

VI. OTHER COMMUNITY BENEFIT REPORTING - BAD DEBT AND SHORTFALLS, RESEARCH, INCOME AND HEALTH INSURANCE COVERAGE LEVELS

A. Overview and Summary of Key Findings

Section VI summarizes the study's other demographic breakdowns of uncompensated care and community benefit expenditures. Section VI.B reports certain community benefit expenditure data for the group of 15 hospitals that reported 93% of the medical research expenditures, and analyzes the impact this group had on the overall results. Section VI.C provides uncompensated care breakdowns by community type and revenue size and analyzes reporting differences depending on whether shortfalls and bad debt are included in uncompensated care. Section VI.D includes a discussion of reported community benefit expenditures depending upon per capita income and insurance coverage levels in the communities surrounding the respondent hospitals.

The key findings of this section are:

1. A group of 15 hospitals, comprising 3% of all hospitals in the study, reported 93% of aggregate medical research expenditures and 58% of aggregate medical education and training expenditures reported by all hospitals in the study. These hospitals had a materially different community benefit mix than did the other hospitals, with medical research expenditures comprising 45% of their total community benefit expenditures, followed by medical education and training (28%), uncompensated care (22%), and community programs (5%). Although this group of 15 hospitals reported lower uncompensated care expenditures as a percentage of revenue than the overall group (6% average and 3% median, respectively, compared to 7% and 4%, respectively, for the overall group), it reported higher community benefit expenditures as a percentage of revenue than the overall group (19% average and median, respectively, compared to 9% and 6%, respectively, for the overall group).
2. Greater percentages of hospitals reported including bad debts and self pay shortfalls in uncompensated care than any other types of shortfalls. This was the case overall and for each community type and revenue size.
3. Rural hospitals (CAH and non-CAH) reported higher percentages of hospitals including private insurance and self pay shortfalls in uncompensated care than did the other community types. Urban and suburban hospitals (high population and other) reported higher percentages of hospitals including bad debt in uncompensated care.

4. The treatment of bad debt as uncompensated care varied slightly more across revenue size categories than it did across community types. The treatment of a particular shortfall as uncompensated care varied more across community types than across revenue size categories.
5. The study did not obtain information regarding the breakdown of reported uncompensated care amounts across bad debt or specific types of shortfalls. Accordingly, the study does not assess the impact that uniform treatment by all respondent hospitals would have on the uncompensated care or aggregate community benefit expenditure levels of the overall group or across the community types or revenue size categories.
6. The study did not find a correlation between community benefit expenditure levels and per capita income levels of the area surrounding the hospital. The average and median percentages of revenues spent on uncompensated care by the hospitals in the low per capita income categories were less than those reported by the overall group, and generally were less than those reported by hospitals in areas with per capita incomes at or above state or federal averages.
7. The study suggests a correlation between community benefit expenditure levels and the health insurance coverage levels of the area surrounding the hospital. The average and median percentages of total revenues reported as spent on community benefit expenditures increased as the surrounding area's health coverage level decreased (uninsured rate increased). The percentage of hospitals reporting spending more than 5% of total revenues on community benefit expenditures also increased as health insurance coverage levels decreased (uninsured rates increased).

B. Hospitals Reporting Largest Amounts of Medical Research Expenditures

A group of 15 hospitals, comprising 3% of the hospitals, reported 93% of aggregate medical research expenditures. Each of these hospitals reported more than \$10 million in medical research expenditures.

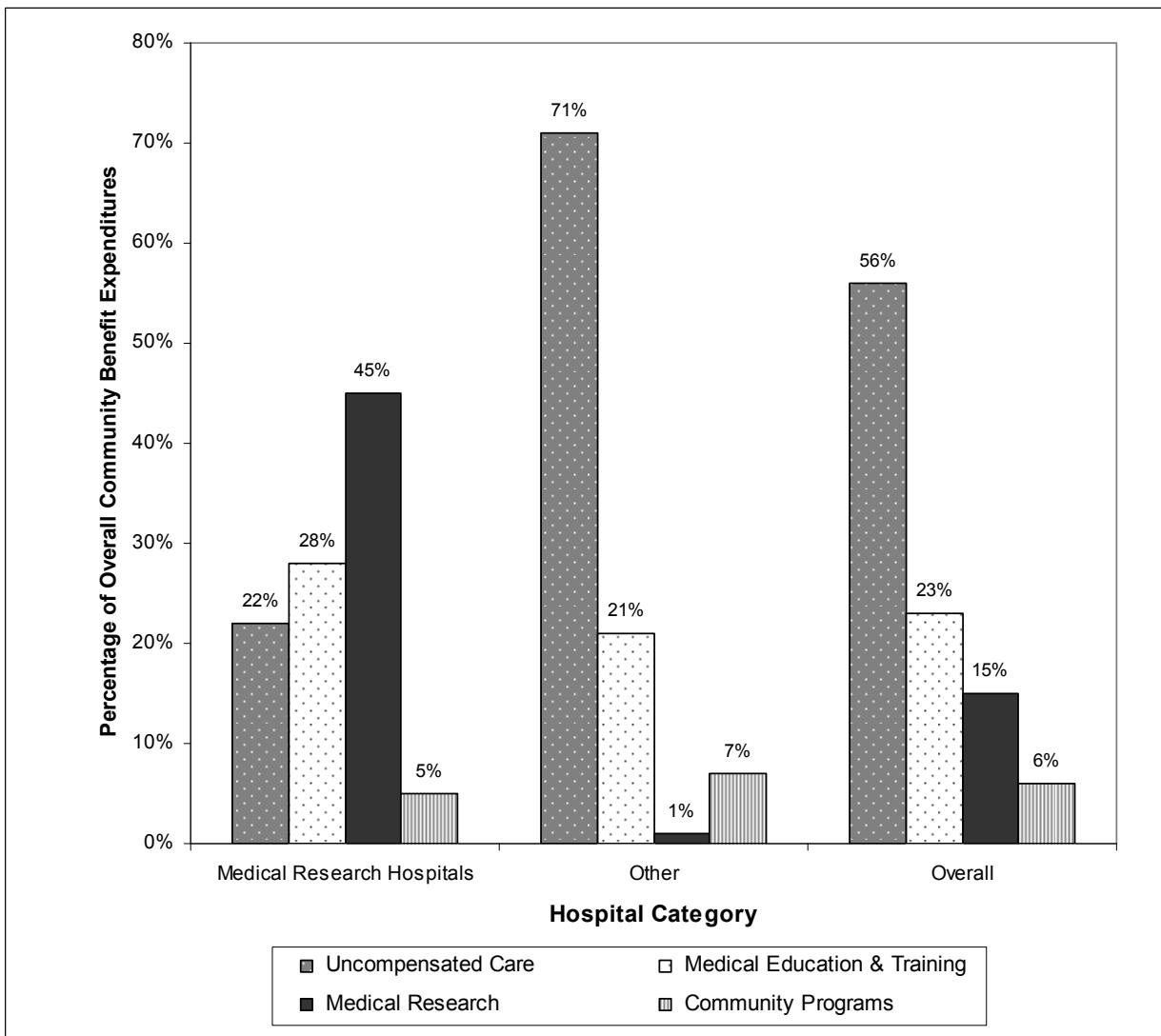
For purposes of this section, this group of 15 is referred to as "research hospitals". The classification is not dependent on whether the hospital considers itself a research hospital. As the case with the report in general, this data has limited use for several reasons, including the relatively small size of this group, that the information reported was not independently verified, and the different measurements and components of uncompensated care included by the respondent hospitals. A material percentage of this group was children's hospitals which also impacted the results.

The average and median medical research expenditure amounts of the 15 medical research hospitals (\$87.9 million and \$44.9 million, respectively) were significantly higher than those reported by the remaining 89 hospitals reporting medical research expenditure amounts (\$1 million and \$0.3 million, respectively). The average and median percentages of revenue reported as spent on medical research by the medical research hospitals (8.3% and 7.1% respectively) were higher than that reported by the other hospitals (0.5% and 0.1%, respectively) and the overall group (1.6% and 0.2%, respectively).

Patient insurance coverage. In general, the research hospitals reported a higher percentage of patients with private insurance (49%) and a lower percentage of patients with Medicare (16%). The lower percentage of Medicare, approximately half that of the overall group, may be affected by the material percentage of children's hospitals included in the group.

Community benefit expenditures mix. The chart below compares the community benefit expenditure mix of the group of 15 hospitals to the mix of all other hospitals in the study, then to the overall group.

Figure 78. Community Benefit Expenditure Mix



The group of 15 research hospitals is the only demographic in the study that did not report uncompensated care as its largest component of community benefit expenditures. When the group of 15 research hospitals was removed from the overall group, the overall mix changed, with uncompensated care increasing from 56% to 71%, and medical research decreasing from 15% to 1% of aggregate reported community benefit expenditures.

Percentage of revenues spent on other components of community benefit.

- **Uncompensated care:** Three research hospitals reported no uncompensated care amounts. The average and median percentages of revenues reported as spent on uncompensated care by the group of medical research hospitals that reported uncompensated care expenditures (6.2% and 3.3%, respectively) were less than the average and median for the other hospitals and the overall group (both 7.2% and 3.9%, respectively).

- **Medical education and training:** The medical research hospitals reported 58% of the aggregate medical education and training expenditures reported overall. The average and median percentages of revenues reported as spent on medical education and training by the medical research hospitals (4.9% and 3.8%, respectively) were higher than reported by the other hospitals (1.2% and 0.3%, respectively) and the overall group (1.3% and 0.3% respectively).
- **Community program expenditures:** The average percentage of revenues reported as spent on community program expenditures was similar to the other hospitals and the overall group. The median was significantly less (.03% in the case of medical research hospitals and 0.2% for other hospitals and overall).

Aggregate community benefit expenditures. The average and median percentages of revenues reported as spent on community benefit expenditures by the medical research hospitals (19% for both) were higher than reported by the other hospitals (9% and 5%, respectively) and the overall group (9% and 6%, respectively).

Excess revenues. The medical research hospitals reported higher average and median annual total revenues as well as average and median excess revenue amounts.

