Nature and Health Discussion Note

Trends in Hospital Charity Care—
An Opportunity for Investment in Nature and Health?

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Background
This discussion note is the first in a series exploring possibilities for linking nature and health. Willamette Partnership is an Oregon-based nonprofit that helps build collaborative solutions to complex conservation problems. Our work is focused on building resilience, both in natural ecosystems and in the human communities that depend on them. Our approach is rooted in a strong sense of place and community, and depends on contributions from a diverse coalition of partners. We believe that solutions to many of our seemingly intractable problems are within reach.

Nature and human health are connected
There is growing interest in the links between healthy environment and healthy people. We have always assumed there are links, but now we are getting clearer about the scope of those links. With regard to conservation, we have used tools like the Clean Water Act and Clean Air Act to treat the most visible symptoms of pollution rather than address the root causes. Regarding health, we have focused on providing healthcare—treating the symptoms of disease rather than the root causes of public health and prevention. Better science, expanded social networks, and the realities of having to do more with less are driving the conservation and health communities to look for integrated evidence-based, outcome-driven solutions. That search is bringing the health and conservation communities closer together.

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A growing base of research demonstrates that nature and access to nature can improve human health\textsuperscript{1}:

- Improve air quality;
- Increase physical activity;\textsuperscript{2}
- Reduce stress and improve mental health; and
- Build better relationships between people.

These are many important determinants linked to some of our most challenging health problems today. For the Willamette Partnership, we see several steps in building from this research into action:

- Synthesize knowledge;
- Connect health and conservation leaders;
- Make the business case for why conservation groups should include human health as one of their core values, and why health providers should invest in nature;
- Demonstrate how nature can or cannot generate health outcomes; and
- Suggest the policy changes to support the links between health and nature.

**Building a business case for investing in health and nature**

This discussion note focuses on one piece of the business case for investing in nature and health—the potential to connect health providers with new approaches to providing community benefits. The IRS and the Affordable Care Act require tax-exempt hospitals to provide community benefits. Community benefits can include a wide range of activities, from providing health care to people who can’t afford it, subsidized health services, educating health professionals, research, supporting community health improvements, contributing to community groups, and many others.

Throughout this discussion note, we reference studies conducted in different years. We are using the most current data we were able to access. The analysis in this discussion note is meant to present a preliminary snapshot that should be expanded over time to include a broader sample of state information and time periods.

**Traditionally hospitals invest many of their community benefit dollars in charity care**

On a national basis, the estimated value of federal, state, and local tax exemption for non-profit hospitals was \$12.6 billion in 2002.\textsuperscript{2} Prior to the Affordable Care Act (ACA), hospitals provided 7.5\% of their operating expenses as community benefits - with 85\% of that amount in low or no-cost charity care.\textsuperscript{3} Nationally, the largest share of community benefit expenditures in 2009 were on:

- Unreimbursed costs for means-tested government programs (45.3\%);
- Charity care (25.3\%); and


- Subsidized health services (14.7%).

With the passage of the Affordable Care Act, states were presented the opportunity to expand Medicaid to people at 138% of the federal poverty level. Twenty-eight states chose to move forward with that expansion. Medicaid enrollments for those states seems to be growing since January 1, 2014. In Oregon, enrollment in the Oregon Health Plan (Medicaid) has increased almost 60% since January 2014. In Washington, almost 600,000 people signed up for insurance through Medicaid or private plans.

Analysis conducted
The Willamette Partnership collected publically available quarterly financial data from hospitals in six states that expanded Medicaid coverage (California, Colorado, Maryland, Nevada, Oregon, and Washington) and one state that did not (Montana). The most recent, comparable, and available data were for the first quarter of 2014 and the first quarter of 2013. We contacted all 50 states for data, but most states either had not gathered the 2014 data or were unable to provide access to those data. Data were gathered at the hospital level for five states, and provided as a statewide aggregate for two states. The analysis incorporated data for 751 hospitals (across seven states) out of the 5,723 registered hospitals in the country. While tax-exempt hospitals represent approximately half of those registered nationally, the specific numbers vary by state. For example, 57 out of the 59 Oregon hospitals in our sample operate as non-profits, but only 70% of those in California were non-profit, church or state-run. Some hospital records were excluded from the analysis due to closings in 2013 and openings in 2014, which prevented comparisons across years (eight in CA, one in OR, and twenty three in WA).

The Partnership looked at quarterly changes in charity care and bad debt between 2013 and 2014. We acknowledge that comparing one quarter’s data from just two years is not a complete reflection of trends in community benefit expenditures, and recognize that there are differences across states. The Partnership was not able to access data from more than one state that did not expand Medicaid. As noted earlier, we hope this analysis is expanded over time to include a broader sample of states and time periods.

