

THE IMPACT OF

Hospital Consolidation on Health Care Affordability in New York State

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CSS Community Service Society

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Executive Summary

Health care in New York is increasingly unaffordable for patients. Over the past 15 years, hospital charges in New York have increased four times as fast as inflation. Hospital spending accounts for over one-third of total health care spending in the State.

This report describes how State policies that encourage hospital consolidation (mergers or acquisitions between hospitals) affect health care costs and charges in New York. It builds on a 2025 report by the Community Service Society of New York (CSS) describing why New York's health care system is so unaffordable.

Between 2009 and 2024, half (101) of New York's hospitals underwent at least one merger. This analysis of state, regional, and procedure-level impacts of hospital consolidation shows:

- Hospital-reported charges increased 1.5 times as fast at hospitals that merged, compared to hospitals that did not merge.
- Hospital consolidation was associated with increased hospital-reported charges compared to relatively static hospital-reported costs. Across regions of New York, charges at merged hospitals increased 1.3 to 4.5 times as fast as costs.
- Patients needing common procedures, such as appendectomies, deliveries, and knee replacements, at merged hospitals were charged significantly more than patients at non-merged hospitals.

This report identifies three targeted policies to improve transparency and affordability absent transformative policy changes at the national or state level – such as the adoption of Medicare for All or the New York Health Act. Interim policies that could abate merger-related price increases are:

- Making New York's All-Payer Database publicly available and requiring policymakers to use this data when approving consolidations and setting health insurance premiums;
- Requiring the Public Health and Health Planning Council to establish post-merger caps on price increases when it approves mergers and consolidations; and
- Enacting a site-neutral policy, such as the Fair Pricing Act, to control rising charges at hospital outpatient departments.

Background

The impact of hospital consolidation nationally

Nationally, health care spending has nearly quadrupled over the past two decades. Hospitals comprise one-third of this growth in spending, a larger share than any other health spending category.[1] As health care prices rise, patients and employers face higher health insurance premiums and out-of-pocket costs.[2] Consolidation does not appear to benefit patients. Researchers have found no significant relationship between mergers and improved clinical outcomes (e.g., reduced mortality

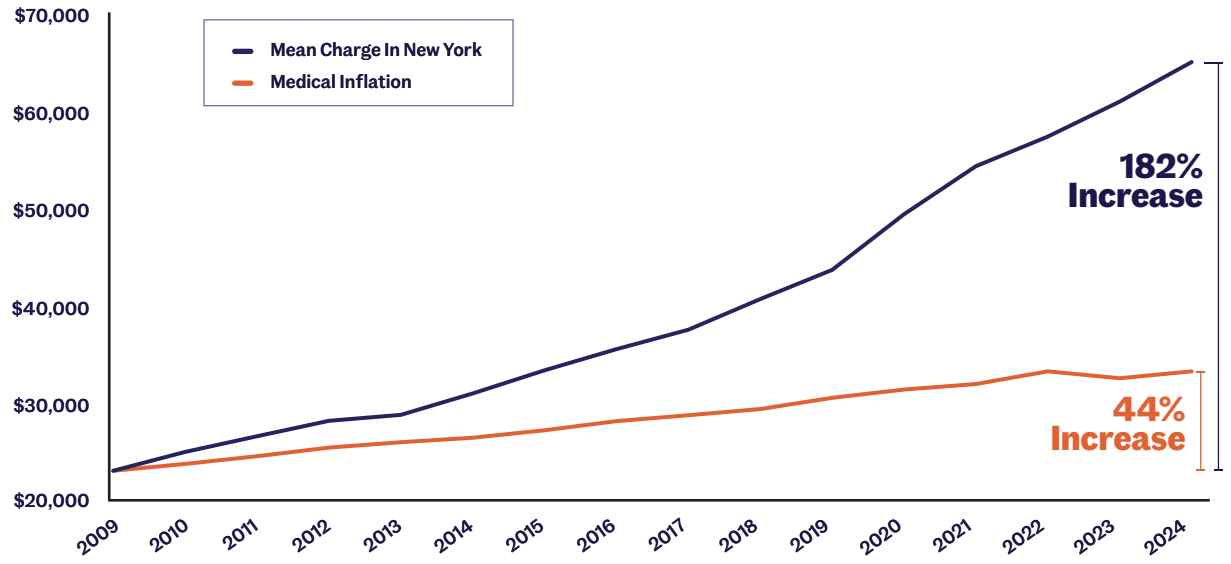
or readmission rates) despite claims by hospital officials that mergers improve quality of care.[3] Moreover, hospital mergers have been associated with *decreased* patient experience ratings.[4]

Government and academic researchers have also found that hospital prices increase following hospital mergers. A 2025 U.S. Department of Health and Human Services study found that hospital prices increased up to 65 percent after horizontal hospital consolidation.[5] These higher post-merger prices likely stem from reduced competition; hospitals without nearby competitors charge an average of 12.5 percent more.[6] Another study investigated the relationship between hospitals and prices during a period of stricter antitrust enforcement (2009-2016) and found a five percent average increase in prices at hospitals that merged.[7] Absent regulatory price controls and transparency mechanisms, hospitals often leverage their increased market power to charge patients and payers more for the same services.[8] A large body of evidence also shows that prices increase after hospitals acquire doctors' offices and clinics, although this paper does not explore this "vertical" consolidation.[9]

Did New York's multi-decade policies encouraging hospital consolidation fuel the rise in hospital charges?

Hospital charges in New York State have risen sharply in recent decades. Between 2009 and 2024, average charges in New York increased 182 percent, or more than four times as fast as both medical and overall inflation. Medical inflation is the rate at which the cost of health care goods and services rises over time.[13] It only increased by 44 percent over the same period. *See* Figure 1.

Figure 1. New York Hospital charges increased three times faster than inflation since 2009



Measuring hospital prices

Definitions

Horizontal consolidation: When two health care entities providing the same or similar services merge with each other (e.g. a hospital merging with another hospital).

Vertical consolidation: When two health care entities that provide different services merge with each other (e.g. a hospital or health system acquiring an independent physician practice).

Prices: An umbrella term that is used in this paper to colloquially refer to measures such as hospital charges and payments.

Cost: The amount of money a hospital spends to provide a visit/procedure. This is a hospital-reported measure.

Charge: The full amount a hospital bills a patient/payer for a given visit/procedure. This is a hospital-reported measure.

Payment: The amount of money a hospital actually receives as payment from a patient and/or payer.

Example:



Kathy goes to the hospital for an appendectomy. The hospital's spending on equipment, staff, a place to operate, and so on is called the **cost** of Kathy's procedure. The hospital then determines the amount a payer (e.g., Kathy or her insurance) should pay for providing the procedure (the full bill). This is the **charge** for Kathy's care. The end amount Kathy and/or her insurance pays for the appendectomy is the **payment**.

Data available to measure hospital prices

In New York, discharge-level charge and cost data from 2009 through 2024 is publicly available through the New York State Department of Health's Statewide Planning and Research Cooperative System (SPARCS).[10] However, ***payment*** data is not currently publicly available. Payment data differs from charge and cost data because insurers and providers often negotiate discounts from the charge. For example, an insurer and a hospital may agree that the negotiated rate is 60 percent of the hospital's gross charges.[11]

In 2011, New York passed legislation creating a public-facing All-Payer Database (APD) that would report data on what patients and payers pay for health care services, but the APD has not published any hospital-related data.[12] In the absence of a public APD, SPARCS charge data across all payers is the only available approximation of what patients and payers in New York spend on health care. That said, if payment data were available, it would likely trend similarly.



New York State's hospital market became more concentrated in the wake of a series of policy decisions. In 2005, New York policymakers established the Berger Commission to identify hospital facilities that should close in response to concerns that the State had too many unutilized hospital beds.[14] The Commission identified nine hospitals for closure in its final report.[15]

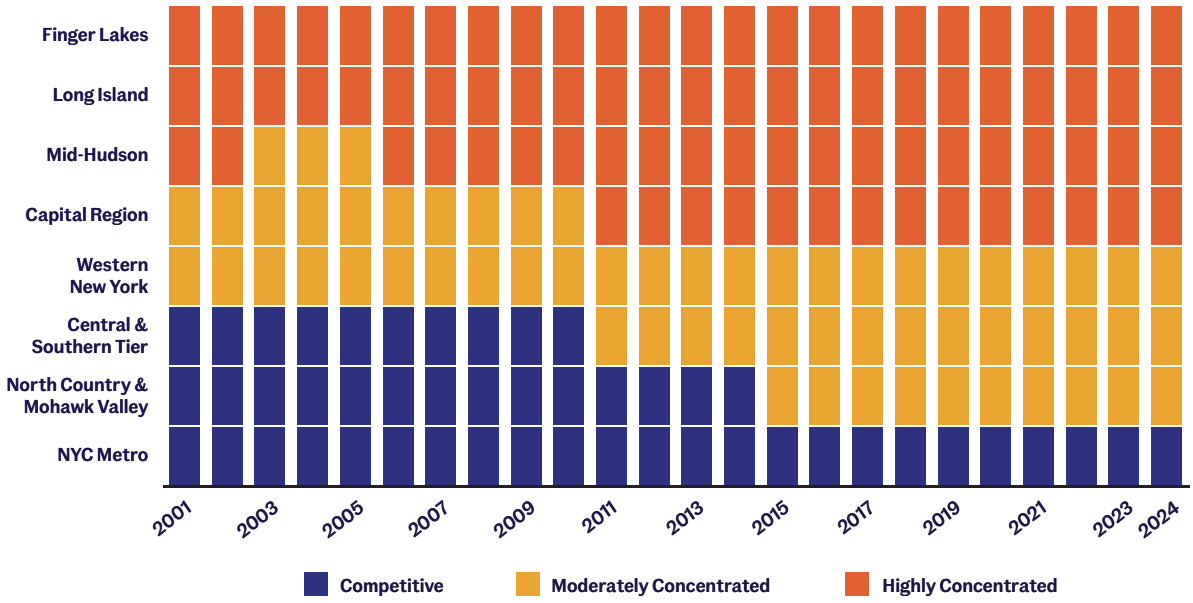
In 2010, New York policymakers tasked the Public Health and Health Planning Council (PHHPC) with state health planning, including reviewing changes in ownership and creating new health facilities.[16] PHHPC is now comprised of political appointees, most of whom are affiliated with hospitals and other health care industry representatives.[17] It tends to approve hospital mergers with few, if any, conditions.[18]