Figure 79. Annual Total Revenues, Total Expenses, and Excess/Deficit Revenues

Hospital Category	Annual Total Revenues			Annual Total Expenses			Annual Excess/Deficit Revenue		
	Aggregate (Billion \$)	Average (Million \$)	Median (Million \$)	Aggregate (Billion \$)	Average (Million \$)	Median (Million \$)	Aggregate (Billion \$)	Average (Million \$)	Median (Million \$)
Medical Research (N = 15)	15.3	1,021.7	995.2	14.3	952.4	913.6	1.0	69.4	57.9
Other (N = 473)	72.2	152.6	85.1	69.2	146.3	83.2	3.0	6.4	2.3
Total (N = 488)	87.5	179.4	89.4	83.5	171.0	87.1	4.1	8.3	2.5

The aggregate excess revenues as a percentage of total revenues was 6.8% for the research hospitals, compared to 4.6% for the overall group. Eight of the 15 hospitals reported a deficit or positive excess revenues less than 5% of total revenues. Seven reported excess revenues as a percentage of revenues greater than 5%.

Percentage of hospitals with uncompensated care and community benefit expenditures at or less than certain revenue levels. All 15 medical research hospitals reported community benefit expenditures greater than 5% of revenues. 40% reported community benefit expenditures greater than 20%. Three hospitals reported no uncompensated care expenditures. Of the remaining hospitals in the group, four reported uncompensated care expenditures in each of the following ranges: over 1% and ≤3%; over 3% and ≤5%; over 5%.

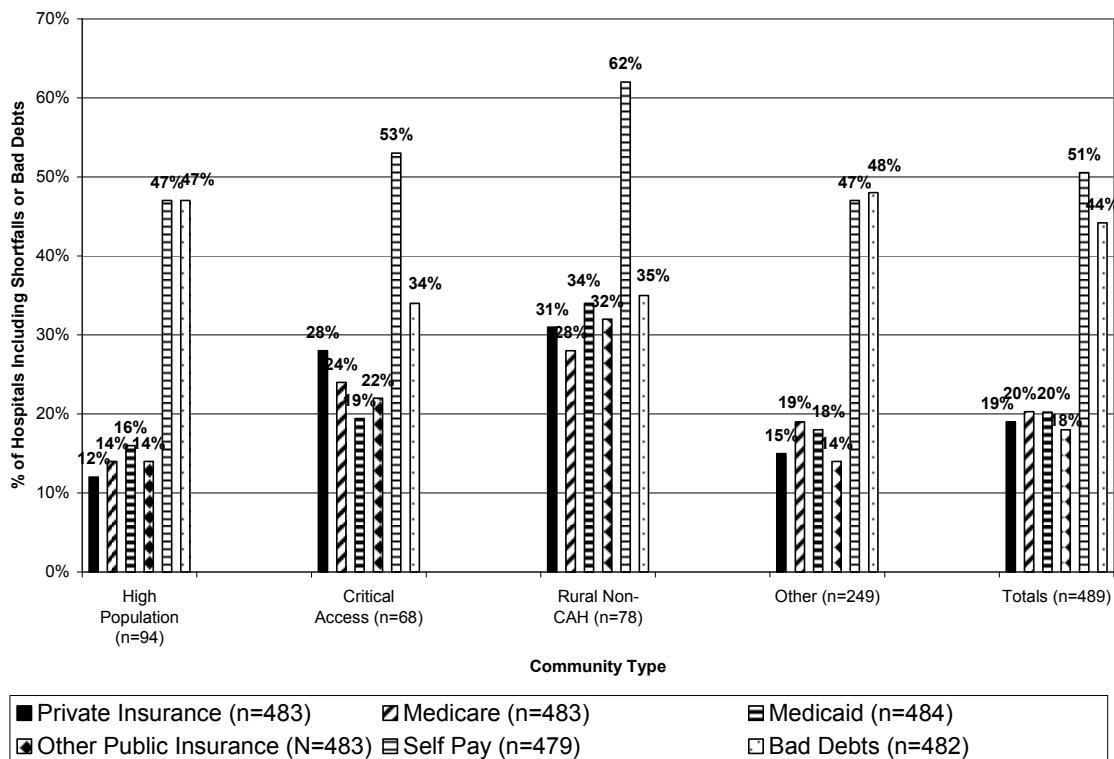
C. Analysis of Bad Debt and Shortfalls as Uncompensated Care

1. Reporting of Shortfalls and Bad Debt by Community Type

Between 18% and 20% of hospitals reported that they included the following items in their calculation of uncompensated care: the difference between hospital charges and the amount private insurance paid or allowed for services (private insurance shortfalls); the difference between hospital charges and the amount Medicare paid or allowed for services (Medicare shortfalls); the difference between hospital charges and the amount Medicaid allowed for services (Medicaid shortfalls); and the difference between hospital charges and the amount other public insurance programs allowed for services (other public program shortfalls). 51% of hospitals reported that they included the difference between hospital charges and the amount paid by individuals without insurance in their calculation of uncompensated care (self pay shortfalls). 44% of the hospitals reported including bad debt in uncompensated care.

Figure 80 below shows the percentage of hospitals in each community type that reported including these various amounts in uncompensated care.

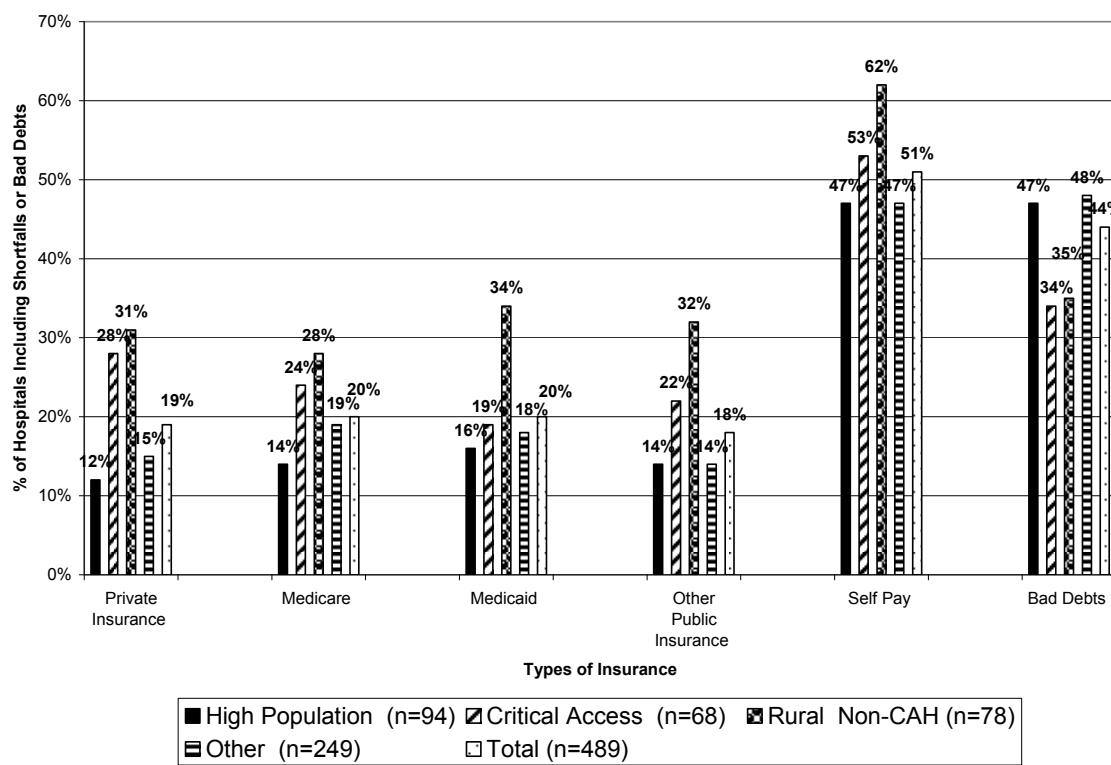
Figure 80. Percentage of Hospitals that Include Various Shortfall Amounts or Bad Debt in Uncompensated Care by Community Type (n=489)



In all categories, fewer hospitals reported including Medicare and Medicaid shortfalls than reported including self pay shortfalls and bad debt in uncompensated care. In most cases, the percentage of hospitals that reported including self pay shortfalls in uncompensated care was more than twice the percentage of hospitals that reported including Medicare, Medicaid, private insurance or other public program shortfalls in uncompensated care. A lower percentage of hospitals in both groups of rural hospitals reported including bad debt in uncompensated care (34% for CAHs and 35% for non-CAH rural) than was included by the other groups (47% for high population areas and 48% for other urban and suburban hospitals). A greater percentage of rural hospitals (28% for CAHs and 31% for non-CAHs) as compared with the other groups (12% for high population and 15% for other urban and suburban) reported including private insurance shortfalls in uncompensated care.

Figure 81 displays the results grouped by type of shortfall or bad debt instead of by community type.

Figure 81. Percentage of Hospitals that Include Various Shortfall Amounts or Bad Debt in Uncompensated Care by Type of Coverage (n=489)



The figure shows that greater percentages of hospitals across all community types reported including shortfalls from self pay patients and bad debt than from Medicare and Medicaid.

The following highlights various reported components of uncompensated care.

- **Bad debt as uncompensated care:** A smaller percentage of both groups of rural hospitals reported including bad debt in uncompensated care compared with the other groups.
- **Medicare shortfalls as uncompensated care:** A larger percentage of both groups of rural hospitals reported including the difference between hospital charges and the amount Medicare paid or allowed for services in uncompensated care compared with the other groups.
- **Medicaid shortfalls as uncompensated care:** Non-CAH rural hospitals reported the highest percentage of hospitals including the difference between hospital charges and the amount Medicaid paid or allowed for services in uncompensated care. The amount reported by non-CAH rural hospitals (34%) is much higher than reported by any other group.
- **Other public insurance shortfalls (other than Medicare and Medicaid) in uncompensated care:** A higher percentage of both types of rural hospitals (CAH and non-CAH) reported including the difference between hospital charges and the amount other public insurance programs paid or allowed in uncompensated care compared with the other groups.
- **Self pay shortfalls as uncompensated care:** At least 47% of the hospitals in each community type reported including the difference between hospital charges and the amount paid by self-pay patients for services as uncompensated care. Hospitals in the rural-non CAH category reported the highest percentage (62%).
- **Private insurance shortfalls as uncompensated care:** The percentage of rural hospitals that reported including the difference between hospital charges and the amount private insurance paid or allowed for services in uncompensated care was higher than that reported by hospitals in the other groups.

