NCRC
National Community Reinvestment Coalition

The Community Reinvestment Act and Its Connections to Health Outcomes

Published: April 2022

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About NCRC

NCRC and its grassroots member organizations create opportunities for people to build wealth. We work with community leaders, policymakers and financial institutions to champion fairness in banking, housing and business.

Our members include community reinvestment organizations, community development corporations, local and state government agencies, faith-based institutions, community organizing and civil rights groups, minority and women-owned business associations, and social service providers from across the nation.

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Key Takeaway:

Policymakers and community organizations should understand CRA as a powerful tool of public health policy, not only the housing and business development heavyweight it has always been – because community wealth shapes community health.

In the past few decades our collective knowledge of public health drivers has shifted. Personal behaviors and clinical care alone don't indicate health as many once thought. With greater understanding of the social determinants of health, the burden of achieving optimal health does not lay with the individual alone, but with the community and neighborhood where one lives, works, plays and ages. The effect of social determinants of health on health outcomes is a burgeoning field of study – and there is already a robust literature indicating that addressing upstream determinants ultimately influences health outcomes.

This move has shifted the burden of improved health care outcomes from individual providers and patients out onto the wider community. This shift brings new interest in community and economic development initiatives addressing upstream drivers. The Coronavirus pandemic especially and its disparate effect on low- and moderate-income communities, predominantly communities of color, has underscored the critical role of hospitals, health systems and medical care, as well as that of banks and financial institutions to lead equitable community economic recovery.

This discussion paper presents the Community Reinvestment Act as fundamental to the improvement of health outcomes in low- and moderate-income communities via development and initiatives that address the social determinants of health and create healthier communities.

The Community Reinvestment Act

The Community Reinvestment Act (CRA) was enacted in 1977 to prevent redlining and encourage banks to help meet the financial needs of their community. The law was designed to aid those from low- and moderate-income (LMI) households, who do not have access to the same financial services as their counterparts. Under CRA, financial institutions have a duty to serve the communities in which they are located. This duty is evaluated based on how well they meet the credit needs of the communities they serve, particularly in LMI neighborhoods that have been historically disadvantaged. The banks

are overseen by three federal regulators: the Office of the Comptroller of the Currency (OCC), the Federal Deposit Insurance Corporation (FDIC) and the Board of Governors of the Federal Reserve System (FRB). Each supervisory agency completes a performance evaluation of each bank's lending, investments and services. Large banks are evaluated once every two to three years, while smaller banks are evaluated less frequently. Based on the results of the performance evaluation, a bank or financial institution may be later granted the opportunity to merge with another bank or open a new branch. Thus, CRA provides an incentive for banks to increase the availability of capital and credit to LMI communities, therefore improving the overall wealth and health outcomes of a particular community. If a bank receives a less-than-satisfactory grade, then it would be deemed in noncompliance with CRA. This would significantly delay or deny the bank's application to merge, open a new branch or acquire another institution, among other effects.

While not initially fundamental to the establishment of CRA, addressing social determinants of health has become a predominant goal of the community development sector. The objectives of CRA, such as supporting affordable housing and promoting economic development, align well with the aim to improve community health equity by addressing the social determinants of health in LMI communities.

According to the Federal Reserve Bank of New York, the four categories of CRA-eligible community development activities are:

- Affordable housing
- Community facilities and services targeted to LMI communities (including financial education and capability, charter schools, community centers and daycare facilities)
- Activities that promote economic development by providing financing for small businesses or small farms (including workforce development and small business technical assistance)
- Neighborhood revitalization and stabilization in LMI geographies, distressed or underserved non-metro middle-income areas or designated disaster areas

Banks are assessed on these categories of work within the geographical area where the bank conducts most of its business activities. Banks can pursue community development activities outside of assessment areas provided they have first met community needs in their assessment areas.

These efforts improve the socioeconomic outcomes of LMI communities. Socioeconomic status has been linked to health outcomes in LMI communities.

How CRA Has Been Used to Create Healthier Communities

CRA has contributed to building healthier communities by addressing the social determinants of health. According to the Lincy Institute, a healthy community is defined as one that "creates and improves the environment and expands resources such that the prerequisites for health are provided." They include aspects such as healthy housing, access to healthy food and medical care, well-maintained landscape and environment, culture, education, public transportation, social services and more – all attributes which can be influenced through community development financing.

CRA examiners assess the level of banks' community development financing which supports affordable housing, economic development and community facilities. These community development financing choices can support residents' health directly – such as support for the development of grocery stores and health clinics – or indirectly by shaping the social determinants of health in LMI communities where historic neglect has created unhealthy and unsafe environments. Banks can improve their CRA scores by investing in health clinics, decreasing food insecurity through local programming and, perhaps more critically, increasing access to healthy housing, which has been found to have a very strong relationship to health outcomes.