Governor Andrew Cuomo's administration (2011-2021) adopted numerous policies that encouraged hospital consolidation. For example, it commissioned Northwell Health to provide recommendations to consolidate three hospitals in Brooklyn.[19] In 2011, it established a Vital Access Provider Program to provide financial support to hospitals undergoing mergers and other types of restructuring.[20] In 2014, it launched the Delivery System Reform Incentive Payment (DSRIP) program that established and funded regional Performing Provider Systems that formed primarily under the umbrella of a leading hospital, further encouraging local hospital consolidations.[21]

During this time, researchers raised concerns about the impact that consolidation had on hospital prices. For example, the New York State Health Foundation issued a report that found that higher-priced hospitals were likely higher priced due to increased market power, and that prices did not necessarily correlate with quality of provided care.[22]

In 2001, three of the eight regions in New York had a Herfindahl-Hirschman Index (HHI) score —a measure of monopoly power—below 1,000 points and were thus considered competitive.[23] Two regions had HHIs between 1,000 and 1,800 points

Figure 2. Market Concentration of Regions in New York by Year



and were considered moderately concentrated. The remaining three regions had HHIs over 1,800 points and were considered "highly concentrated."[24] But by 2024, only one of New York's eight regional hospital markets remained competitive; three were categorized as moderately concentrated, and four were categorized as highly concentrated. *See* Figure 2.

From 2011 to 2023, 103 transactions occurred in New York that either involved establishing a new health system or expanding an existing one.[25] This trend paralleled national observations, where by 2024, inpatient hospital markets in nearly all metropolitan areas were considered "highly concentrated," according to antitrust guidelines from the Federal Trade Commission and Department of Justice.[26] In 38 percent of these metropolitan areas, a single health care system controlled more than 90 percent of the market for inpatient hospital care.[27]

Compounding the impact of these mergers, between 1997 and 2023, 53 hospitals closed in New York State.[28] Between 2001 and 2023, New York had the second highest net loss of hospitals of any state.[29] Hospital consolidation and closures are not felt equally across communities. Evidence indicates that consolidation has the greatest impact on rural communities and urban neighborhoods of color, whose already-impeded access to health care services is often disproportionately impacted by post-merger unit closures and price increases.[30]

To date, New York-specific analyses of the impact of hospital consolidation on hospital charges and costs have been limited. National studies that include data from New York State hospitals have primarily focused on relatively short-term impacts of consolidation (e.g., four to six years), on a few procedures, or on only certain payer types.[31]

This report first analyzes the impact of hospital consolidation on charges and costs in New York across all payers and procedures; second, how consolidation manifests at the regional level; and third, how consolidation affects the prices patients pay for several common procedures.

Methods

Between 2001 and 2024, 81 horizontal mergers involved a New York hospital/system merging with another hospital/system in New York or a neighboring state. *See* Appendix C for detailed list of transactions.

This report used discharge-level charge and cost data across all payers for the years available through the New York Department of Health SPARCS public use files (2009-2024) to analyze the impact of horizontal consolidation on hospital charges and costs.[32] Data from the American Hospital Association (AHA) Annual Survey and a supplemental dataset of hospital mergers as described in Cooper et al. (2019) were used to identify hospital-level merger data for this period.[33]

Analyses were restricted to the 180 hospitals with available charge, cost, and hospital-level merger data. Between 2009 and 2024, 101 hospitals in this sample were involved in 65 mergers, while 79 hospitals did not merge. An extended two-way fixed effects estimator was used to examine the causal effects of hospital mergers on charges and costs.[34] *See* Appendix A for detailed methodology.

The Impact of Hospital Consolidation on Charges and Costs Across New York

An analysis of hospital and charge data reveals that charges increased much faster at hospitals that merged than at those that never merged, whereas costs did not change significantly during that time. *See* Figure 3. The left side of Figure 3 shows the change in charges between 2009 and 2024. By 2024, charges had increased one and a half times as fast at merged hospitals than at never-merged hospitals. The right side of Figure 3 shows changes in costs during the same period. Costs increased between 2009 and 2024 for both groups; however, the increases were comparable in magnitude. Accordingly, the relatively small cost increases were unrelated to whether a hospital merger occurred.

Across New York mergers led to a statistically significant average increase in charges over the 10 years following a hospital merger, after controlling for hospital- and year-specific variables ($p < .001$). *See* Figure 4. This increase is attributable to the hospital merger. Hospital-reported costs were not significantly impacted by hospital mergers, as shown by the flat orange line. *See* Appendix A for detailed methodology and Appendix B for detailed findings.

Accordingly, hospital mergers increase inflation-adjusted hospital charges but not inflation-adjusted costs, effectively rebutting industry arguments that rising hospital costs justify higher charges.[35]

Figure 3. Charges increased 1.5 times as fast at hospitals that merged between 2009 and 2024, compared to those that did not merge, while costs increased similarly across all hospitals

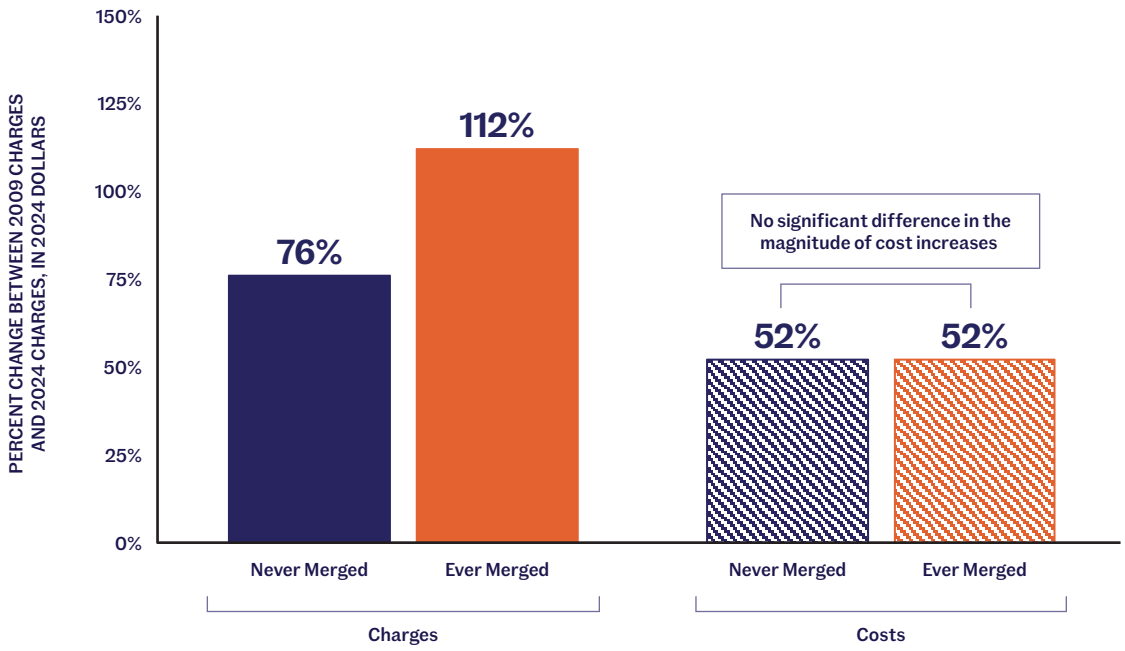
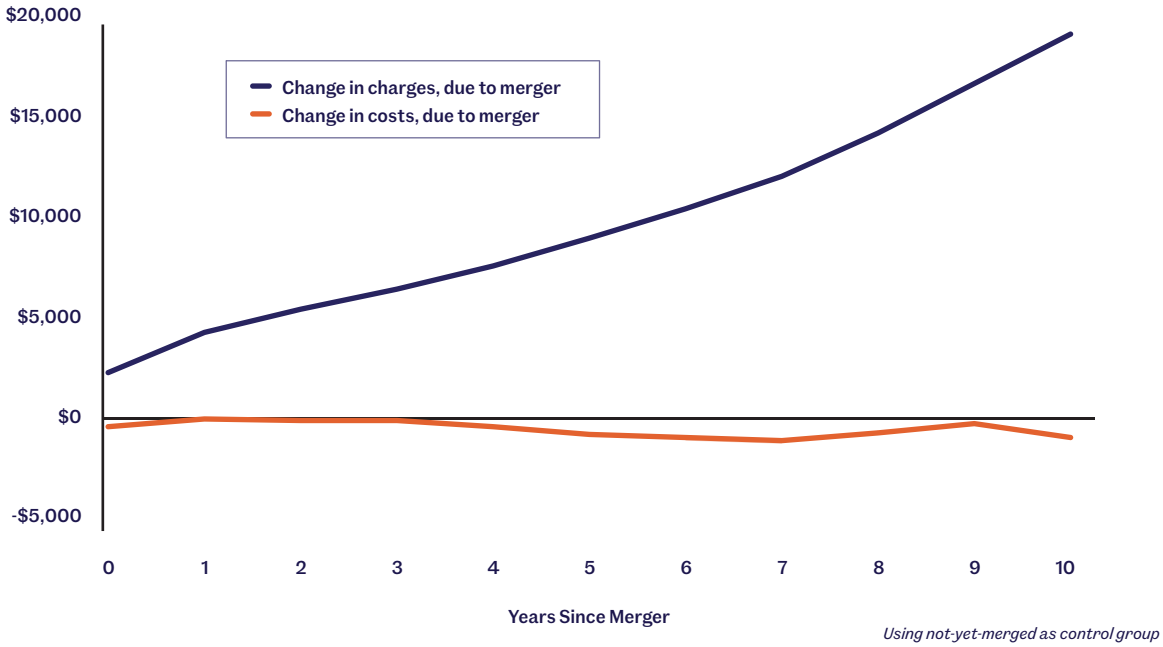


