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August 10, 2021

Via Electronic Delivery

Ann E. Misback
Secretary, Board of Governors of the Federal Reserve System
20th Street and Constitution Avenue NW
Washington, DC 20551

Re: Docket No. R-1748, RIN 7100-AG15; Debit Card Interchange Fees and Routing

Dear Ms. Misback:

HealthEquity, Inc. (HQY) is submitting this letter in response to the request from the Board of Governors of the Federal Reserve System (the Board) for comment on its notice of proposed rulemaking to amend Regulation II and the Official Board Commentary (Commentary) on Regulation II to clarify Regulation II requirements related to the prohibition on network exclusivity and standardize certain terminology (the Proposal). HealthEquity appreciates the opportunity to comment on the Proposal.

HealthEquity is an Internal Revenue Service (IRS) authorized non-bank custodian of Health Savings Accounts (HSAs) and a directed third-party administrator (TPA) of other consumer-directed benefits such as health flexible spending arrangements (Health FSAs) and health reimbursement arrangements (HRAs), collectively referred to herein as "health benefits." Health benefits are governed by statute and regulation overseen by the IRS, the U.S. Departments of Health and Human Services (HHS) and Labor (DOL), and by individual plan documents of sponsoring employers. We serve nearly 10 million account beneficiaries and plan participants in health benefits and other similar benefits (collectively referred to as "members"), in partnership with nearly 100,000 employers, benefits advisors, and health and retirement plan providers. In many cases, our members access health benefits through the use of specialized health payment debit cards (Health Benefit cards), which permit members to pay or reimburse health care expenses in a convenient, secure, and cost-efficient manner.

As explained below, Health Benefit cards are unlike other debit cards and their transactions are unlike other debit card transactions. We believe the Proposal would have particular and significant negative impacts on the operation, use, security, availability and cost of Health Benefit cards that it might not have on other types of debit cards, without providing offsetting benefits for Health Benefit card users. As a result, we believe that the application of the Proposal to Health Benefit cards would hurt consumer beneficiaries and employer sponsors of health benefits as well as doctors, hospitals and other providers of healthcare services paid or reimbursed through these cards, ultimately increasing the cost of and reducing access to healthcare.

Therefore, we request that the Board confirm that cards associated with HSAs/bona fide trust accounts; HRAs, FSAs, and other health benefits; and employer sponsored transportation and other

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reimbursement programs are exempt from the application of the Proposal, for the reasons outlined below.

Background

Here we offer background on the current rule, Health Benefit card development and adoption, and unique issues in Health Benefit card operations—including medical expense substantiation and Inventory-Information-Approval Systems (IIAS), challenges to the utility of PIN debit, transaction value determination in Health Benefit card transactions and uniform coverage in Health Benefits.

Current Rule

In June 2011, the Board issued Regulation II, implementing Section 1075 of the Dodd-Frank Wall Street Reform and Consumer Protection Act (Dodd-Frank). Section 1075 of Dodd-Frank amended the Electronic Fund Transfer Act[1] and required the Board to develop rules that prohibit payment card networks and issuers from: (i) restricting the payment card networks on which an electronic debit transaction may be processed to a single payment card network or affiliated group of payment card networks (the Network Exclusivity Prohibition); and (ii) inhibiting the right of a person accepting or honoring debit cards to route an electronic debit transaction over any payment card network that is enabled to process such transaction (the Routing Restriction Prohibition).[2]

Section 235.7(a) of Regulation II implements the Network Exclusivity Prohibition, which prohibits an issuer or payment card network from "restrict[ing] the number of payment card networks on which an electronic debit transaction may be processed to less than two unaffiliated networks."[3] Current law specifies an issuer can comply with this requirement by allowing "an electronic debit transaction to be processed on at least two unaffiliated payment card networks, each of which does not, by rule or policy, restrict the operation of the network to a limited geographic area, specific merchant, or particular type of merchant or transaction, and each of which has taken steps reasonably designed to enable the network to process the electronic debit transactions that the network would reasonably expect will be routed to it."[4]

Section 235.7(b) of Regulation II implements the Routing Restriction Prohibition, which restricts any issuer or payment card network from "inhibit[ing] the ability of any person that accepts or honors debit cards for payments to direct the routing of electronic debit transactions for processing over any payment card network that may process such transactions."[5]

Health Benefit Cards

Unlike other debit cards, Health Benefit cards were created to remove barriers to consumer use of health benefits. Specifically, applicable law and regulations prohibit health benefit funds from being provided to beneficiaries prior to a qualifying expense having been incurred.[6] Before the advent of Health Benefit cards, beneficiaries first paid out-of-pocket for healthcare services, then submitted

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[1] 15 U.S.C. § 1693 et seq.