Findings: Expenditures on charity care and bad debt have dropped substantially
Across all six states that expanded Medicaid, charity care and bad debt expenditures decreased at an average rate of 30% for charity care and 28% for bad debt between Q1 2013 and Q1 2014 (See Table 1). In dollar terms, hospitals in these six states spent roughly $737 million less on charity care and $397 million less on bad debt across Q1 2013 and Q1 2014. In a similar review, the Colorado Hospital Association looked at 450 hospitals across a sample of 25 states. For the 13 states within the subset that expanded Medicaid, charity care dropped

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5 Young et al. (2013).
10 Hospitals in the Kaiser network were also excluded from analysis because they did not report values to Databank.
from an average of $2.8 million per hospital in Q2 2013 to $1.5 million per hospital in Q2 2014. For the 12 states that did not expand Medicaid, charity care dropped from $4 million per hospital in Q2 2013 to $3.4 million per hospital in Q2 2014.\textsuperscript{11} We found that in Montana, charity care expenditures increased in total across 31 hospitals (roughly half of hospitals in the state) from $37.5 million in Q2 2013 to $40.2 million in Q2 2014, but bad debt decreased from $42.6 million to $39.6 million across that same time.\textsuperscript{12}

### Table 1: Changes in charity care and bad debt from 2013 to 2014 by state

<table>
<thead>
<tr>
<th>State</th>
<th>Q1 2013 ($million)</th>
<th>Q1 2014 ($million)</th>
<th>Change (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Charity care</td>
<td>Bad debt</td>
<td>Charity care</td>
</tr>
<tr>
<td>California\textsuperscript{13}</td>
<td>$1,207</td>
<td>$1,430</td>
<td>$955</td>
</tr>
<tr>
<td>Colorado</td>
<td>$455</td>
<td>$270</td>
<td>$277</td>
</tr>
<tr>
<td>Montana</td>
<td>$38</td>
<td>$43</td>
<td>$40</td>
</tr>
<tr>
<td>Maryland</td>
<td>$116</td>
<td>$178</td>
<td>$78</td>
</tr>
<tr>
<td>Nevada</td>
<td>$417</td>
<td>$255</td>
<td>$299</td>
</tr>
<tr>
<td>Oregon</td>
<td>$203</td>
<td>$99</td>
<td>$134</td>
</tr>
<tr>
<td>Washington</td>
<td>$331</td>
<td>$216</td>
<td>$247</td>
</tr>
<tr>
<td>TOTAL</td>
<td>$2,765</td>
<td>$2,491</td>
<td>$2,030</td>
</tr>
<tr>
<td>MEAN</td>
<td>$395</td>
<td>$356</td>
<td>$290</td>
</tr>
<tr>
<td>MEDIAN</td>
<td>$331</td>
<td>$216</td>
<td>$247</td>
</tr>
<tr>
<td>STD DEV</td>
<td>$389</td>
<td>$481</td>
<td>$310</td>
</tr>
</tbody>
</table>

Charity care does not always equal surplus funds for hospitals
Although there were significant drops in both charity care and bad debt across the six states that expanded Medicaid, there are many other financial and operational elements that influence how this translates to a hospital’s balance sheet and long-term financial stability.

Across all Washington hospitals, there was a 52% increase in total margin, but for CA, MD, NV, and OR hospitals, total margin decreased an average of 25% between Q1 2013 and Q1 2014. In Colorado, total margins decreased for large urban hospitals (18.4%) and increased for rural (8.2%) and other urban (8.1%) hospitals. One analysis in Washington explained that the mixed results were caused by different combinations of increasing cost of providing healthcare, reduced reimbursements for Medicare and Medicaid, in combination with the increasing numbers of Medicaid-covered patients increasing margins for some hospitals and decreasing them for others\textsuperscript{14}.


\textsuperscript{12} Montana data were provided as aggregated values from 32 hospitals in 2013 and 31 hospitals in 2014. In total, Montana reports 65 hospitals, including specialty clinics.

\textsuperscript{13} Hospital-level data for Q2 2013 were used because they were available. Breaking annual 2013 data into 4 quarters only resulted in ~10% in total margin, but no real differences in charity care or bad debt trends.

\textsuperscript{14} Ostrom, 2014.
Shortfalls and losses linked to reimbursements for Medicaid and Medicare will certainly influence hospitals’ financial outcomes. The American Hospital Association reports underpayment of $56 billion in 2012, equivalent to hospitals receiving payments of only 89 cents per dollar spent on Medicaid patients. While some states, including Oregon, specifically allow for these losses to be counted as community benefits, it remains to be seen whether the drop in charity care will be offset by shortfalls in federal reimbursements.