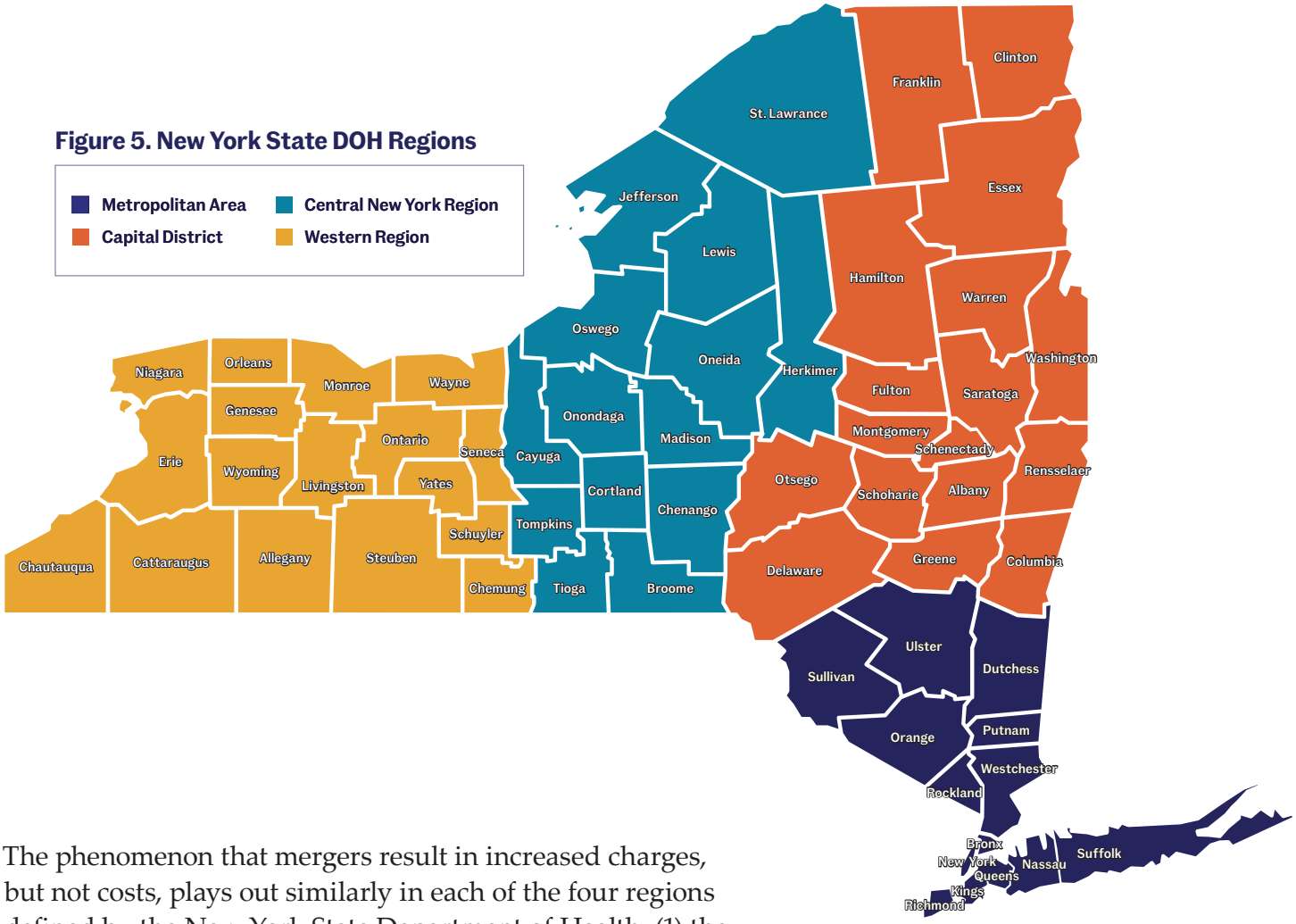
Figure 4. Charges significantly increased at hospitals that merged, while costs stayed relatively flat



Using not-yet-merged as control group

The Impact of Hospital Consolidation on Charges and Costs by Region

Figure 5. New York State DOH Regions



The phenomenon that mergers result in increased charges, but not costs, plays out similarly in each of the four regions defined by the New York State Department of Health: (1) the Metropolitan Area; (2) Central New York; (3) the Capital District; and (4) the Western Region.[36] *See* Figures 5-9.

The Metropolitan Area. Of the 99 hospitals in the New York City Metropolitan Area, 58 were involved in a merger between 2009 and 2024. In this region, **charges increased 2.2 times as fast as costs**. Average charges increased by 71 percent, from $51,660 at the time of a hospital's merger to $88,120 nine years post-merger. At the same time, average costs rose just 32 percent, from $16,560 at the time of the merger to $21,820 nine years later. *See* Figure 6. As was observed statewide, there was a clear regional trend of increased charges post-merger without a comparable increase in costs.

The sample of merged and unmerged hospitals in the Metropolitan Area was large enough to determine a causal relationship between hospital mergers and increased charges.[37] Hospital mergers in this area led to a statistically significant increase in charges, after controlling for hospital- and year-specific variables ($p < .001$).

The Capital District. Of the 20 hospitals in the Capital District, 11 were involved in a merger between 2009 and 2024. In this region, **charges increased 1.5 times as fast as costs**. Average charges increased by 26 percent, from $22,250 at the time of a hospital's merger to $28,360 at nine years post-merger. Average costs increased at a slower rate of just 17 percent, rising from $9,850 at the time of the merger to $11,520 nine years later. *See* Figure 7.

Figure 6. Metropolitan Area hospital charges increased 2.2 times as fast as costs

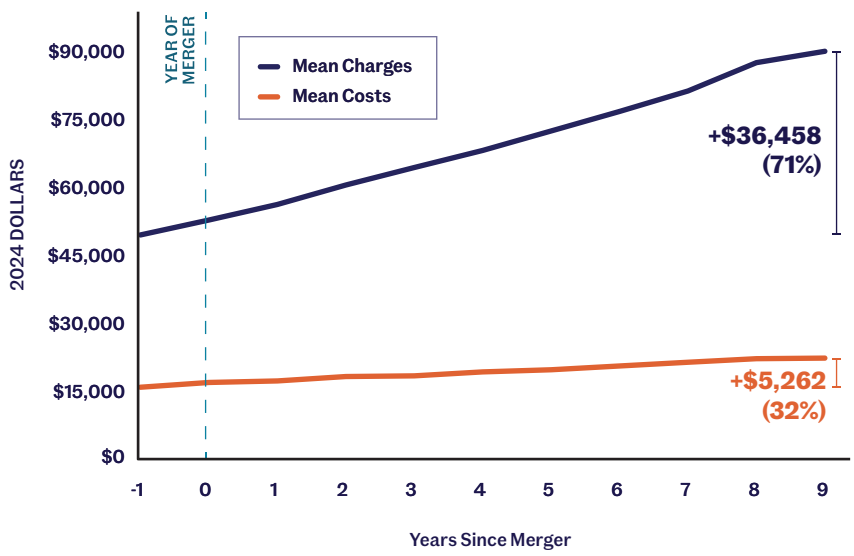
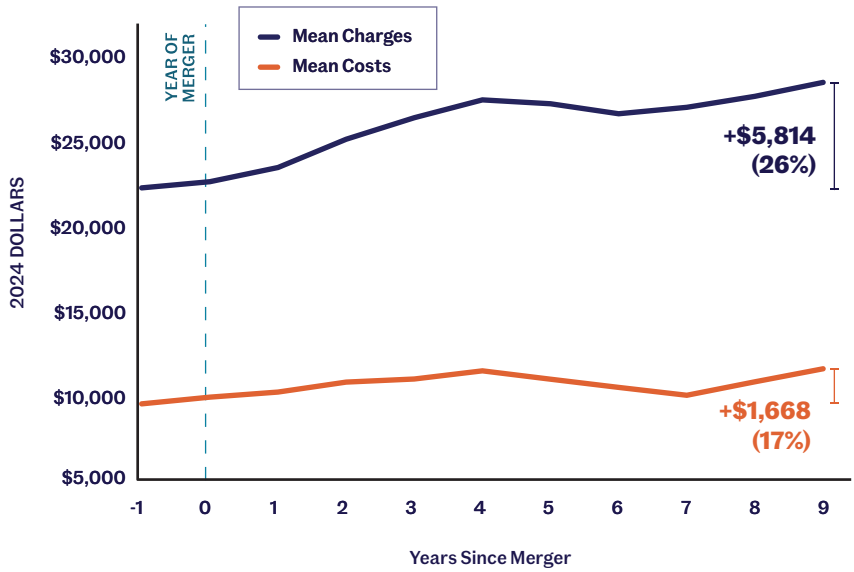