2. Reporting of Shortfalls and Bad Debt by Revenue Size

Figure 82 shows the percentage of hospitals in various revenue size categories that reported including shortfall amounts or bad debt in uncompensated care. The two largest revenue sizes (\$250 million to \$500 million and over \$500 million) were combined to prevent potential identification of respondent hospitals.

Figure 82. Percentage of Hospitals that Include Various Shortfall Amounts or Bad Debt in Uncompensated Care by Revenue Size (n=489)

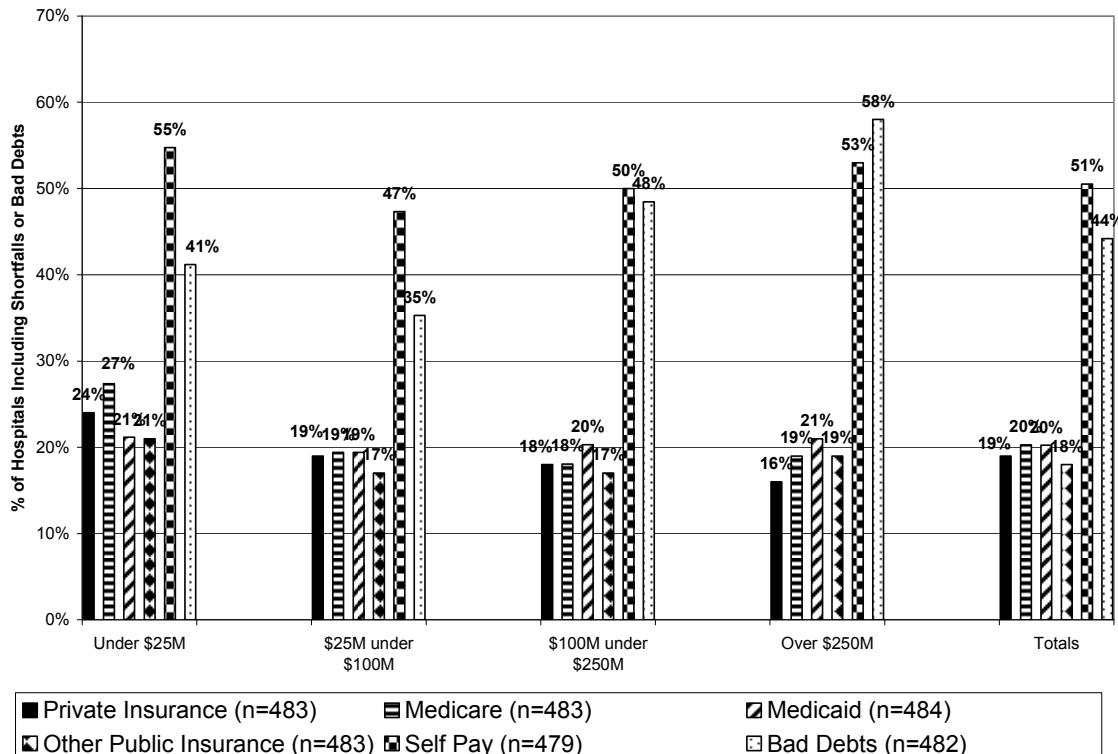
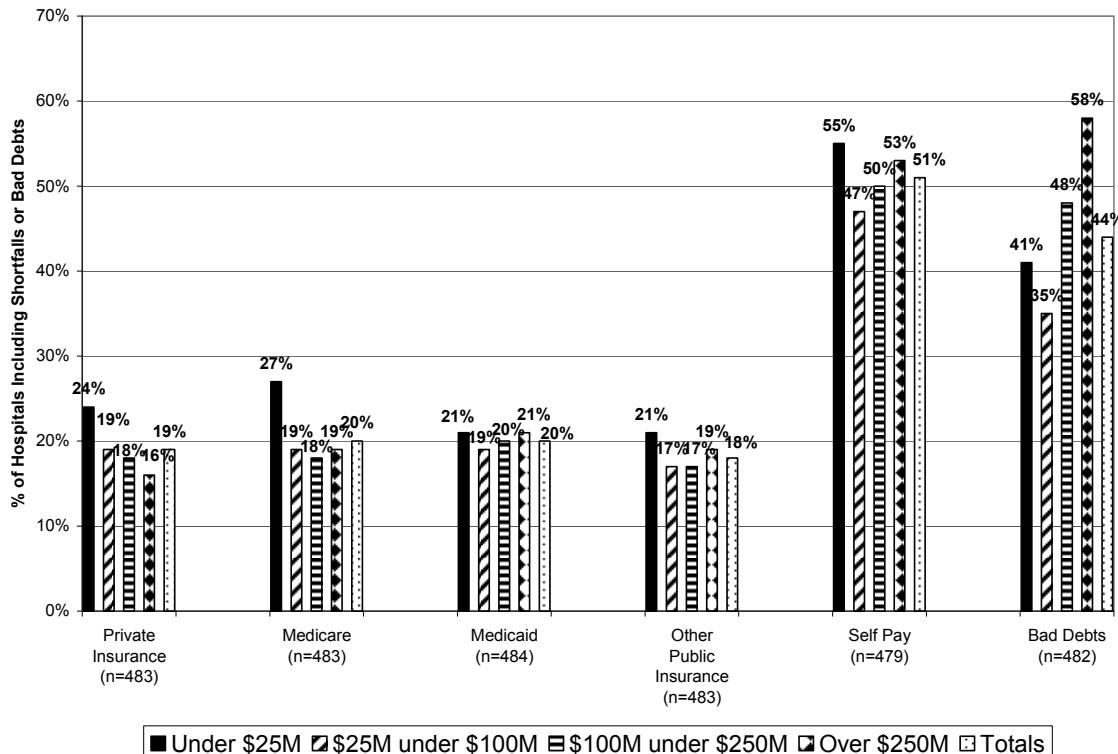


Figure 82 shows that the percentage of hospitals that reported including Medicare or Medicaid shortfalls was materially less than the percentage that reported including shortfalls from self pay patients or bad debt. This variance was more pronounced in hospitals that reported total revenues of more than \$250 million, but was less pronounced in hospitals that reported total revenues under \$25 million. Although not displayed in these figures to prevent potential identification of respondent hospitals, hospitals in the over \$500 million revenue size had the highest percentage of hospitals including bad debt in uncompensated care and the smallest percentages of hospitals including private insurance, Medicare, Medicaid, or other public insurance in uncompensated care.

Figure 83 displays the results grouped by type of shortfall or bad debt instead of by revenue size.

Figure 83. Percentage of Hospitals that Include Various Shortfall Amounts or Bad Debt in Uncompensated Care by Type of Shortfall or Bad Debt (n=489)



The following highlights various reported components of uncompensated care.

- **Bad debt as uncompensated care:** By revenue size, with the exception of the under \$25 million group, the percentage of hospitals including bad debt in uncompensated care increased as hospital size increased.
- **Medicare shortfalls as uncompensated care:** Hospitals in the under \$25 million revenue category reported the highest percentage including Medicare shortfalls in uncompensated care. Although not displayed in the figures to prevent potential identification of respondent hospitals, the percentage of hospitals in the over \$500 million revenue category was lower than that reported by all other groups.
- **Medicaid shortfalls as uncompensated care:** Although not displayed in the figures to prevent potential identification of respondent hospitals, hospitals in the \$250 million to under \$500 million revenue category reported the highest percentage of hospitals including Medicaid shortfalls in uncompensated care. Hospitals in the over \$500 million revenue category reported a smaller percentage compared with the other groups. The percentage reported by the remaining groups was very similar.

- **Other public insurance shortfalls (other than Medicare and Medicaid) in uncompensated care:** Hospitals in the \$25 million to under \$250 million revenue categories reported percentages very similar to the total group. Although not displayed in the figures to prevent potential identification of respondent hospitals, hospitals in the largest revenue category (over \$500 million) reported a smaller percentage of hospitals including other public insurance shortfalls in uncompensated care.
- **Self pay shortfalls as uncompensated care:** By revenue size categories, the percentages reported by the groups were similar, ranging from 47% (\$25 million to under \$100 million) to 55% (under \$25 million).
- **Private insurance shortfalls as uncompensated care:** With the exception of the over \$500 million revenue category, the percentage of hospitals that reported including private insurance shortfalls was similar ranging from 18% to 24%. Although not displayed in the figures to prevent potential identification of respondent hospitals, the percentage reported by the over \$500 million category was smaller (9%).