[2] Further, we believe that 15 U.S.C. § 16930-2(b) indicates that the Proposed Rules are outside of the Board's rulemaking purview.

[3] 12 C.F.R. § 235.7(a)(1).

[4] 12 C.F.R. § 235.7(a)(2).

[5] 12 C.F.R. pt. 235, app. A, at 7(a)-2.

[6] See for example IRS Rev. Rule. 2002-80.

receipts or other evidence that a qualified expense had been incurred along with a request for reimbursement. By providing more efficient ways for beneficiaries to access their funds and in many cases, eliminating the need for beneficiaries to pay out of pocket, Health Benefits cards made health benefits more accessible, particularly for consumers living paycheck to paycheck, by making funds available at the point of service.

Unlike other debt cards, Health Benefit cards are required to employ health expense adjudication technology to limit where and how they can be used. IRS Revenue Ruling 2003-43 (the Ruling) addressed the use of Health Benefit debit cards, including requirements surrounding the substantiation of medical expenses. The Ruling approved the use of Health benefit cards provided their use was limited to certain merchants in health-care-related merchant category codes (MCCs), for example doctors' offices, hospitals and medical imaging facilities. The Ruling established additional requirements and administrative procedures which employers, and TPAs on their behalf, must follow when offering Health Benefit cards. Importantly, an MCC alone does not satisfy the requirement for receipts or other evidence of a qualified medical expense. The Ruling described technologies and processes needed to meet this requirement beyond the point of sale, which have subsequently been deployed by TPAs, card processors, issuers and in some cases merchants. Subsequent rulings expanded the use of Health Benefit cards to additional merchants, most notably retail pharmacies and later supermarkets and big box stores, provided there was implementation by issuers and these merchants of an IIAS to restrict transactions at the point of sale to qualified medical expenses.

Special Interest Group for IIAS Standards

The Special Interest Group for IIAS Standards (SIGIS), a non-profit membership corporation, launched in 2007, is responsible for the development and management of an industry standard to meet IRS requirements for operating an IIAS. SIGIS offers certification of individual merchants and oversees certification programs run by third party servicers of small-to-midsized merchants. Card issuers, processors, and the signature and PIN networks that the transactions are routed through are also certified to assure compliance with the SIGIS standard.

In order for Health Benefit cards to meet IRS requirements, their bank identification numbers (BINs) are maintained by the payment networks. Transactions from Health Benefit card BINs, when presented by SIGIS-certified merchants to SIGIS-certified networks, will be adjudicated using the SIGIS standard. Such transactions passed by a non-certified merchant or routed through a non-certified network will be denied in order to maintain compliance.

All SIGIS-certified IIAS Merchants are certified as to their signature debit routes. However, only one merchant has chosen to also certify their PIN debit routing and no merchants have chosen to exclusively certify PIN debit routing.[7]

Market Adoption

Health Benefit cards were adopted widely following the Ruling and the establishment of an IIAS standard, resulting in growing consumer access to and use of health benefits. Today, the vast majority of

[7] The infrastructure network for PIN debit routing, which relies upon single message systems, is separate and apart from the dual-message system used for signature routing. The failure of merchants to certify their PIN debit routing creates network expansion challenges for Health Benefit card issuers.

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employers offering health insurance to their employees also offer one or more health benefits. About 38% of US consumers' out-of-pocket medical expenses are paid from health benefits.[8] Pharmacies routinely tout their acceptance of Health Benefit cards. Healthcare service providers have also embraced these cards because payment at point-of-service eliminates the enormous cost associated with patient billing and collections. Unpaid medical bills are the largest source of business for collections agencies, with 18% of US households holding medical debt in collections.[9]

PIN Networks

All Health Benefit cards are both PIN and signature enabled but, unlike with other debit cards, PIN networks and merchants have shown little interest in the work required to route transactions within the SIGIS standard. Health Benefit card transactions are not permitted at merchants such as gas stations where PIN use is most common, nor can most be used at ATMs. As a result, consumers have little reason to request, retain or use a PIN. Online merchants who have or might conceivably allow card-not-present online PIN-less debit transactions for other debit cards have limited Health Benefit card volume to justify the additional effort. Of the dozen or so companies owning PIN networks (beyond MasterCard and Visa), only two have certified their networks' compliance with SIGIS. Only one merchant has chosen to obtain SIGIS certification to support routing IIAS transactions on PIN debit networks.[10] Among HealthEquity members, nearly all transactions today are signature debit.