Figure 7. Capital District hospital charges increased 1.5 times as fast as costs



The Central New York Region. The difference between the rise in hospital charges and rise in costs was more pronounced in the Central New York Region. Of 23 hospitals, nine were involved in a merger between 2009 and 2024. In this region, **charges increased 4.5 times as fast as costs**. Average charges increased by 80 percent, from $24,310 at the time of merger to $43,860 at nine years post-merger. At the same time, average costs only rose by $2,250—or 18 percent. *See* Figure 8.

The Western Region. Of the 38 hospitals in the Western Region, 23 were involved in a merger between 2009 and 2024. In this region, **charges increased 1.3 times as fast as costs**. Average charges increased by 46 percent, from $19,489 at the time of a hospital's merger to $28,490 at nine years post. At the same time, average costs only rose by 36 percent, from $9,333 at the time of a hospital's merger to $12,725 nine years later. *See* Figure 9.

In all four regions of New York State, post-merger hospitals' charges were higher than costs and increased more rapidly. The difference in the rate of increase in charges and costs at merged hospitals ranged from 1.3 times to 4.5 times, depending on the region.

Figure 8. Central New York hospital charges increased 4.5 times as fast as costs

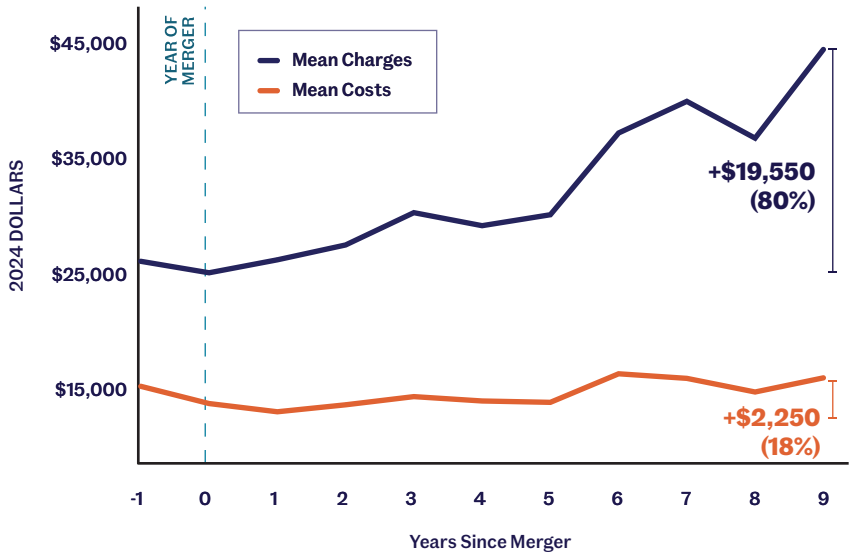
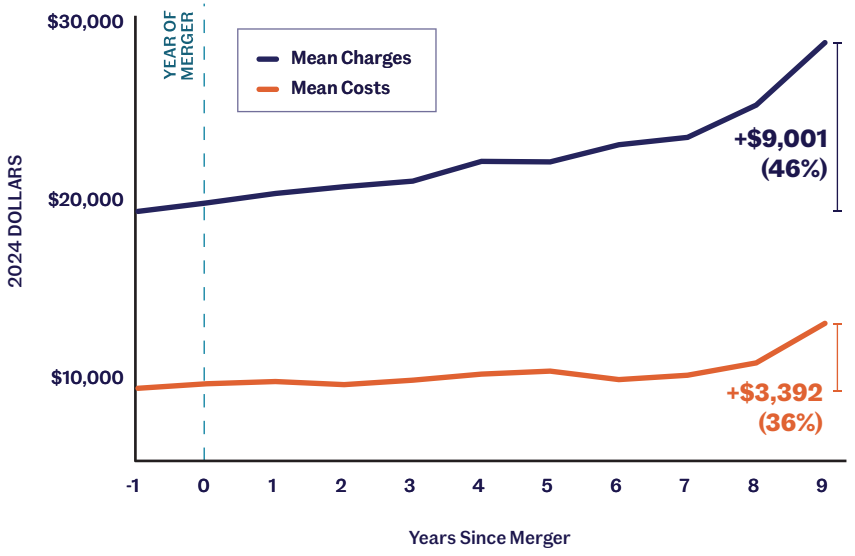


Figure 9. Western New York hospital charges increased 1.3 times as fast as costs





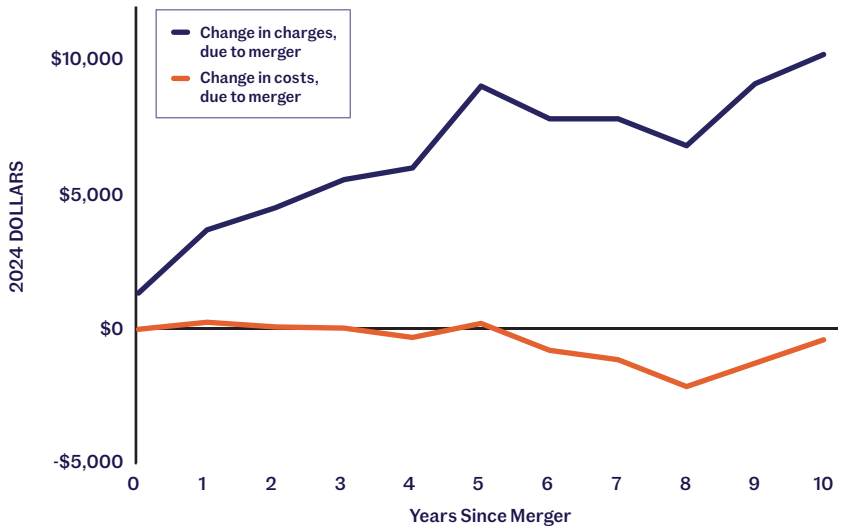
The Impact of Hospital Consolidation on Charges and Costs at the Procedure-level

High post-merger hospital charges impact patients and payers when they seek and pay for care. This is illustrated at the procedure level through an analysis of: (1) appendectomies; (2) vaginal deliveries; and (3) knee replacements. These procedures are selected because they are common, span a wide age range, and do not necessarily co-occur with other inpatient procedures.[38]

The analysis of these procedures reveals a trend of increased charges post-merger without a comparable increase in costs, similar to trends at the statewide and regional levels.

Appendectomies. Mergers led to a statistically significant overall increase in charges of $6,269 for appendectomy patients after controlling for hospital- and year-specific variables ($p < .001$). By contrast, mergers had no significant impact on hospitals' costs for appendectomy patients. Increased charges for appendectomy patients post-merger were not caused by a comparable increase in costs. *See* Figure 10.

Figure 10. Average hospital charges for appendectomy patients are higher at hospitals that merged, while costs show no significant change



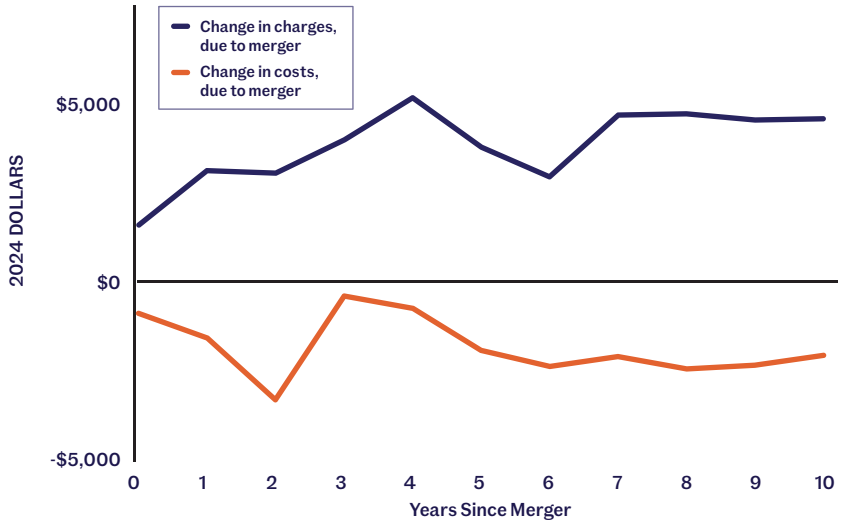
Using not-yet-merged as control group

Vaginal deliveries. Mergers were associated with increased charges for vaginal deliveries. Mergers led to a overall increase in charges of $3,525 for vaginal delivery patients. The impact of mergers on hospital charges was statistically significant from two years post-merger through ten years post-merger ($p < .001$). Again, there was no significant effect of mergers on costs for vaginal delivery patients. *See* Figure 11.