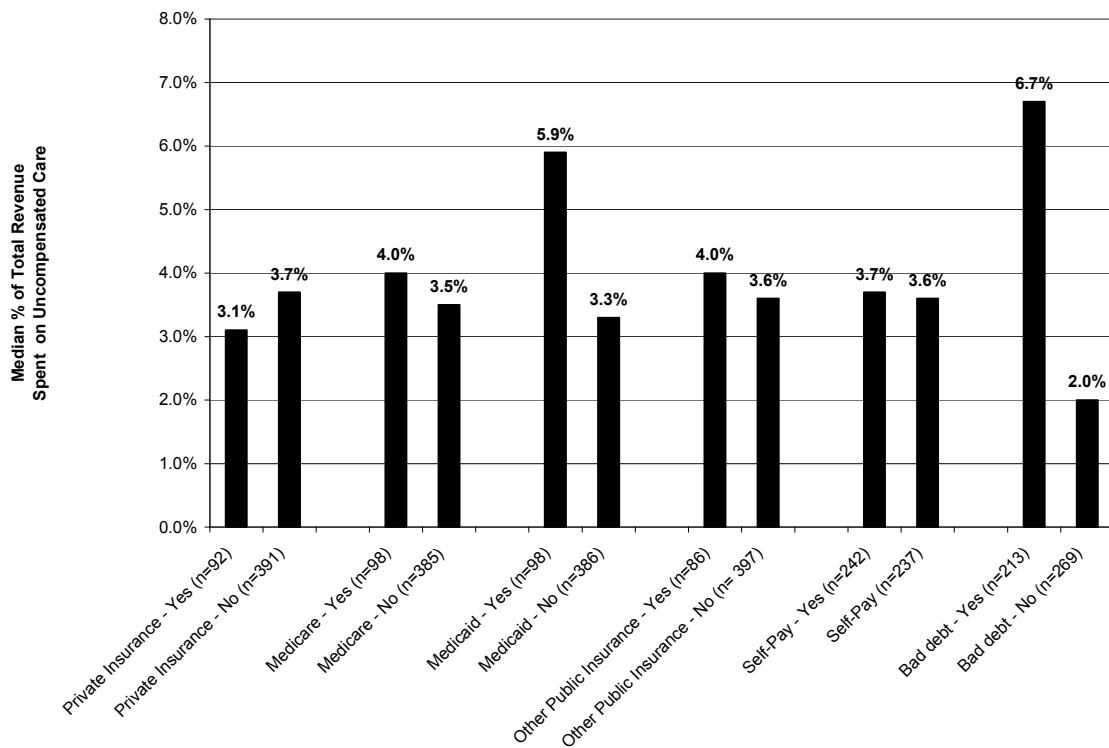
3. Reporting Differences when Shortfalls and Bad Debt are Included in Uncompensated Care

This section compares aggregate uncompensated care amounts reported by hospitals depending upon whether they included or excluded particular items of uncompensated care.

Figure 84, below, shows the median percentage of revenue reported as spent on all uncompensated care, depending on whether the hospital included or excluded the relevant shortfall or bad debt expense in uncompensated care. For example, the first two bars in the chart show that for the 92 hospitals that reported including private insurance shortfalls in uncompensated care, the median percentages of aggregate reported uncompensated care as a percentage of total revenues was 3.1%, contrasted with a median of 3.7% for the 391 hospitals that did not include private insurance shortfalls in uncompensated care.

The median percentage of revenues reported as spent on uncompensated care was relatively similar for respondents that reported including payment shortfalls from private insurance, Medicare, other public insurance, and individuals without insurance in their calculation of uncompensated care and those that did not. However, greater differences are shown in the median percentage of revenue reported as spent on uncompensated care, depending upon whether organizations included Medicaid shortfalls or bad debt expense in uncompensated care.

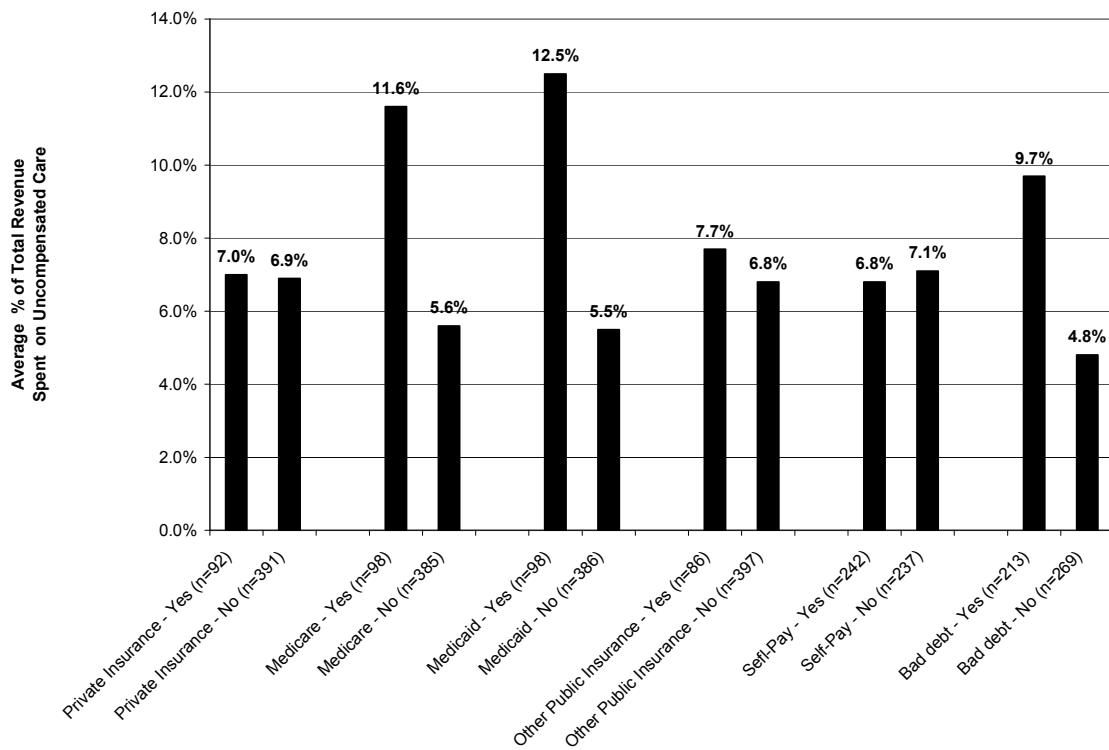
Figure 84. Reporting Differences When Shortfalls and Bad Debt are Included in Uncompensated Care (Median % of Revenue Spent)



The median percentage of revenue reported as spent on uncompensated care of respondents that included the difference between what Medicaid paid or allowed for services and hospital charges reported was 5.9% while the median percentage of those that did not include these amounts was 3.3%. The median percentage of revenue reported as spent on uncompensated care of respondents that included bad debt expense in uncompensated care was 6.7% while the median percentage of those that did not include bad debt in uncompensated care was 2%.

Figure 85 shows the average percentage of revenue reported as spent on uncompensated care was relatively similar for respondents that reported including payment shortfalls from private insurance, other public insurance, and individuals without insurance, in their calculation of uncompensated care and those that did not. However, greater differences are shown in the average percentage of revenue reported as spent on uncompensated care, depending on whether organizations included shortfalls from Medicare, Medicaid or bad debt expense in uncompensated care.

Figure 85. Reporting Differences When Shortfalls and Bad Debts are Included in Uncompensated Care (Average % of Revenue Spent)



The average percentage of revenue spent on uncompensated care was higher for respondents that reported including bad debt, Medicare, and Medicaid shortfalls than for those that excluded such items.

D. Comparison of Community Benefit Expenditures Across Various Income and Health Insurance Coverage Levels

1. Overview

This section examines whether there is a correlation between the level of community benefit expenditure and the income or health insurance coverage level of the community where the hospital is located. In looking at the connection between income levels and community benefit expenditures, the study focused on per capita income levels, using both a statewide and nationwide comparison. The possible connection between community benefit expenditures and health insurance coverage levels was also analyzed under two approaches. The first looked at insurance coverage rates within counties. The second compared the county coverage rate with coverage rates nationwide.⁵⁶

⁵⁶ Two approaches were utilized to examine the possible connection between income and health insurance coverage levels to gauge the validity of the results and to determine whether a different methodology would produce materially different results.

2. Community Benefit Expenditures Across Community Per Capita Income Levels

Demographic information was collected from the US Census Bureau for each of the areas where the 485 respondent hospitals that reported community benefit expenditures were located. This information was collected and tabulated both by state and by county using the ZIP Code for each hospital's address that was on the questionnaire. Information collected included population, per capita income,⁵⁷ levels of insurance coverage,⁵⁸ and percentage of the population living in poverty.

Utilizing the information collected from the US Census Bureau, hospitals were classified based upon the per capita income of the surrounding geographic area, as designated by the county in which each hospital was located. Two different methods were employed to divide the sample into per capita income categories.

State per capita income method

The first method categorized hospitals based on how the per capita income in its county compared to the statewide per capita income (referred to as the "state per capita income" method). Under the state per capita income method, the hospitals were divided into the following categories:

- **Below state average:** includes respondents in counties where the per capita income was more than 5% below the per capita income of the corresponding state (276 hospitals);
- **At state average:** includes respondents in counties where the per capita income was within 5% above or below the per capita income of the corresponding state (89 hospitals); and
- **Above state average:** includes respondents in counties where the per capita income was more than 5% higher than the per capita income of the corresponding state (120 hospitals).⁵⁹

⁵⁷ Per capita income information was drawn from the U.S. Census Bureau's 2000 Census of Population and Housing. Per capita income is the average money income received in 1999 computed for every man, woman, and child in a geographic area. It is derived by dividing the total income of all people 15 years old and over in a geographic area by total population in that area. Income is not collected for people under 15 years old even though those people are included in the denominator of per capita income.