Transaction Value Determination

Health Benefit card transactions, unlike other debit card transactions, typically do not reflect merchants' prices for goods or services, but rather cost-sharing or patient responsibility amounts, co-payments, co-insurance, or deductible contributions pursuant to the beneficiary's health insurance plan. For this type of transaction, interchange fees have little to no practical impact on the prices paid by consumers.[11]

Uniform Coverage

At present there are very few Health Benefit card issuers. In addition to the complexities described above, Health Benefit card issuers, unlike those of other debit cards, typically hold funds equal to only a fraction of the cards' open-to-buy balances. This is primarily because health benefits, and in particular Health FSAs, are required to provide "uniform coverage"—that is, the full amount of the benefit must be available throughout a benefit year even though premiums are collected ratably over the course of the year.[12] Uniform coverage creates risks to Health Benefit card issuers and TPAs akin to the risks borne by credit card issuers and program managers. Employers sponsoring health benefits may not make good on Health Benefit card transactions. Nefarious parties may take over legitimate employer-level accounts or create fake ones through commercial identify theft. TPAs are also typically responsible for beneficiary-

[8] https://aitegroup.com/us-health-benefit-account-sizing-total-accounts-and-hsas
[9] https://www.nytimes.com/2021/07/20/upshot/medical-debt-americans-medicaid.html
[10] The Special Interest Group for IIAS Standards, SIGIS Member Networks, available at: https://sig-is.org/publications/sigis-member-networks.
[11] Employers, who pay the bulk of commercial healthcare costs through premium contributions, simultaneously benefit from Health Benefit card interchange fees, which effectively offset a portion of the cost of administering health benefits.
[12] See Prop. Tres. Regis. Sec. 1.125-5(d). While uniform coverage is not required of HSAs, employers may provide it by accelerating pro-rata contributions when the beneficiary incurs a qualified medical expense, See, for example, https://www2.healthequity.com/hsa/balance-booster. This practice, like uniform coverage, frequently results in an open-to-buy balance significantly in excess of funds held by the issuer.

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level fraud. Health Benefit cards generate neither loan income nor spread income given uniform coverage with which to offset the cost of managing these risks.

Benefit cards should be excluded from network exclusivity, routing restrictions, and interchange fee caps

HealthEquity appreciates the opportunity to comment on the Proposal. We urge the Board to exclude Health Benefit (and other similar benefit) cards from the Network Exclusivity and Routing Restriction Prohibitions, and to take this opportunity to codify the existing de facto exclusion of Health Benefit cards from Interchange fee caps. Application of the proposal to Health Benefit cards would, we believe, raise healthcare costs and risk unintended consequences to compliance and healthcare access, while hurting rather than helping consumers who use these cards.

Congressional Intent with Respect to Health Benefit Cards

Prior to Dodd-Frank becoming law, the Senate author of the legislation, Senator Chris Dodd (D-CT), Chairman of the Senate Committee on Banking, made comments on the floor of the United States Senate citing many of the same factors we have described here and indicating that Health Benefit cards (and other similar benefit cards) were intended to be exempt from the Network Exclusivity Prohibition.[13] Thus, granting regulatory relief to Health Benefit cards and their issuers would be consistent with Congressional intent. In addition, the Board has previously acknowledged that certain Health Benefit cards may qualify for a general-use prepaid card exemption.[14] We request that the Board acknowledge and include the exemption in any final regulations.

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[13] 156 Cong. Rec. S5927 (2010). Senator Dodd stated on the floor of the Senate that payment cards used in connection with FSAs, HRAs, and HSAs were not intended to be exempt from the Network Exclusivity Prohibition: "Mr. President, I would also like to clarify the intent behind another of the provisions in the conference report to accompany the financial reform bill, H.R. 4173, the Dodd-Frank Wall Street Reform and Consumer Protection Act of 2010. Section 1075 of the bill amends the Electronic Fund Transfer Act to create a new section 920 regarding interchange fees. This is a very complicated subject involving many different stakeholders, including payment networks, issuing banks, acquiring banks, merchants, and, of course, consumers. Section 1075 therefore is also complicated, and I would like to make a clarification with regard to that section.
Since interchange revenues are a major source of paying for the administrative costs of prepaid cards used in connection with health care and employee benefits programs such as FSAs, HSAs, HRAs, and qualified transportation accounts--programs which are widely used by both public and private sector employers and which are more expensive to operate given substantiation and other regulatory requirements—we do not wish to interfere with those arrangements in a way that could lead to higher fees being imposed by administrators to make up for lost revenue. That could directly raise health care costs, which would hurt consumers and which, of course, is not at all what we wish to do. Hence, we intend that prepaid cards associated with these types of programs would be exempted within the language of section 920(a)(7)(A)(ii)(II) as well as from the prohibition on use of exclusive networks under section 920(b)(1)(A)." (Emphasis added.)