Knee replacements. Mergers were associated with an overall increase in charges for knee replacement patients of $11,508. The impact of mergers on hospital charges was statistically significant at four and six years post-merger, and at eight to nine years post-merger ($p < .001$). The impact of mergers on hospital costs for knee replacement patients was not significant. Thus, increased charges for knee replacement patients post-merger were not caused by a comparable increase in costs. *See* Figure 12.

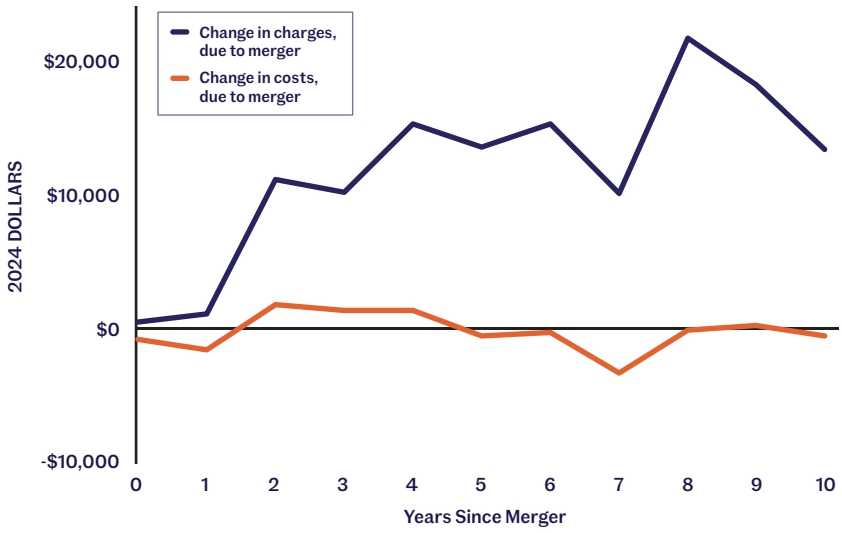
Patients with appendectomies, deliveries, and knee replacements all experienced a post-merger increase in hospital charges, suggesting this observation is not procedure specific. Additionally, there is no indication that any associated cost savings are passed on to patients or payers.

Figure 11. Average hospital charges for vaginal delivery patients are higher at hospitals that merged, while costs show no significant change

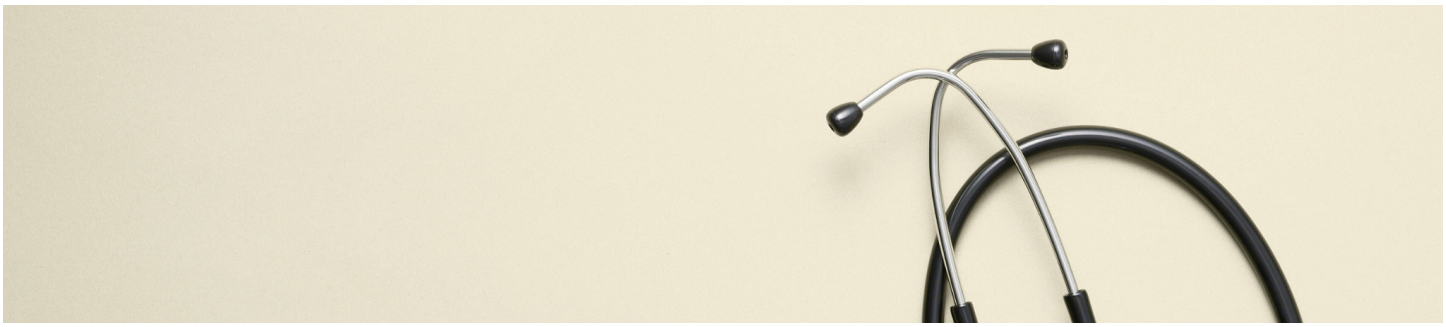


Using not-yet-merged as control group

Figure 12. Average hospital charges for knee replacement patients are higher at hospitals that merged, while costs show no significant change



Using not-yet-merged as control group



Policy Recommendations

At the state, regional, and procedure level, hospital mergers are associated with a significant increase in hospital-reported charges. To secure more affordable and equitable health care for New Yorkers, a government-administered health care system, as is outlined in the New York Health Act, would be optimal.[39] Alternatively, New York could return to its all-payer rate system, where the state sets the reimbursement rate charged to all payers for a given hospital visit/procedure.[40]

Absent this type of systemic policy change, New York can consider three targeted actions to address the impact hospital market consolidation has on prices, including: (1) requiring the robust publication of New York's All-Payer Database, and its use by policymakers to control health care expenditures; (2) directing the Public Health and Health Planning Council to establish guardrails to control post-merger prices; and (3) enacting price regulation, such as the Fair Pricing Act.

Improve transparency by publishing New York's overdue All-Payer Database.

Public access to credible, accurate data on prices paid by payers and patients is essential to closing the data transparency gap and enabling regulators to monitor the impact of hospital consolidation on prices.

New York, along with more than 20 states, moved to establish an All-Payer Database (APD) that can provide meaningful data to track the impact of policy decisions—for example, the impact of approving a merger on local and regional health care prices. As of 2026, eight states (CA, CT, DE, MA, NJ, OR, RI, and WA) have established public-facing APDs that are leveraged to control health care costs through cost-growth benchmarks.[41] While New York led the way in enacting APD legislation in 2011, 15 years and $159 million later, it has fallen behind many peer states by not releasing any data publicly.[42] An accurate APD could also help the Department of Financial Services (DFS) determine rates during the state's annual health insurance rate review process, ensuring more accurate and affordable rates for individuals and small businesses.

Without a publicly available APD, patients, researchers, and lawmakers have limited information to access and compare health care prices without paying for privately sourced data. The best available proxy for pricing data in a publicly-available APD is SPARCS hospital-reported discharge data. However, SPARCS includes only charges, which may not reflect the actual payments made by payers and patients. New York State regulators should leverage the APD to conduct regular price analyses in the wake of mergers.

Establish guardrails to control post-merger prices.

Controlling post-merger price increases calls for stricter regulation of hospital consolidation. During its approval process, the PHHPC should require that merging hospitals/systems predict the expected impact of a transaction on prices for affected patients and payers. This report should also be accompanied by a document in which merging health care entities pledge not to increase prices past a set threshold. These price caps could be informed by trending historical data available through the APD or by multiplying the price of services in the final year pre-merger by one plus the CPU-I of the prior year.

In 2025, three states (IN, VT, and WA) passed legislation with some form of hospital price capping that applied to a specified health system or patient population.[43] Though these caps are not triggered by a hospital merger, they set a precedent for state-imposed price ceilings for hospital services.

Enact Price Regulation, such as the Fair Pricing Act.

Another modest proposal to control rising prices and reduce overpayment for routine procedures is the Fair Pricing Act, which would set an upper limit of 150 percent of the Medicare rate for a set of services that most people get at the doctor's office. Currently, if hospitals buy doctor's offices, they can increase rates significantly for the same care, even in the same building with the same providers, due to increased hospital market power following vertical integration. This cap will help counter such merger-induced price increases and ensure patents can access the same care at the same price.

Brown University researchers estimate that the Fair Pricing Act would generate $1.1 billion in annual savings in commercial payments for insured New Yorkers alone, of which $213 million would make health care more affordable for individual patients.[44]

Conclusion

This report demonstrates that hospital consolidation in New York has led to increased charges at merged hospitals. Post-merger rises in hospital charges were not unique to any one region or procedure and were not explained by inflation or proportionate rises in hospital costs. New York policymakers can address the negative consequences of hospital consolidation. A publicly available APD, post-merger price controls, and site-neutral payments would make health care more affordable and accessible for all New Yorkers.

Appendix A. Detailed Methods

Data Sources

Hospital-level data for the years 2001-2024 came from the American Hospital Association (AHA) Annual Survey, as well as a supplemental dataset of hospital mergers as described in Cooper et al. (2019).[45] Between 2001 and 2024, 81 mergers involved a New York hospital/system merging with another hospital/system in New York or in a neighboring state. This analysis focuses on these mergers (a hospital/system merging with another hospital/system) due to the availability of pre- and post-merger hospital charge and cost data.

Cost and charge data for hospital discharges in 2009-2024, across all payers, came from the New York State Department of Health's Statewide Planning and Research Cooperative System (SPARCS) public use files.[46] Based on 37,462,168 inpatient claims from 244 hospitals, CSS calculated the average charge and cost for each hospital each year. Charges and costs were adjusted for inflation using the Northeast regional medical care Consumer Price Index for All Urban Consumers (CPI-U).[47]

These hospital-level charge and cost averages for each year (in 2024 inflation-adjusted dollars) were then combined with the AHA/merger data; CSS matched hospitals across datasets by their street address, as hospital names often changed over time. The final sample included 180 hospitals for which both charge/cost data and hospital-level merger data were available for at least one year.