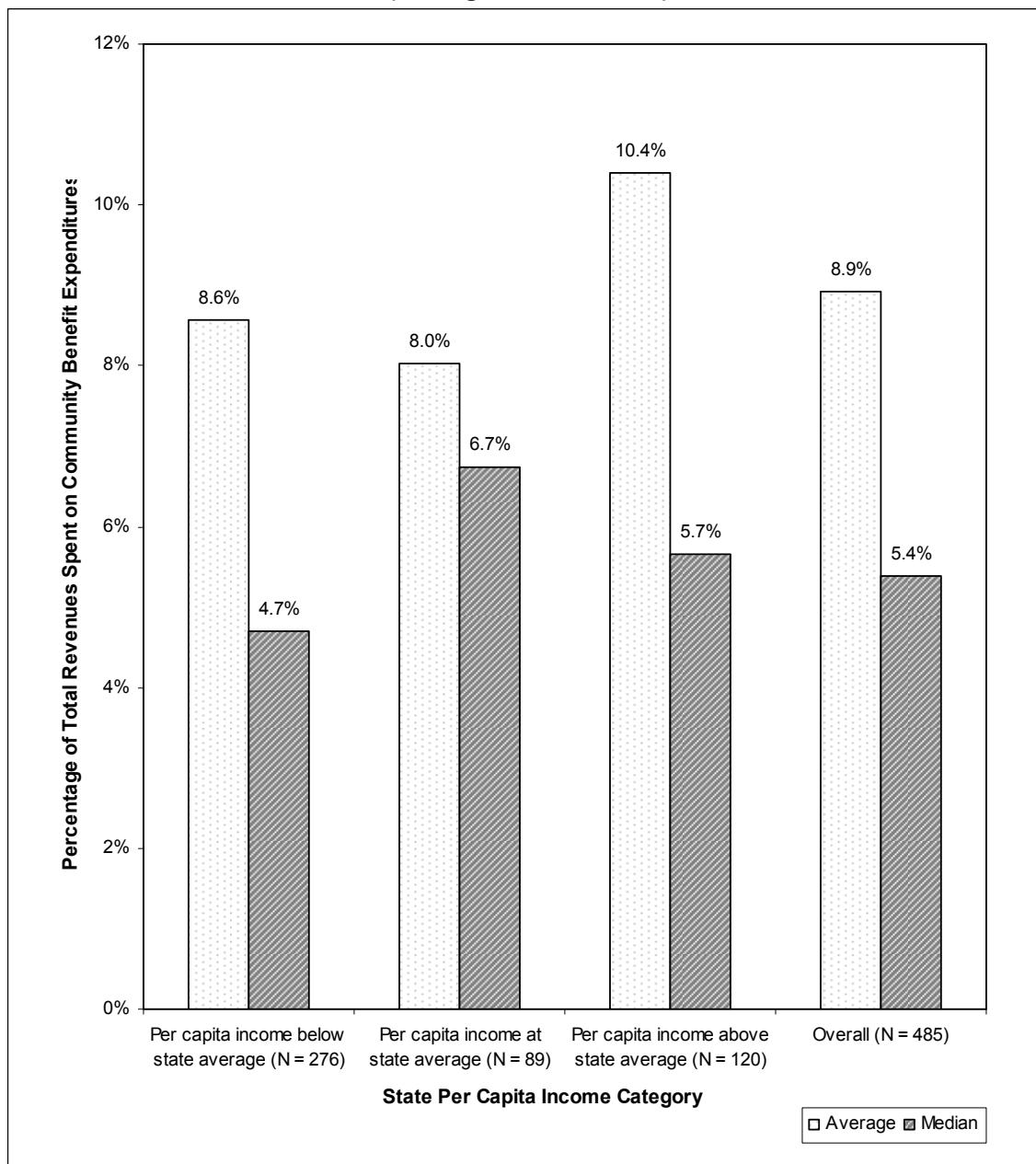
⁵⁸ Information on health coverage was drawn from the U.S. Census Bureau's 2000 Small Area Health Insurance Estimates (SAHIE). The Census Bureau defines persons insured as those who have health insurance coverage, including private health insurance, Medicaid, Medicare, and/or State Children's Health Insurance Program (but not including the Indian Health Service). Persons uninsured are those who are not categorized as insured through any of those programs. The SAHIE are experimental estimates. The SAHIE is a new program at the Census Bureau and the first ever set of estimates was released in July, 2005.

⁵⁹ 5% above or below was arbitrarily selected to represent a material deviation from the state average. This resulted in a greater distribution of hospitals in the "below state average" group than in the other groups. This might be the result of a study sample with a disproportionately

Figure 86, below, shows the percentage of total revenues reported as spent on community benefit expenditures across per capita income categories under the state per capita income method.

higher percentage of hospitals in areas with low per capita income amounts, or our selection of 5% as not accurately distinguishing “below” or “above” hospitals from the norm.

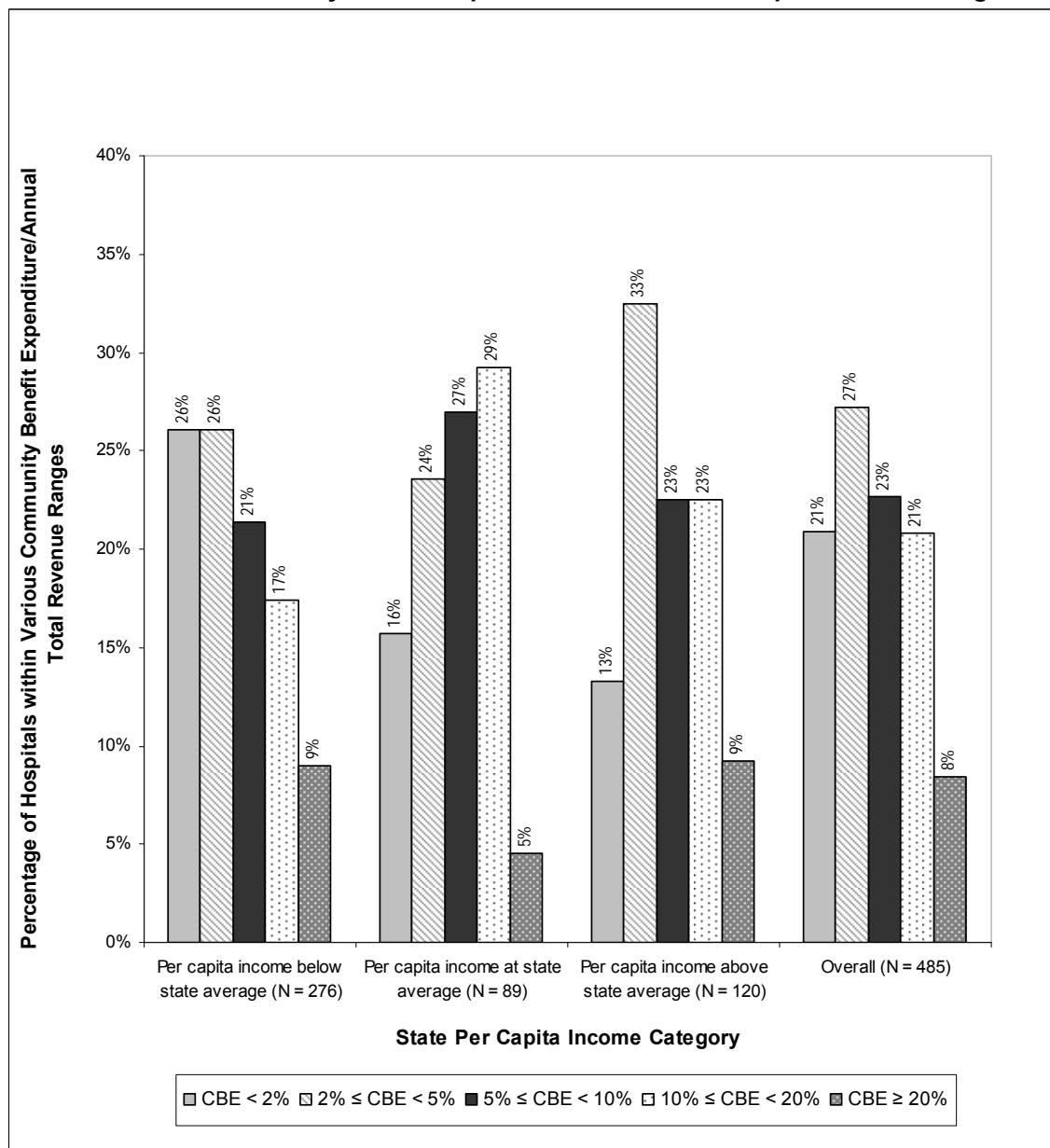
Figure 86. STATE PER CAPITA INCOME METHOD
Percentage of Total Revenues Spent on Community Benefit Expenditures
Across Various Per Capita Income Categories
(Averages and Medians)



The results indicate that hospitals in areas with per capita income above the state average reported spending a higher percentage of their total revenue on community benefit expenditures (average, 10.4% and median, 5.7%) than did respondents in areas with per capita income below the state average (average, 8.6% and median, 4.7%). The average and median percentages for the overall group of 485 hospitals were 8.9% and 5.4%, respectively.

Figure 87 illustrates the percentage of hospitals within each of various ranges of total revenue spent on community benefit expenditures across the three per capita income categories under the state per capita income method.

Figure 87. STATE PER CAPITA INCOME METHOD
Distribution of Community Benefit Expenditures Across Per Capita Income Categories



The chart does not show a clear correlation between per capita income and the level of community benefit expenditure. The percentage of hospitals that reported community benefit expenditures at less than 2% of revenues (i.e., the lowest percentage of revenue category) was highest (26%) when per capita income was below the state level and lowest (13%) when the per capita income was above the state level.