CRA and Health Clinics

When it comes to community health and development, CRA and the Affordable Care Act (ACA) are largely related. The ACA was enacted in March 2010 under President Barack Obama, as a health care reform act with three pertinent goals:

1. Increase affordable health insurance to more people.
2. Expand the Medicaid program, which primarily aids LMI individuals and families.
3. Support and lower the cost of medical care delivery methods.

Combined, these goals promote community investment and complement CRA. Both the ACA and CRA offer tools and resources which can be used to expand access to healthcare and promote affordability within LMI communities. While the ACA increases the number of insured Americans, CRA focuses investing in the overall economic well-being of LMI communities. This bridge between health and banking has generated increased oversight and investments into nonprofit hospitals and surrounding communities which have historically lacked access to these basic necessities. The ACA also borrows from CRA's incentives-based approach by requiring hospitals that seek tax-exempt status to conduct community health needs assessments and implement strategic plans in response to their findings. Each law uses public accountability mechanisms to nudge private actors toward the goal of improving the well-being of the communities they serve.

Even with the ACA in place, however, over 8% of the country remained uninsured in 2020. These 28 million Americans are less likely to seek and/or afford healthcare. In LMI communities that lack access to adequate and affordable health care, residents may live with undiagnosed diseases or conditions and lack access to major treatments for both communicable and chronic illnesses. This is where CRA becomes especially critical, as it incentivizes banks to seek CRA credit by increasing funding in health initiatives, such as healthcare centers, homeless shelters or drug recovery centers, which all directly affect community health. Typically, health centers tend to be prevalent in metropolitan and wealthier areas. The healthcare industry is choosing to prioritize revenue, leaving people in LMI communities to seek care in wealthier areas. The vast majority of new hospitals opened since 2000 are in wealthy suburbs, for example. Many LMI communities are located within urban areas, where there has been a major increase in hospital closings. LMI families face a lack of healthcare options within proximity to their neighborhoods.

One way that CRA has been used to create healthier communities is through federally qualified health centers. Such facilities "provide life-sustaining services to residents in economically challenged neighborhoods," according to the OCC, creating upstream effects of social determinants of health. These health centers receive federal grants under the Public Health Service Act and, preferentially, from cost-based reimbursement under Medicare/Medicaid programs. Federally qualified health centers are especially necessary in LMI communities, as they provide services to all persons regardless of insurance status.

CRA investments made in health care are largely in response to a long, racially biased history of redlining in the United States. Fifty-plus years after the formal end of this official policy of disinvestment, redlining continues to affect LMI communities, especially those with large Black populations. In other words, one's zip code is one of the most significant components of one's projected health outcomes. On its own, location and environmental factors can determine up to 60% of one's projected health risk and outcomes, exemplifying that health is determined by the environment more than it is by genetics, clinical care or personal behavior in America. Access to primary care, emergency rooms and other preventive services are all determinants of health that CRA can be used to improve.

According to the 2019 study, "Comparison of Healthcare Delivery Systems in Low- and High-Income Communities," by the *American Journal of Accountable Care*, low income communities are less likely to have a high density of primary provider care as compared to their wealthier, more urban counterparts. A lack of physician density is associated with various incidences of disease or conditions. The researchers found that to combat this issue, local delivery systems should be implemented in these communities that lack preventative measures. CRA investments would be a plausible solution to aid in the creation and distribution of these systems.

CRA and Food Insecurity

Food insecurity is one of the nation's leading health and nutrition issues, affecting 11% of US households. Food insecurity is influenced by income, employment, race/ethnicity and disability, making it a very complex issue on its own to address. Neighborhood conditions may affect accessibility to food. Residents of low income, predominantly Black communities have to travel an average of 1.1 miles farther to the closest grocery store than those in predominantly White neighborhoods. This added barrier also diminishes access to healthy food options, exacerbating other potential health issues that exist in the communities. Food insecurity is associated with a myriad of negative health outcomes for adults and children alike, including birth defects, anemia, anxiety, depression, diabetes, hypertension and poor sleep.

According to the Silicon Valley Bank, food insecurity only accelerated during the COVID-19 pandemic, generating heavy and prolonged reliance on food banks. While food assistance programs help, they are a small fix to a very widespread problem. CRA could be leveraged to generate increased investments in food banks, markets, grocery stores, delivery programs and distribution and processing centers.