Hospital Market Concentration

To quantify regional hospital market concentration, CSS calculated the yearly Herfindahl-Hirschman Index (HHI) for the eight Department of Financial Services (DFS) insurance rating regions within New York State, which CSS identified by the names in the table below.[48]

Using hospital bed totals for each year, CSS calculated the yearly market share of each health system in each region (or the hospital market share for those not part of a health system). CSS then calculated the sum of the squared market shares of the hospitals/health systems in each region to obtain their HHIs in the years 2001 through 2024.[49] For each year, CSS categorized the regions as "competitive", "moderately concentrated," or "highly concentrated," according to the U.S. Department of Justice and Federal Trade Commission Merger Guidelines.[50]

DFS Insurance Rating Regions

Region Name	Counties
Capital Region	Albany, Rensselaer, Saratoga, Schenectady, Columbia, Fulton, Greene, Montgomery, Warren, Washington, Schoharie
Western New York	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming
Mid-Hudson	Delaware, Dutchess, Orange, Putnam, Sullivan, Ulster
NYC Metro	Bronx, Kings, New York, Queens, Richmond, Rockland, Westchester
Finger Lakes	Livingston, Monroe, Ontario, Seneca, Wayne, Yates
Central & Southern Tier	Broome, Cayuga, Chemung, Cortland, Onondaga, Schuyler, Steuben, Tioga, Tompkins
North Country & Mohawk Valley	Chenango, Clinton, Essex, Franklin, Hamilton, Herkimer, Jefferson, Lewis, Madison, Oneida, Oswego, Otsego, St. Lawrence
Long Island	Nassau, Suffolk

Charges and Costs at Never-Merged and Ever-Merged Hospitals

Analyses of hospital charges and costs were restricted to the years for which charge and cost data were available (2009-2024). Of the 180 hospitals in the sample, 101 hospitals underwent at least one merger with another hospital/system in New York or in a neighboring state between 2009 and 2024 ("ever-merged hospitals"). Mergers were not counted if a hospital in New York merged only with hospitals/systems in distant states. For example, Our Lady of Lourdes Hospital in Binghamton, NY was Ascension Healthcare system's only campus in the Northeast when the system acquired Three Rivers Hospital in Waverly, Tennessee in 2021. Thus, CSS did not count this event as a merger for Our Lady of Lourdes Hospital.

In the sample of 180 hospitals, 79 hospitals did not merge between 2009 and 2024, or merged only with a hospital/system in a distant state ("never-merged hospitals").

Comparisons Between 2009 and 2024 Charges/Costs at Never-Merged and Ever-Merged Hospitals

CSS conducted paired samples t-tests to examine the change in inflation-adjusted average charges and costs at "never-merged" hospitals between 2009 and 2024. CSS also conducted paired samples t-tests to examine changes in inflation-adjusted charges and costs at hospitals that were involved in at least one merger between 2009 and 2024 ("ever-merged" hospitals).

For both never-merged and ever-merged hospitals, CSS calculated the percent change from their average 2009 charges/costs to their average 2024 charges/costs. CSS then conducted an independent samples t-test to examine whether there was a significant difference between never-merged and ever-merged hospitals in their respective increases in charges and/or costs between 2009 and 2024. CSS used the Bonferroni correction to adjust for multiple comparisons and reported significance at $p < .001$.

Analysis of Causal Effect of Hospital Mergers on Charges and Costs

To examine the causal effect of hospital mergers on charges and costs, CSS used the extended two-way fixed effects estimator described by Woolridge (2021).[51] The fixed effects estimator does not require demonstrating parallel pre-trends. However, the pre-treatment estimates were examined nonetheless and found to be close to zero (indicating that pre-treatment trends were near parallel).

Using the etwfe package in R, CSS estimated the average effect of treatment (hospital merger) in the context of staggered rollout.[52] Hospitals were grouped into cohorts based on the year of their first merger between 2009 and 2024; hospitals that never merged during this time period were also grouped together. The specified models were fully saturated with cohort x time (i.e., calendar year) interactions.

The specified models also controlled for time (calendar year) fixed effects and entity (hospital) fixed effects. For example, consider a hypothetical hospital in Manhattan, Hospital X, that underwent a merger in late 2019. It is possible that Hospital X has always had high charges due to its location. It is also possible that charges increased at hospitals across the state in 2020 due to the onset of the COVID-19 pandemic. Controlling for hospital- and year-specific variables allows for the isolation of the change in charges at Hospital X that is attributable to its 2019 merger, rather than its characteristics (e.g., location) or other contextual factors (e.g., COVID-19).

Using not-yet-merged hospitals as the control group, CSS estimated the overall average treatment effect on the treated (ATT). CSS also estimated the ATT for each cohort in each calendar year and aggregated these estimates to yield the ATTs in each post-merger year. Although the figures show the 95% confidence intervals for these analyses, results are only reported as significant at $p < .001$ to adjust for multiple comparisons.

Region-Level Charges and Costs at Merged Hospitals

Region-level analyses were based on the boundaries of the four New York State Department of Health (NYSDOH) regional offices, described in the table below.[53]

NYSDOH Regions

Region Name	Counties
Metropolitan Area	Bronx, Kings, New York, Queens, Richmond
Capital District	Albany, Clinton, Columbia, Delaware, Essex, Franklin, Fulton, Greene, Hamilton, Montgomery, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Warren, Washington
Central New York Region	Broome, Cayuga, Chenango, Cortland, Herkimer, Jefferson, Lewis, Madison, Oneida, Onondaga, Oswego, St Lawrence, Tioga, Tompkins
Western Region	Allegany, Cattaraugus, Chautauqua, Erie, Genesee, Niagara, Orleans, Wyoming, Chemung, Livingston, Monroe, Ontario, Schuyler, Seneca, Steuben, Wayne, Yates

CSS identified hospitals that had merged at least once between 2009 and 2024. For each hospital in each calendar year, CSS calculated the number of years before or since the hospital's first merger. CSS then grouped the merged hospitals by region and calculated average inflation-adjusted charges and costs at 11 time points: one year pre-merger through nine years post-merger. CSS also calculated the percent change in charges and costs from the time of the merger to nine years post-merger.

Causal Effect of Hospital Mergers on Charges and Costs in the Metropolitan Area NYSDOH Region

For the Metropolitan Area NYSDOH Region alone, CSS used the extended two-way fixed effects estimator to estimate the average effect of hospital mergers on charges and costs, overall and at each post-merger time point. The Metropolitan Area NYSDOH Region was the only region with a sufficient hospital sample size for this analysis.

Procedure-Level Charges and Costs at Merged Hospitals

In addition to exploring region-level trends in post-merger charges and costs, CSS also examined procedure-specific trends for three procedure categories: (1) appendectomies, (2) vaginal deliveries, and (3) knee replacements. These procedures were selected because they are common and collectively span a wide range of ages. According to the most recent data available from the Healthcare Cost & Utilization Project, appendectomies are the most common inpatient operating room procedure for children ages 0 to 17 years, while knee replacements are the most common inpatient operating room procedure for adults ages 65 to 74 years.[54] The average maternal age at the time of childbirth is in between, at 29.6 years old.[55] Since SPARCS provides hospital charge and cost data at the level of each patient discharge, not each procedure, CSS also chose these procedures because they do not necessarily co-occur with other inpatient procedures.

CSS used the extended two-way fixed effects estimator to estimate the average effect of hospital mergers on charges and costs for patients in each procedure category, overall and at each post-merger timepoint.

Appendix B. Detailed Findings

Many figures in the report have been simplified for clarity and accessibility. The following detailed findings describe more complex versions of the figures in the report, by figure.

Figure 3 Detail

The detailed version of Figure 3 displays the average charges in each year, not just the differences between years, as Figure 3 in the report does.

The left side of the more detailed Figure 3 shows the change in charges at never-merged (teal) and ever-merged (purple) hospitals between 2009 and 2024. In 2009, before the merger activity began, there was no significant difference in charges between never-merged (light teal) and ever-merged (light purple) hospitals. By 2024, however, charges were significantly higher at ever-merged (dark purple) hospitals than at never-merged (dark teal) hospitals. While the 2009-2024 increase in charges was significant for both groups, the magnitude of the difference for ever-merged (purple) hospitals was significantly larger ($p < .001$). Charges at never-merged (teal) hospitals increased by 76 percent, compared to an increase of 112 percent at ever-merged (purple) hospitals. In other words, charges increased one and a half times as fast at the merged hospitals than they did at the never-merged hospitals.

The right side of the more detailed Figure 3 explores the changes in costs at hospitals that never merged (yellow) and at hospitals that merged at least once (orange) during the same period. There was no significant difference between 2009 costs at never-merged (light yellow) and ever-merged (light orange) hospitals. There was also no significant difference in 2024 costs at never-merged (dark yellow) and ever-merged (dark orange) hospitals. Costs *did* increase between 2009 and 2024 for both groups, but the magnitude of their increases was the same. Accordingly, the relatively small increases in costs were unrelated to hospital mergers.