U.S. per capita income method

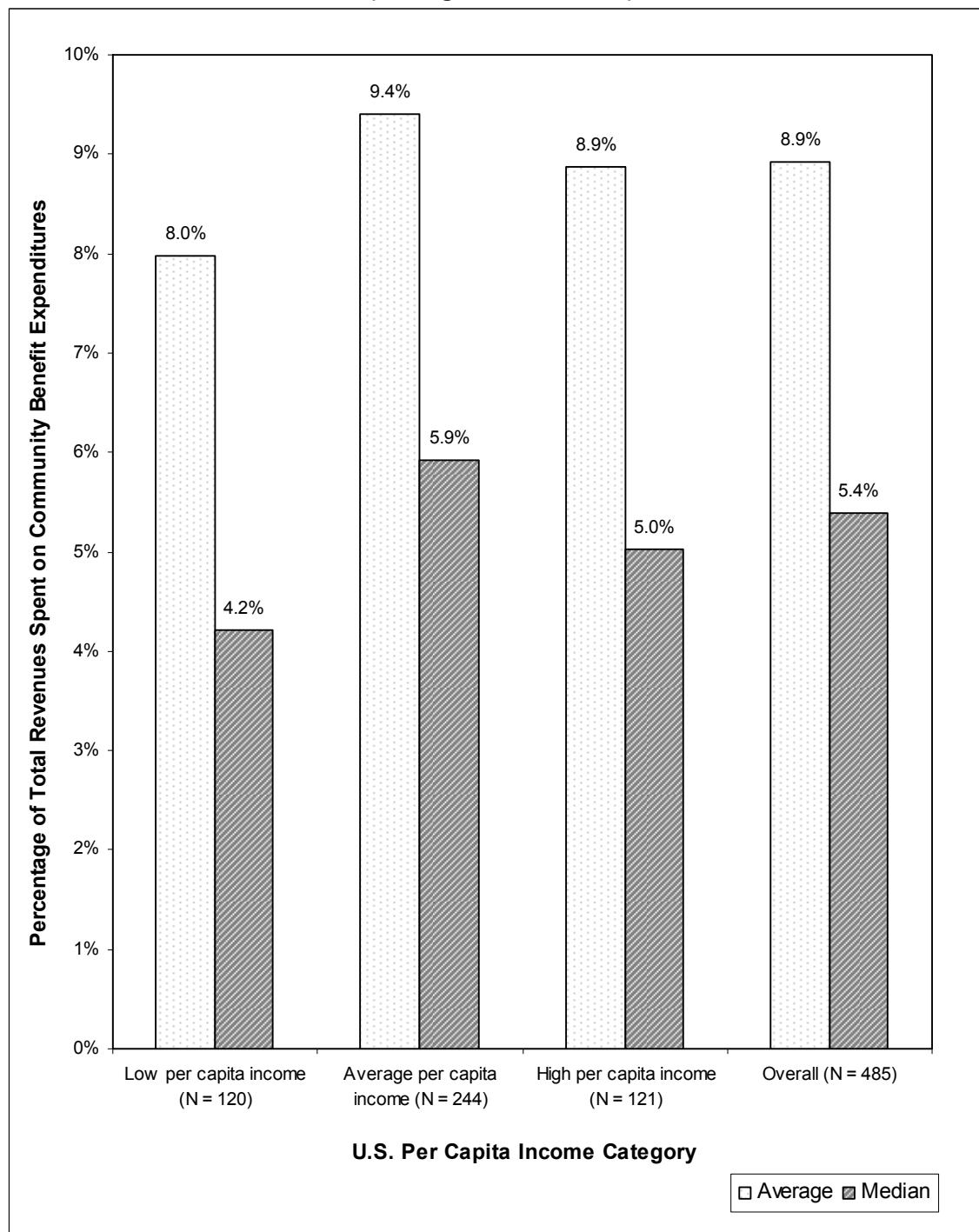
The second approach used to classify hospitals into per capita income categories was based on how the per capita income in the respondent's county compared to the per capita income of U.S. counties nationally (referred to as the "U.S. per capita income" method). Under the U.S. per capita income method the hospitals were divided into the following categories:

- **Low per capita:** includes respondents in counties where the per capita income was in the bottom 25% of U.S. counties nationwide (120 hospitals);
- **High per capita:** includes respondents in counties where the per capita income was in the top 25% of U.S. counties nationwide (121 hospitals); and
- **Average per capita:** includes respondents in the remaining U.S. counties that were not described in either of the above two categories (244 hospitals).⁶⁰

Figure 88 shows the percentage of total revenues spent on community benefit expenditures across the per capita income categories under the U.S. per capita income method.

⁶⁰ This method forced a bell curve distribution to test whether the results would vary compared to the state per capita income method.

Figure 88. U.S. PER CAPITA INCOME METHOD
Percentage of Annual Total Revenues Spent on Community Benefit Expenditures
Across Various Per Capita Income Categories
(Averages and Medians)

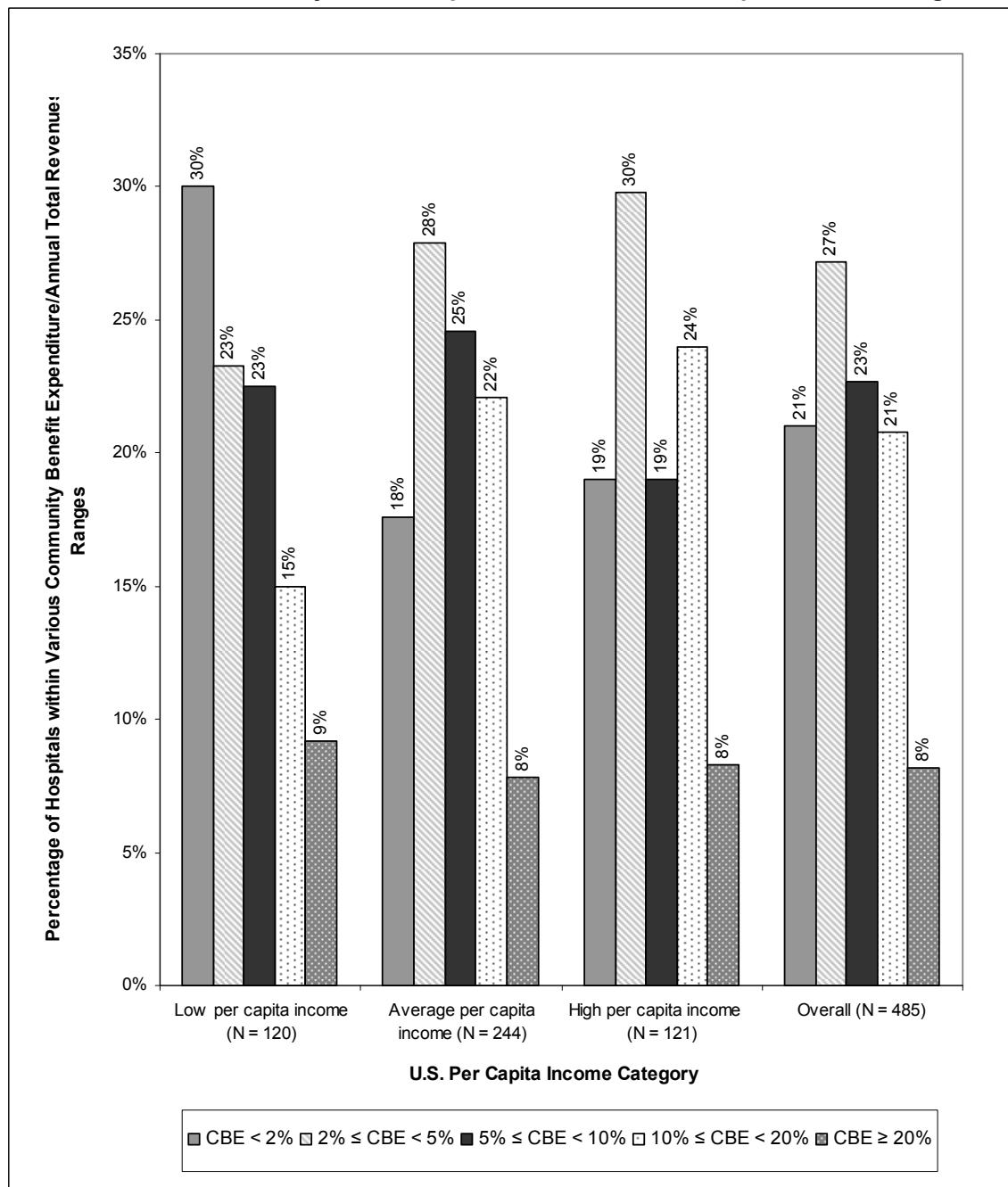


The chart shows relatively similar percentages for each group. The results indicate that respondent hospitals in areas with low per capita income under the U.S. per capita income method reported spending a slightly lower percentage of

their total revenue on community benefit expenditures (average, 8.0% and median, 4.2%) than did respondents in either of the two other per capita income categories. These results differed somewhat from those under the state per capita income method under which the amount of community benefit expenditure by the hospitals with per capita income below the state level was very similar to that of the overall group. The state per capita income method also showed a less uniform distribution in the averages and medians for the various groups than the chart above.

Figure 89 illustrates the percentage of hospitals that fall into various ranges of total revenue spent on community benefit expenditures across the three U.S. per capita income categories.

Figure 89. U.S. PER CAPITA INCOME METHOD
Distribution of Community Benefit Expenditures Across Per Capita Income Categories



This chart illustrates a similarity among all three categories in the percentage of hospitals that reported spending 20% or more of total revenue on community benefit expenditures (8%-9%). The percentage of hospitals that reported spending less than 2% of total revenues on uncompensated care was highest for hospitals in the low per capita income categories. This is consistent with the state per capita income method.

Based on the reported data, both the state and U.S. per capita income method suggest that there does not appear to be a correlation in the study group between per capita income of the surrounding area and the amount of community benefit expenditures incurred by the hospital.

3. Community Benefit Expenditures Across Community Health Insurance Coverage Levels

This section analyzes the extent to which aggregate community benefit expenditures varied depending upon the insurance coverage levels (uninsured rate) of the hospital's surrounding area.

Hospitals were analyzed based upon levels of insurance coverage in the county where the hospital is located. Two different methods were employed to divide the sample into insurance coverage rate categories. Both methods categorize respondents into three categories: high, medium, and low health coverage rates.