[14] Frequently Asked Questions About Regulation II (Debit Card Interchange Fees and Routing, 235.5(c) General-Use Prepaid Card Exemption, Q/A 5, available at: Federal Reserve Board - Frequently Asked Questions -- Regulation II.

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The Proposal Would Increase the Cost of Health Benefits

Application of the Proposal to Health Benefit cards would increase employer costs to offer health benefits (which are voluntary on the employer's part), perhaps significantly so by further reducing the number of issuers. Health Benefit cards serve a valuable and specific social purpose enshrined in law and regulation of health benefits: lowering the cost of and increasing access to healthcare. Health Benefit cards are of particular value to those who live paycheck to paycheck, because they eliminate the need to go out of pocket for expenses covered by health benefits and subsequently seek reimbursement. Health Benefit cards also benefit doctors and hospitals, because they enable payment at point-of-service versus expensive and difficult medical bill collections. Serving this purpose requires Health Benefit cards to operate in compliance with applicable law and regulations governing health benefits. The costs to do so (including third-party certified health expense adjudication technology and uniform coverage compliance) are unique to Health Benefit cards. Issuers, TPAs and, ultimately, employers bear these costs without the benefit of non-interchange income sources typical of either consumer bank account or credit card relationships. This is evidenced by the limited number of Health benefit card issuers despite rapid growth in cards and their de facto exclusion from interchange fee caps.

The Proposal Would Have Unintended Consequences to Health Benefit Compliance and Card Acceptance

Application of the Proposal to Health Benefit cards is subject to significant unintended consequences due to conflicts with health benefits law and regulation, resulting either in non-compliant cards or reduced merchant acceptance. For example, the proposed amendment to Section 235.7(a)(2) would require an issuer to enable "at least two unaffiliated payment card networks to process an electronic debit transaction" for every specific merchant and every particular type of merchant in order to comply with the Network Exclusivity Prohibition. We believe the terms "specific merchant" and "particular type of merchant" are currently ambiguous. In particular, it is unclear if categories for a "particular type of merchant" would be determined based on payment card network MCCs. MCCs are critical in determining if Health Benefit cards are able to be used to pay for health care expenses.

As previously highlighted, IRS guidance only permits a limited set of health care related MCCs to be enabled to accept Health Benefit cards. In some of these MCCs, merchant-level restriction (for example, based on IIAS certification) is critical to compliant and efficient card operation. Finally, we note that specific issuers impose other restrictions (such as geographic restrictions) based on the unique spending patterns and fraud dynamics of Health Benefit cards, which may differ from network to network based on each network's security capabilities. As a second example, because Health benefit card transactions are a modest proportion of all transactions, merchants and their acquirers may choose to route transactions through networks other than the limited number that have made the significant investment associated with Health Benefit card compliance and SIGIS certification. Merchants and their third-party providers, and not issuers, will typically control which networks they will choose to route transactions through and whether they will enable cardholder choice. Merchants may, knowingly or unknowingly, prioritize other legitimate business objectives over Health Benefit card acceptance irrespective of the social value.

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The Proposal Would Not Help and May Hurt Consumers

When the final rule was announced by the Board in 2011, the Board highlighted that the savings to merchants "could potentially be passed on to consumers at lower retail prices."[15] As explained above, the price of most goods and services for which health benefits may be used is determined by negotiations between providers (that is, doctors, hospitals and drug companies) and health plans on behalf of employers who pay the bulk of these costs. Consumer transactions typically involve only co-payments, co-insurance, or deductible contributions determined by the terms of the beneficiary's health insurance plan. Obviously, application of the Rule will not reduce co-payments, co-insurance or deductibles.

However, the Proposal may have the unintended consequence of increasing consumer costs and administrative burden. Health benefits lower consumers cost of healthcare and Health Benefit cards grant beneficiaries immediate and convenient access to health benefits funds. However, as previously highlighted, Health Benefit card transactions cannot be routed on non-SIGIS certified networks successfully. Thus, if a network is not SIGIS certified, cardholders will be forced to pay out of pocket and submit documentation substantiating their purchases. The Proposal may limit the number of merchants accepting Health Benefit cards at the point of sale. Increased costs, as explained above, may cause fewer employers to offer health benefits or Health Benefit cards, also increasing costs to consumers.

For avoidance of doubt, our comments on the Proposal should be read only as to its application to Health Benefit (or other similar) cards. **We take no position on the application of the Proposal to other types of debit cards, other than to applaud the Board for its advocacy on behalf of competition that benefits consumers.**

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Thank you for the opportunity to comment on the Proposal. Please contact me at jdietel@healthequity.com or 650.577.6372 if you have any questions or would like for us to provide any additional information regarding this matter.

Sincerely,

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[15] Debit Card Interchange Fees and Routing, 76 Fed. Reg. 43394, 43420 (July 20, 2011).