Detailed Figure 3: Charges and Costs in Never vs. Ever Merged Hospitals

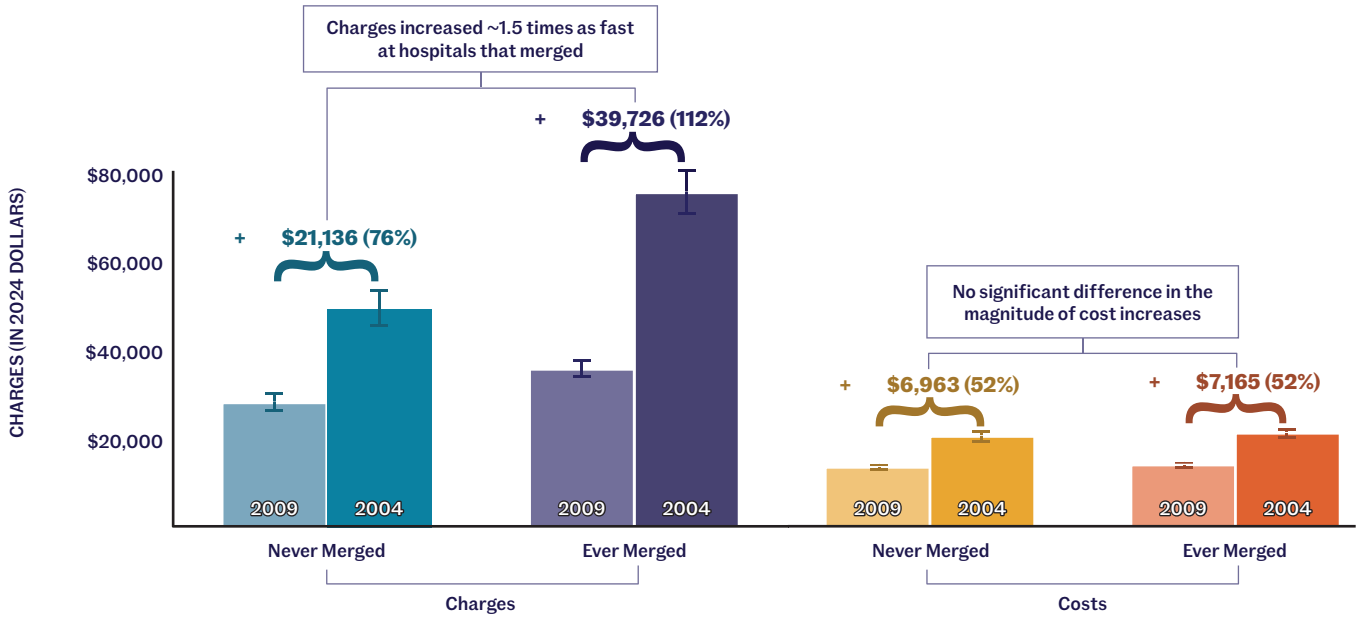


Figure 4 Detail

In the report, Figure 4 shows the average effect of hospital mergers on hospitals' charges and costs at each post-merger timepoint, adjusted for inflation. The more detailed version of Figure 4, below, has shaded regions, representing the 95 percent confidence intervals. It also includes the overall average effect of mergers: a $9,008 increase in hospital charges. This analysis uses not-yet merged hospitals as a control group and indicates a causal relationship between hospital mergers and increased charges.

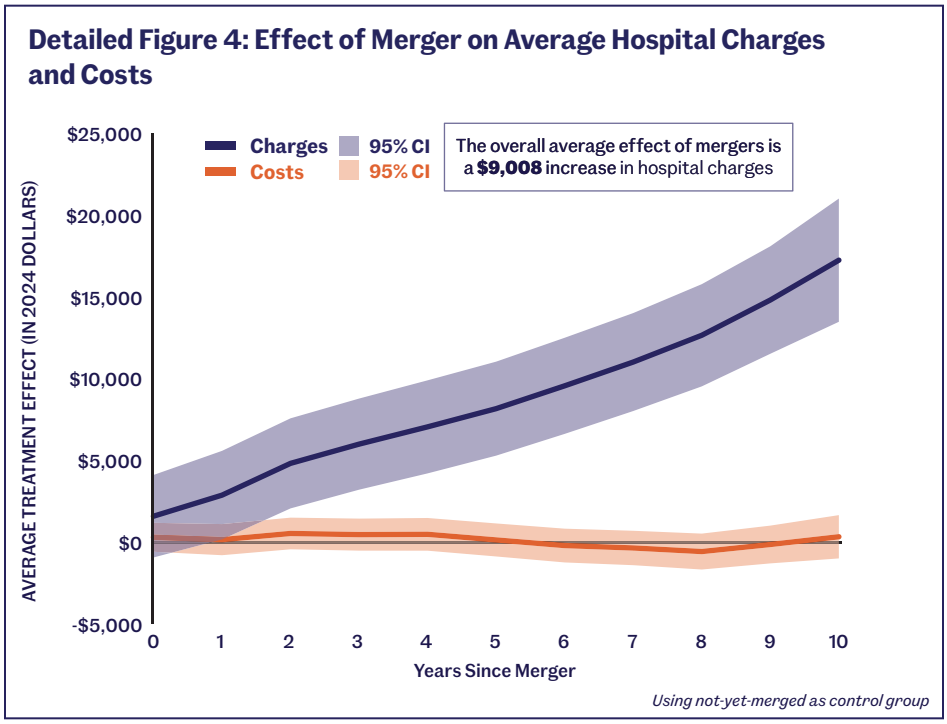


Figure 10 Detail

In the report, Figure 10 shows the average treatment effect (causal impact of mergers) on hospital charges and costs for appendectomy patients. The more detailed version of Figure 10 shows the same effect, but with the addition of shaded regions representing 95 percent confidence intervals, and a box indicating the overall average effect.

Mergers led to a statistically significant overall increase in charges of $6,269 ($p < .001$) for appendectomy patients after controlling for hospital- and year-specific variables. The effect of mergers on charges was statistically significant from two years post-merger through 10 years post-merger (p's < .001).

By contrast, mergers had no significant overall effect on hospitals' costs for appendectomy patients, as indicated by the 95 percent confidence interval until seven years post-merger. By contrast, inflation-adjusted costs trended downward, reaching statistical significance at eight years post-merger ($p < .001$). The post-merger increase in charges for appendectomy patients was not attributable to a corresponding increase in reported hospital costs.

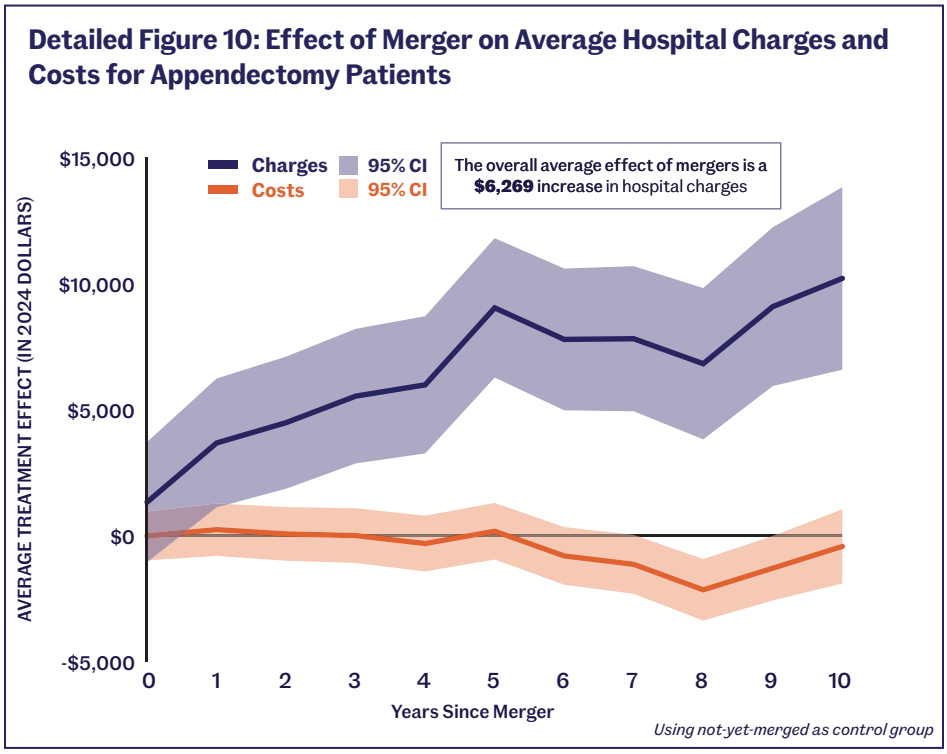
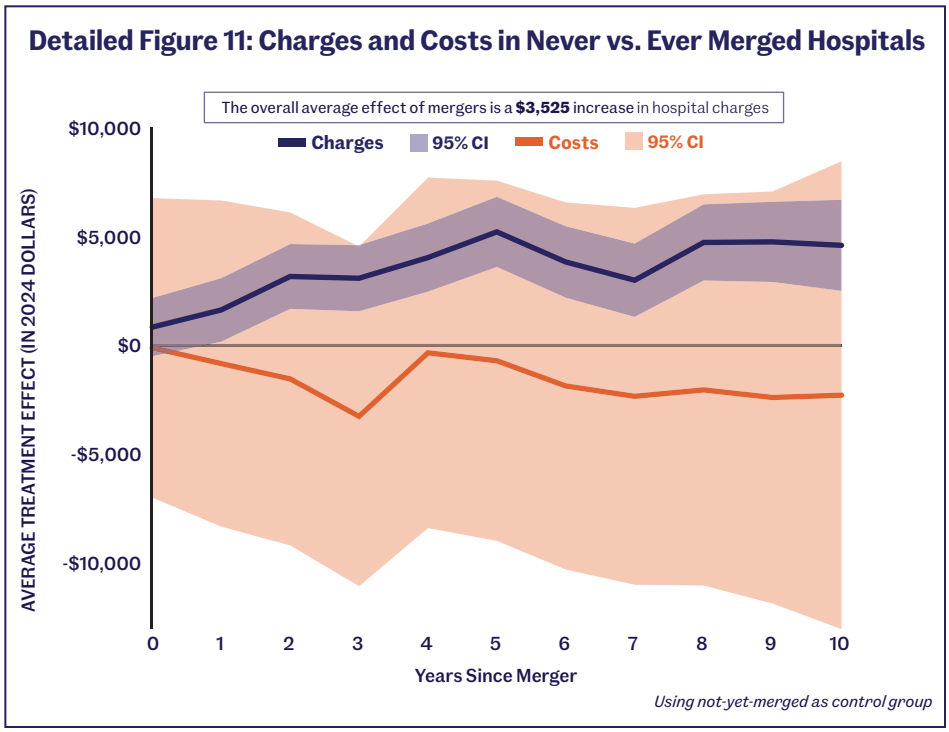