County uninsured rate method

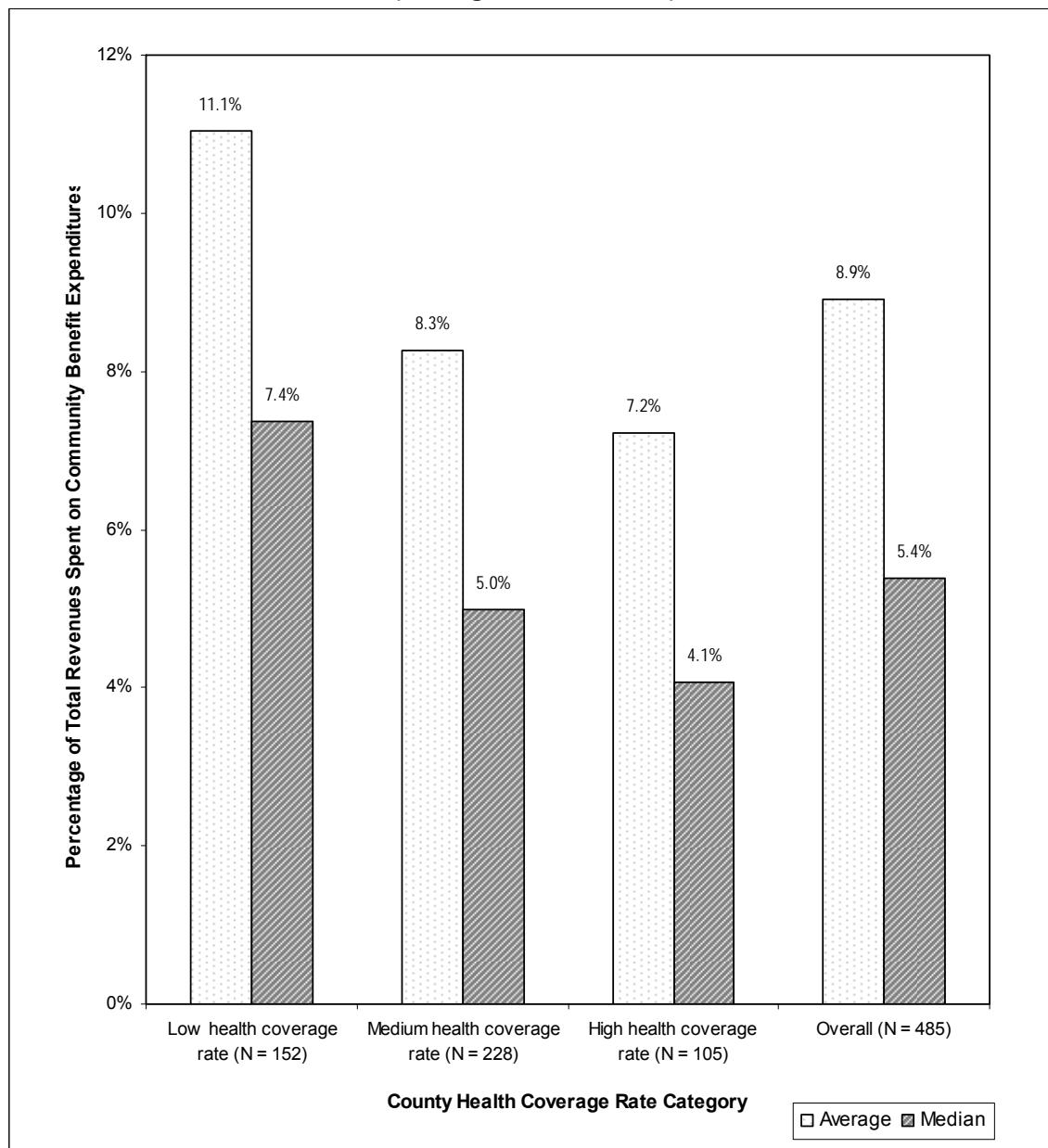
Under the first method (referred to as the “county uninsured rate” method), hospitals were divided into the following categories based on the uninsurance rate of the county where located:

- **Low health coverage rate:** includes counties where more than 13% of the population was uninsured (152 hospitals);
- **Medium health coverage rate:** includes counties where between 9% and 13% of the population was uninsured (228 hospitals); and
- **High health coverage rate:** includes counties where less than 9% of the population was uninsured (105 hospitals).⁶¹

Figure 90 shows the percentage of revenues spent on community benefit expenditures by hospitals as categorized under the county uninsured rate method.

⁶¹ The coverage rates were selected based on the distribution of the coverage rates of the counties of the hospitals in the study.

Figure 90. COUNTY UNINSURED RATE METHOD
Percentage of Annual Total Revenues Spent on Community Benefit Expenditures
Across Health Coverage Categories
(Averages and Medians)

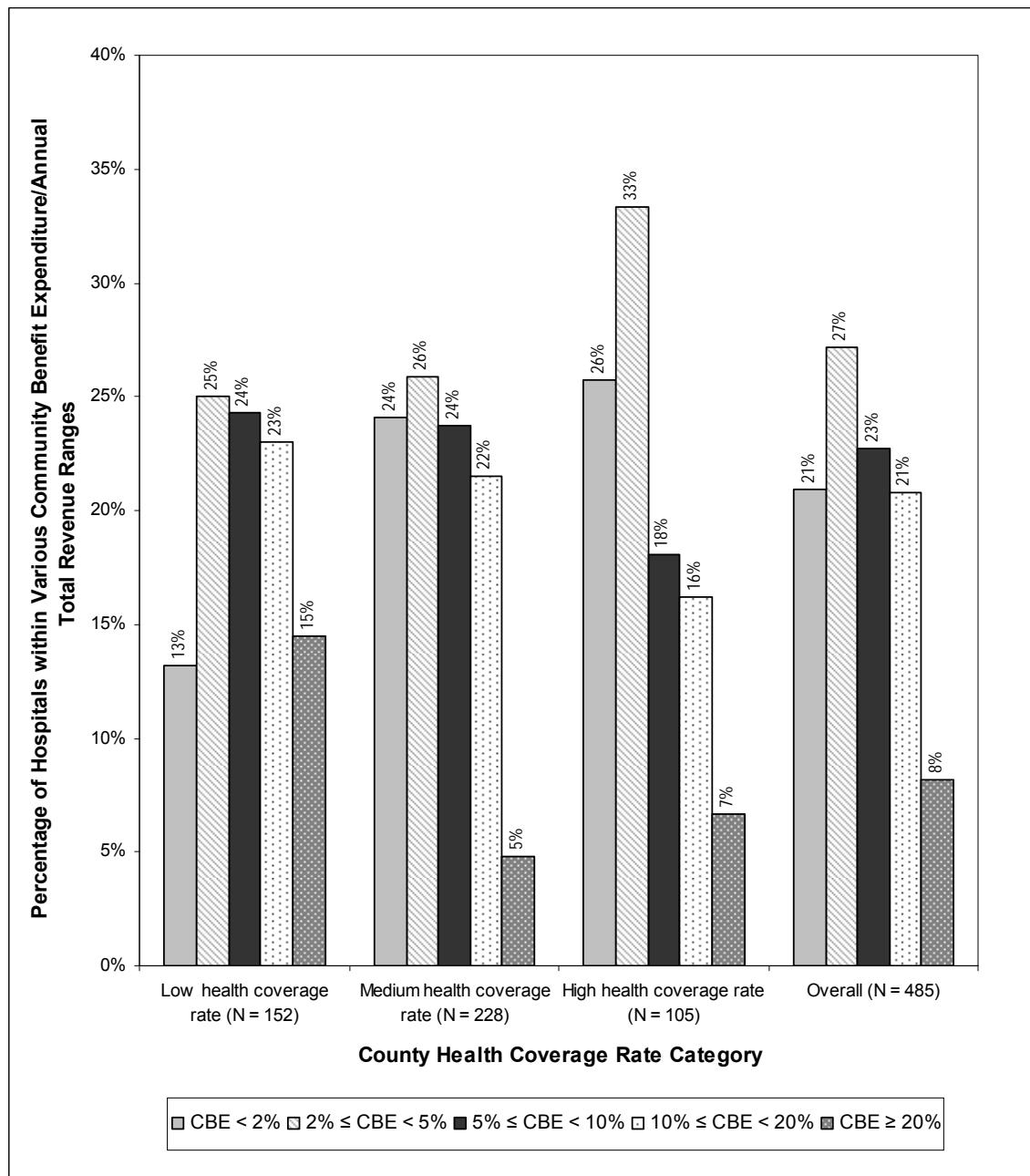


The results indicate that respondents in areas with low health coverage rates (higher uninsured rates) reported higher levels of community benefit expenditures. Under this method, the percentage of revenues reported as spent on community benefit expenditures increased as the percentage of uninsured individuals increased. Hospitals in low health coverage areas (higher uninsured rates) reported an average community benefit expenditure amount of 11.1% of their total revenue (median 7.4%) while hospitals in high health coverage areas

(lower uninsured rates) reported an average community benefit expenditure of 7.2% of total revenue (median 4.1%).

Figure 91 further illustrates the distribution of hospitals within varying community benefit expenditures across the different county health coverage rates under the county uninsured rate method.

Figure 91. COUNTY UNINSURED RATE METHOD
Distribution of Community Benefit Expenditures Across Health Coverage Categories



The chart shows that the low health coverage group reported a higher percentage of hospitals spending at least 20% of revenues on community benefit

expenditures. The largest percentage of hospitals spending less than 2% of revenues on community benefit expenditures was in the high health coverage (lower uninsured rates) group. The percentage of hospitals reporting <5% of total revenues on community benefit expenditures decreased as insurance coverage levels decreased. These results suggest a connection between community benefit expenditure levels and the uninsured rate of the area surrounding the hospital (i.e., expenditures generally increased as the uninsured rate increased).