CRA and Housing

Housing is a well-established social determinant of health, as it has a significant influence on multiple factors that affect health outcomes. The affordability, condition, location and stability of a home determines the housing quality, which is an indicator of the community's projected health outcomes. Housing quality is defined as the physical condition of a person's home, as well as the quality of the social and physical environment where the home is located. Stable and affordable housing has been found to improve health and reduce health care costs. Further, affordable housing can allow for greater access to food, healthcare and education, which are all determinants of health. As residents spend less on housing than the market rate, they have a greater ability to afford food and healthcare costs. Since LMI neighborhoods are frequently exposed to poor housing quality as a direct result of redlining, these vulnerable households are particularly susceptible to these challenges, which may significantly affect their short- and long-term health risks. For example, poor conditions that affect housing quality may include lead poisoning, poor ventilation, asbestos and mold, residential crowding, and unregulated climate. These conditions may aggravate already-poor health conditions, potentially making it progressively difficult to improve health outcomes.

Under CRA, banks can be leveraged to address upstream efforts of poor housing qualities in LMI communities by investing in affordable housing initiatives. Supportive housing outcomes demonstrate the connection between housing and health. For example, a Housing First philosophy in supportive housing and care tends to lower the overall cost of services for people who experience homelessness.

In Orlando, Florida, a Housing First initiative was launched after patients with underlying substance abuse or mental health issues exhibited an overreliance on local hospital emergency care. Leadership at the Adventist hospital system, a mission-driven health care institution, set aside $6 million in community benefit spending to improve case management for the chronically homeless. The hospital system then invested further community benefit funds into a local homeless impact fund and acquired a transitional housing center, recognizing that investments in housing would ultimately be a cost savings to the hospital and system.

This system "played a key role in [Orlando]'s homeless services system transition toward a Housing First model," according to the Federal Reserve Bank of Atlanta. This is important because housing instability may also lead to chronic homelessness, which has been linked to higher morbidity of physical and mental health, as well as increased mortality. Housing programs can ameliorate many of these issues, leading to not only healthier local economies but to better health outcomes for the entire community.

CRA, Telemedicine and Broadband Access

Telemedicine can be a powerful tool in addressing health disparities. At the start of the pandemic, the federal government encouraged financial institutions to focus their contributions to broadband connectivity for low-income communities. Low-income communities demonstrate a severe need for increased access to broadband to ensure effective and accessible telemedicine. Income and broadband access are positively correlated. According to the US Census Bureau, 30% of households earning less than $50,000 a year do not have an internet subscription. Financial institutions recognize disparities in broadband infrastructure and pinpoint them as a driver of telemedicine inaccessibility. In light of the COVID-19 pandemic, utilizing CRA to support broadband access is critical as ever for both rural and urban communities. To close the digital divide the Federal Reserve, FDIC and OCC note that CRA may support broadband infrastructure. Along with educational and economic impacts, access to telemedicine reduces health disparities. Expanded broadband access and subsequent telehealth is prioritized under CRA; it is the responsibility of banks to act.

Conclusions

A lack of affordable housing is linked to high poverty rates, low employment rates, low access to health care, food insecurity and many other health determinants. Since affordable housing is at the forefront of many of these issues, it is absolutely an appropriate area for investment, especially as gentrification continues to exacerbate the issue. In addition, CRA evaluations encourage banks to pursue opportunities for holistic development that includes financing community facilities, grocery stores, health clinics and small businesses in addition to affordable housing. Considering how these investments are optimally reported

and analyzed as part of the CRA exam process ensures reliable assessment of these health equity investments.

Looking Ahead: The Future of CRA

In early 2022, the FDIC, FRB and OCC will be undertaking an interagency rulemaking process to update CRA regulations, which have been largely static since 1995. This effort involves mandating a more rigorous CRA exam and improving the quality of community development finance. Currently, there is no publicly available database on community development finance. NCRC has asked the agencies to consider requiring banks to submit community development data on a census tract or at least county level and to indicate dollars for major categories of community development finance including affordable housing and community facilities. This would help determine whether communities in need are receiving the community development finance they need to promote healthy outcomes for their residents.

The COVID-19 pandemic has demonstrated the intense need for increased CRA developments to combat the health disparities in LMI communities by addressing social determinants of health, The ongoing COVID-19 pandemic illustrates the need to increase the consideration given under CRA to the social determinants of health. COVID-19 has disproportionately affected LMI communities. The pandemic has made clear that healthcare must be improved and made more readily accessible across the United States — and that some places need that change more urgently than others. CRA is one such tool for making such large-scale change happen. The federal agencies that provide oversight of CRA have advised banks to aid in the economic recovery from the pandemic by increasing community development financing and waiving certain loan fees, increasing credit limits, expanding the availability of short-term, unsecured credit products for creditworthy borrowers and more.

The continued socioeconomic response of banks in the face of the COVID-19 pandemic is greatly related to health clinics, food insecurity and housing, as discussed above. To expand health care as a form of community development, these factors, as well as many others, must be taken into consideration. By increasing investments in federally qualified health centers, food banks and housing programs, CRA would be adapting to reflect the freshly-bared needs of the LMI communities it is designed to serve.