from making longer-term CRA investments in deposit-based assessment areas. Instead, banks that delineate assessment areas based on HSA deposits are likely to make short-term investments or participate in activities that they can easily terminate without notice, which is a poor strategy for meaningful development and revitalization of LMI and underserved communities. Indeed, such a strategy is most likely to harm CRA deserts, which lack the investments of multiple banks and would suffer the greatest harm if a CRA investment were to suddenly disappear based on changes to the associated institution's HSA deposit base. Overall, tying CRA assessment areas to deposits harms not just banks holding large amounts of HSA accounts but also the communities intended to benefit from the CRA.

## V. The Board Should Exclude HSA Deposits from Any Determination of Assessment Areas or CRA Performance Metrics

Webster strongly encourages the Board to exclude HSA deposits from any deposit-based assessment area requirements. This would alleviate all of the issues discussed in this comment, and present the least burden to institutions with respect to its operations and record keeping. Although HSA deposits are not a line item in Call Reports, aggregate HSA volume can easily be tracked by institutions and verified by regulators.

Importantly, the Board should not be tempted to view HSA deposits as a niche issue affecting a de minimis number of institutions that can be addressed on a case-by-case basis through performance contexts or strategic plans. This risks creating an exception that swallows the rule and defeats one of the primary purposes of CRA modernization. HSAs have proven to be an effective and widely popular healthcare product that has consistently grown in popularity since its introduction. At the end of 2011, there was a total of 6.76 million accounts nationally representing $11.1 billion in assets. In 2019, those figures were estimated to have ballooned to over 28 million accounts and $66 billion in assets, and were

projected to grow to $77 billion by the end of 2020.[16] As the demand for HSAs continues to grow, so too will the number of institutional participants and the degree with which HSA balances will affect each institution. Further, unnecessarily pushing an increasing number of banks into strategic plans or relying on performance contexts and discretion puts at risk the goals of clarity, consistency, and transparency in this CRA Modernization Proposal.[17]

## VI. Conclusion.

The Board's efforts to modernize CRA are welcome and laudable, and Webster appreciates this opportunity to inform the Governors' views. Given the unique characteristics of HSA deposits, HSAs should not be permitted to affect assessment area delineations or Community Development Financing Metrics. Doing so would place institutions holding large amounts of HSA accounts at a competitive disadvantage and may have negative repercussions for the very underserved communities CRA is intended to benefit.

Moreover, there is benefit to the stability of the overall financial ecosystem for consistency among regulatory approaches to HSA deposits. The OCC's decision to exclude HSA deposits from its determination of deposit-based assessment areas represents an insightful and nuanced approach to new forms of CRA regulation; we urge the Board to propose rules related to deposit-based assessment areas in a manner that aligns with the OCC's approach.

We therefore respectfully urge the Board, should it seek to incorporate deposit-based assessment areas in its CRA regulations, to exclude HSAs from any determination of proposed deposit-based assessment areas. Doing so is consistent with the goals of more effectively meeting the needs of LMI communities and fostering clarity, consistency, and transparency.

Respectfully,

/s/ Jennifer L. Harris

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cc: Mitchell, A.
Wolfe, H.M.

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[16] *2019 Year-End HSA Market Statistics & Trends Executive Summary*, DEVENIR RSCH., 3 (Mar. 3, 2020),

https://www.devenir.com/wp-content/uploads/2019-Year-End-Devenir-HSA-Research-Report-Executive-Summary.pdf.

[17] CRA Modernization Proposal, *supra* note 1, at 66410 (stating that contemplated changes to Regulation BB are guided by objectives including "[m]ore effectively meet[ing] the needs of LMI communities" and "[i]ncreas[ing] the clarity, consistency, and transparency of supervisory expectations and of standards regarding where activities are assessed).