Nationwide comparison method

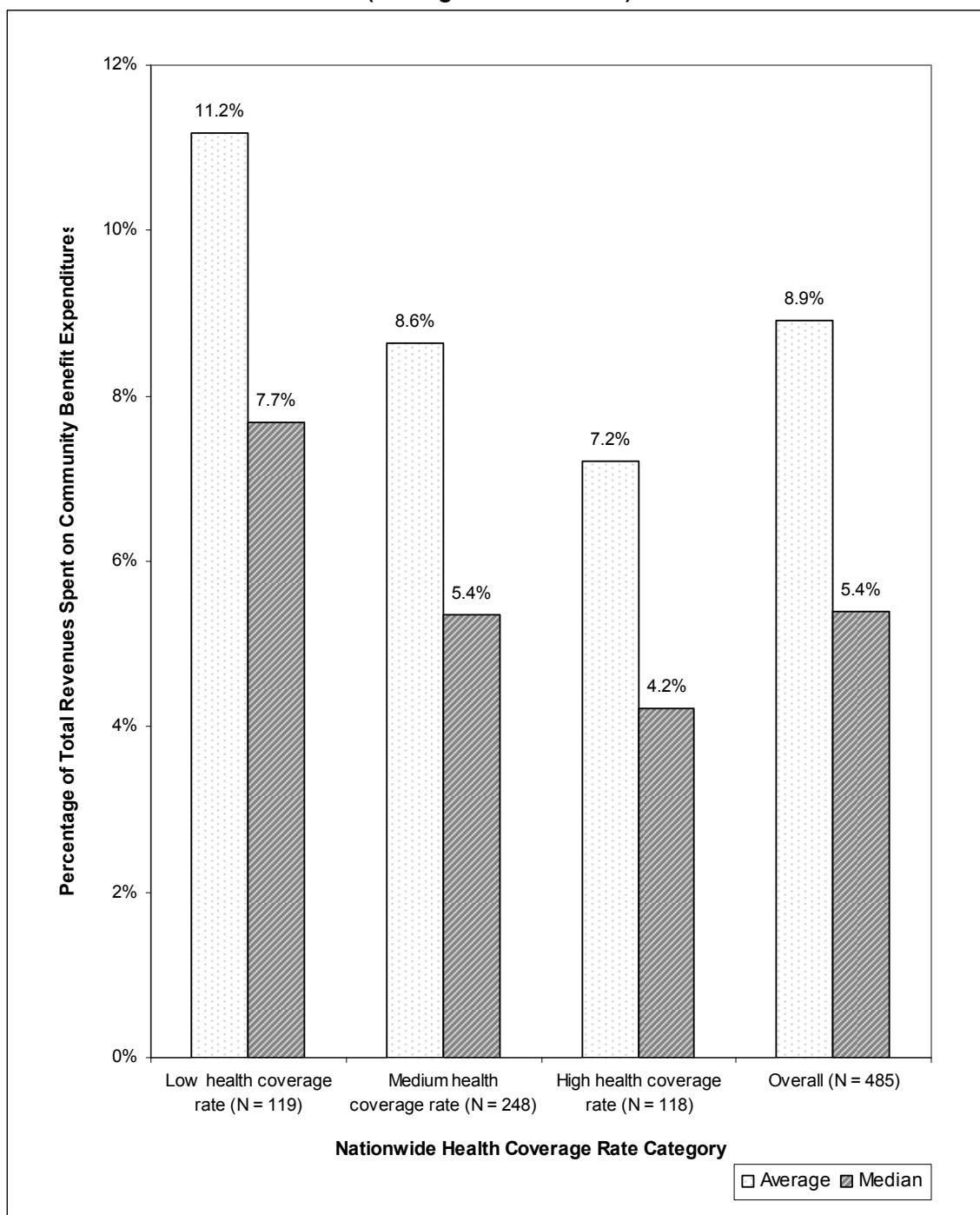
The second method used to assess the possible correlation of community benefit expenditures to health insurance coverage levels categorized the hospitals by comparing the county's percentage of insured individuals with the percentage for counties nationwide (referred to as the "nationwide comparison method"). Under this method, the communities were divided into the following three categories:

- **Low health coverage rate:** includes counties where the percentage of the population insured was in the bottom 25% of counties nationwide (119 hospitals);
- **High health coverage rate:** includes counties where the percentage of the population insured was in the top 25% of counties nationwide (118 hospitals); and
- **Medium health coverage rate:** includes the remaining counties that were not included in either of the above two categories (248 hospitals).⁶²

Figure 92 reports the percentages of revenues spent on community benefit expenditures across these health insurance coverage categories.

⁶² This method forced a bell curve distribution to test whether the results would vary compared to the county uninsured rate method.

Figure 92. NATIONWIDE COMPARISON METHOD
Percentage of Annual Total Revenue Spent on Community Benefit Expenditures
Across Health Coverage Categories
(Averages and Medians)

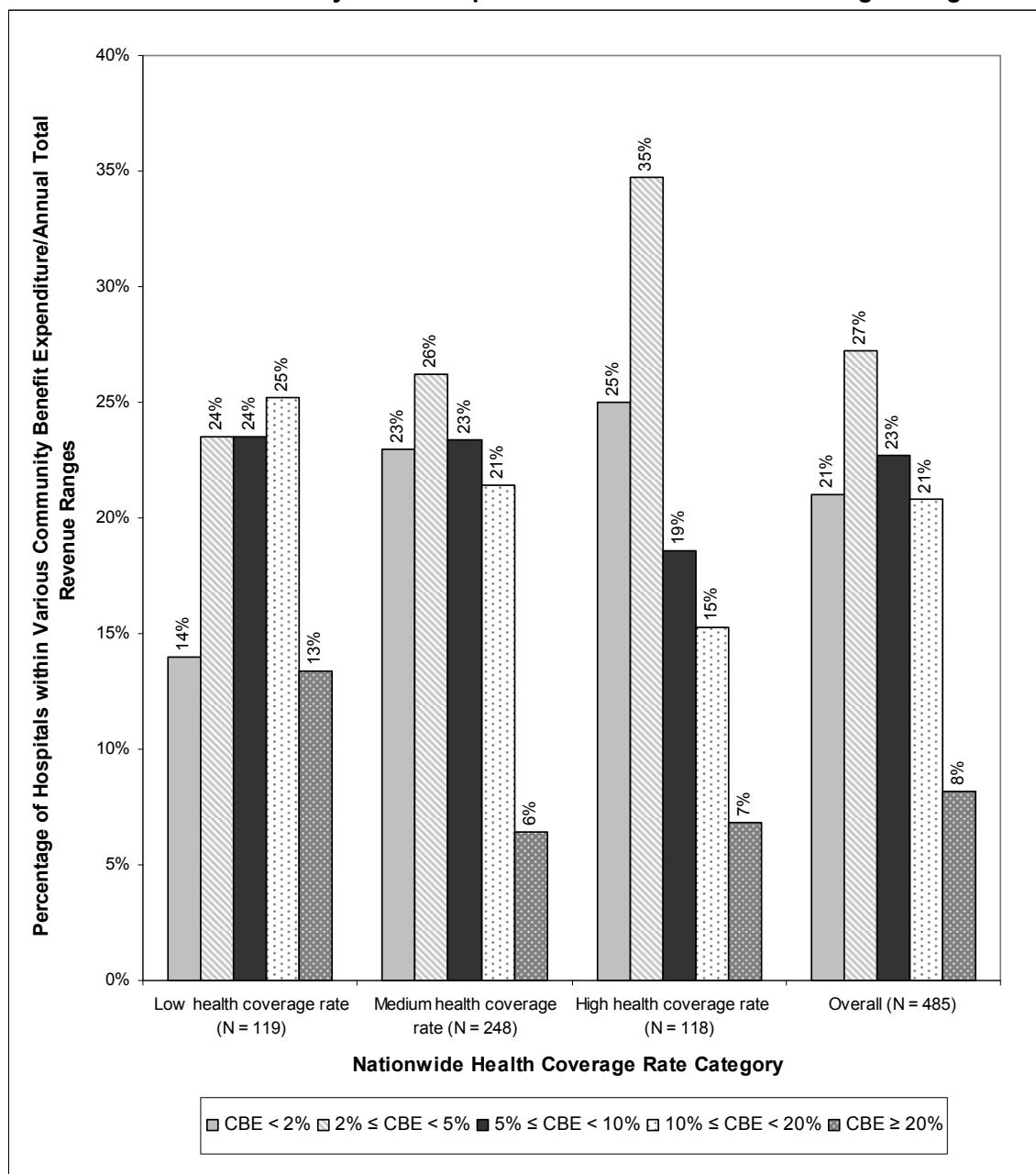


The results under this method are similar to those under the county uninsured rate method. As under the county uninsured rate method, the results indicate that respondents in areas with low health coverage rates reported higher levels of community benefit expenditures. Hospitals in low health coverage areas

reported an average community benefit expenditure amount of 11.2% of their total revenue (median 7.7%) while hospitals in high health coverage areas reported spending an average of 7.2% of their total revenue (median 4.2%) on community benefit expenditures.

Figure 93 shows the distribution of hospitals by the health coverage rate category determined under the nationwide comparison method and percentage of revenues spent on community benefit expenditures.

**Figure 93. NATIONWIDE COMPARISON METHOD
Distribution of Community Benefit Expenditures Across Health Coverage Categories**



This distribution is similar to that under the county uninsured rate method. As the charts above show, a greater percentage of hospitals in the low health coverage rate category spent more than 20% of revenues on community benefit expenditures. Hospitals in the high health coverage rate category had the greatest percentage of hospitals that reported spending less than 5% of revenues on community benefit expenditures. This was consistent with the results under the county uninsured rate method, and suggests a connection between community benefit expenditure levels and the uninsured rate of the area surrounding the hospital (i.e., expenditures generally increased as the uninsured rate increased).

4. Interaction Between Per Capita Income and Health Insurance Coverage

The figures presented earlier in this section suggest that there does not appear to be a correlation between per capita income and the aggregate amount of community benefit expenditure for the various hospitals, but there does appear to be a correlation between the amount spent on community benefit expenditures and the health insurance coverage rate (or uninsured rate) of the surrounding community.⁶³

The figures below show the distribution of the hospitals as categorized under the per capita and health insurance coverage methods described above.

Figure 94 shows the distribution of the hospitals as categorized by the state per capita income method and the two health insurance coverage categories. Figure 95 shows the distribution of the hospitals by the U.S. per capita income method and the two health insurance coverage categories.

Figure 94. Distribution of Hospitals as Categorized by the State Per Capita Income Method and Health Insurance Coverage Categories

State per capita income	Health Coverage under County Uninsured Rate Method				Health Coverage under Nationwide Comparison Method			
	Low health coverage rate	Medium health coverage rate	High health coverage rate	Overall	Low health coverage rate	Medium health coverage rate	High health coverage rate	Overall
Below state level	91	140	45	276	73	148	55	276
At state level	24	45	20	89	16	50	23	89
Above state level	37	43	40	120	30	50	40	120
Total	152	228	105	485	119	248	118	485

⁶³ The study focused on comparing aggregate community benefit expenditures rather than on components thereof, such as uncompensated care.

Figure 95. Distribution of Hospitals as Categorized by the U.S. Per Capita Income Method and Health Insurance Coverage Categories

	Health coverage under County Uninsured Rate method				Health coverage under Nationwide Comparison method				
	U.S. per capita income	Low health coverage rate	Medium health coverage rate	High health coverage rate	Overall	Low health coverage rate	Medium health coverage rate	High health coverage rate	Overall
Low per capita	55	56	9	120	49	61	10	120	
Average per capita	76	107	61	244	53	118	73	244	
High per capita	21	65	35	121	17	69	35	121	
Total	152	228	105	485	119	248	118	485	