It’s clear that understanding the financial implications of changing healthcare coverage will be complicated and may take several years to understand as implementation continues. Further analysis looking at audited financial statements from hospitals may be needed.

**Hospitals play a critical role in fostering health— which means a lot more than providing free health care now**

Hospitals will need to think about how they provide community benefits. Their commitment to community health, both in providing community benefits and in implementing community health needs assessments, is likely to increase. For Willamette Partnership, it is key that the growing body of research demonstrating the community health benefits of nature, and access to nature, are brought into that discussion. We know that providing natural areas and access to nature can provide community health in a way that is safe, cost-competitive, and creates new partnerships with a broad array of community groups. Access to nature is not the only solution, and in some cases may not even be a good solution.

**Can greenspace groups work with hospitals to re-envision community benefits?**

In 2009, only 5.3% of community benefit expenditures focused on improving community health. The jump in Medicaid enrollment is changing how hospitals provide access to healthcare for the people who are least able to afford it. Some healthcare providers are already targeting some of their community benefit funding. With expenditures on charity care decreasing, can hospitals think about how to spend some of their community benefits budget improving community health—specifically improving by improving access to greenspaces and other natural areas?

Most states require some investment in community benefit, and the Affordable Care Act added its own requirements. NV, PA, TX, and UT are the four states that require some level of minimum investment in community benefit. For example, Nevada requires that both for-profit and non-profit hospitals above a certain size provide charity care at a level equal to 0.6% of the previous year’s net revenue.

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16 Young et al. (2013).
Why should environment be considered a community benefit?
Tax-exempt hospitals report their community benefit expenditures on Schedule H of their IRS form 990. Part II, line 4 of the IRS Schedule H form has a place for expenditures on “environment”, which includes “…alleviation of water or air pollution, safe removal or treatment of garbage or other waste products, and other activities to protect the community from environmental hazards.”

Taken more broadly, we know that nature and access to nature can more broadly mitigate environmental hazards. Across the U.S., numerous studies have linked access to parks and open spaces to increased physical activity and decreased obesity.\(^\text{19}\) In Portland, Oregon, increasing the density of tree canopy can reduce exposure to PAHs, NOx, and NO2—all important factors in respiratory health. Urban tree canopy was associated with up to a 45% reduction in NO2 levels, which was connected to about $7 million/year in reduced costs of treating respiratory disease.\(^\text{20}\)

Access to greenspaces have been linked to physical activity.\(^\text{21,22}\) Throughout the country, a number of health providers are participating in park prescription programs to get kids outside and playing in parks.\(^\text{23}\) There are also efforts underway working with landowners to provide healthcare as an incentive for providing nature or access to nature.\(^\text{24}\)

In Greater New Haven – 13 cities and towns in Connecticut – initial data suggest an association between access to parks and health outcomes ranging from measures of obesity and chronic disease to depressive symptoms. And these relationships are mediated, as expected, by improvements in air quality, increased physical activity, greater social cohesion and reduced stress.\(^\text{25}\) Compared to other public health interventions, these early findings point to significant community benefits.

Nationally, a group of leaders from the worlds of health and nature convened June 22-24, 2014 at the Johnson Foundation in Wisconsin to discuss ways to further the links between health and nature. There was a broad recognition that we know enough to act, and that engaging health providers in making that link was important.

We don’t know how nature and access to nature adds up in terms of cost-effectiveness relative to other community health initiatives, but these strategies are important to consider.

**We know enough to start a conversation now**
The Partnership conducted this initial analysis because it was hearing anecdotal stories of significant changes in how hospitals are thinking about delivering community benefits. This

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discussion note is intended to spark more conversation about how hospitals and groups providing access to nature can interact more. Specifically:

- What tools might hospitals need to incorporate nature and access to nature as part of their Community Health Needs Assessments—refining the section on how they will provide community benefits;

- How can hospitals access existing inventories of parks and natural areas to connect their providers to community resources;

- How can groups helping provide access to nature support health providers in delivering programs that benefit both the environment and human health;

- What are the broader trends around charity care, how are they influencing hospital economic viability, in ways where nature and access to nature might provide one small part of the solution; and

- What additional research needs to be done to quantify the value of nature for community health?

For Willamette Partnership, we feel there is a strong business case to be made for why investing in nature and access to nature (more parks, greener trails, programs to get kids outdoors, and planting trees at schools and along roadways) is an important part of providing community benefits. Our hope is that this note can help hospitals and people providing nature and access to nature open new conversations about improving both nature and health. Contact us if you want to discuss more.

For further information

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