Figure 11 Detail

In the report, Figure 11 shows the average treatment effect (causal impact of mergers) on hospital charges and costs for vaginal delivery patients. The more detailed version of Figure 11 shows the same effect, but with the addition of shaded regions representing 95 percent confidence intervals, and a box indicating the overall average effect.

Mergers led to an overall increase in charges of $3,525 ($p < .001$) for vaginal delivery patients after controlling for hospital- and year-specific variables. For vaginal delivery patients, the effect of mergers on hospital charges was statistically significant from two years post-merger through 10 years post-merger (p's < .001).

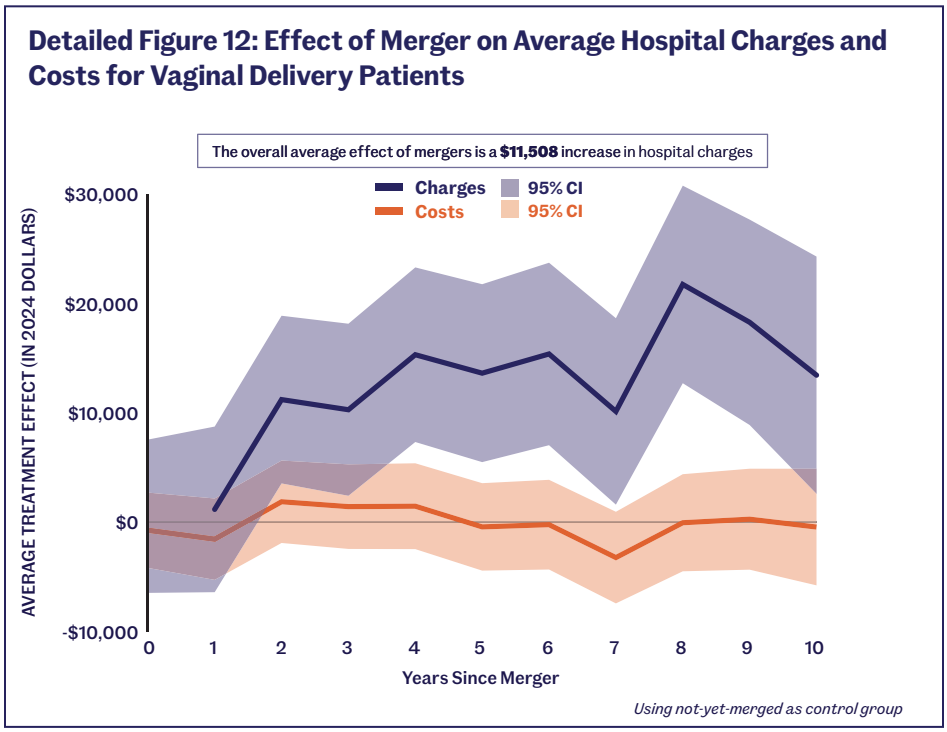


There was no significant effect of mergers on hospital costs for vaginal delivery patients overall or at any post-merger timepoint. However, hospital costs varied widely between patients, leading to a large 95 percent confidence interval (orange shaded region).

Figure 12 Detail

In the report, Figure 12 shows the average treatment effect (causal impact of mergers) on hospital charges and costs for knee replacement patients. This more detailed version of Figure 12 shows the same effect, but with the addition of shaded regions representing 95 percent confidence intervals, and a box indicating the overall average effect.

Mergers were associated with an overall $11,508 increase in charges for knee replacement patients. The effect of mergers on hospital charges reached statistical significance at four and six years post-merger, and at eight to nine years post-merger (p's < .001). The effect of mergers on hospital costs for knee replacement patients was not significant overall or at any post-merger timepoint.



Appendix C. List of hospitals / systems involved in mergers, 2001 – 2024

Year	Target Hospitals / System	Acquirer Hospitals / System
2001	Putnam Hospital Center	Health Quest
2001	Tri-County Memorial Hospital	Lake Shore Hospital
2002	Carondelet Health System	Ascension Health
2002	St Vincent's Catholic Medical Center	Saint Vincent Catholic Medical Centers
2002	Community Hospital at Dobbs Ferry	St. John's Riverside Hospital
2003	Marian Community Hospital	Catholic Health East
2003	Mercy Jeannette Hospital	Catholic Health East
2004	Our Lady of Mercy Medical Center	Montefiore Health System
2004	Little Falls Hospital	Bassett Healthcare
2006	St Vincent's Hospital	Bridge Regional Health System
2006	Wyckoff Heights Medical Center	Saint Vincent Catholic Medical Centers
2007	Catskill Regional Medical Center	Greater Hudson Valley Health System
2008	Columbus Hospital; Saint Michael's Medical Center	Catholic Health East
2008	Ira Davenport Memorial Hospital	Arnot Health
2008	Bradford Regional Medical Center	Upper Allegheny Health System
2008	Ellis Hospital McClellan	Ellis Hospital
2009	Amsterdam Memorial Hospital	Ascension Health
2009	Kingston Hospital	Benedictine Hospital
2009	Margaretville Hospital	Benedictine Hospital
2010	Lenox Hill Hospital	North Shore LIJ Health System
2010	St. Joseph Hospital	Catholic Health Services of Long Island
2010	Aurelia Osborn Fox Memorial Hospital	Bassett Healthcare
2011	St. Mary's Hospital	Catholic Health East
2011	Albany Memorial Hospital	Catholic Health East
2011	Samaritan Hospital	Catholic Health East
2011	St. Joseph's Hospital	Arnot Health
2011	University Hospital of Brooklyn	SUNY Downstate Medical Center University
2011	Community-General Hospital of Greater Syracuse	Upstate Medical University
2012	Saint Vincent Health Center; Westfield Memorial Hospital	West Penn Allegheny Health System
2012	F. F. Thompson Hospital	University of Rochester Medical
2013	New York Downtown Hospital	New York Presbyterian Healthcare
2013	Jefferson Regional Medical Center	West Penn Allegheny Health System
2013	Sound Shore Medical Center of Westchester; Mount Vernon Hospital	Montefiore Health System
2013	Alice Hyde Medical Center	University of Vermont Health Network
2013	Champlain Valley Physicians Hospital	University of Vermont Health Network
2013	Continuum Health Partners	Mount Sinai Health System
2014	Unity Hospital	Rochester Regional Health System
2014	Lawrence Hospital Center	New York Presbyterian Healthcare System
2014	Nyack Hospital	Montefiore Health System
2014	Gouverneur Hospital	Canton-Potsdam Hospital
2014	Lutheran Medical Center	NYU Medical Center
2014	Schuyler Hospital	Cayuga Medical Center at Ithaca
2015	United Memorial Medical Center	Rochester Regional Health

Year	Target Hospitals / System	Acquirer Hospitals / System
2015	Clifton Springs Hospital and Clinic	Rochester Regional Health
2015	Northern Westchester Hospital	North Shore Long Island Jewish Health System
2015	Phelps Memorial Hospital Center	North Shore Long Island Jewish Health System
2015	New York-Presbyterian/Hudson Valley Hospital	New York Presbyterian Healthcare System
2015	Mount St. Mary's Hospital and Health Center	Catholic Health System
2015	White Plains Hospital Center	Montefiore Health System
2015	Guthrie Towanda Memorial Hospital	Guthrie Clinic
2015	Saint Francis Hospital and Medical Center	Trinity Health
2015	St. Joseph's Hospital Health Center	Trinity Health
2015	Bon Secours Health System Inc	WMCHealth
2015	MidHudson Regional Hospital of Westchester Medical Center	WMCHealth
2016	Peconic Bay Medical Center	Northwell Health
2016	Woman's Christian Association Hospital	UPMC
2016	Nicholas H. Noyes Memorial Hospital	University of Rochester Medical Center
2016	Jones Memorial Hospital	University of Rochester Medical Center
2016	Johnson Memorial Medical Center	Trinity Health
2016	Saint Mary's Hospital	Trinity Health
2016	HealthAlliance of the Hudson Valley	WMCHealth
2016	Winthrop-University Hospital	NYU Medical Center
2017	John T. Mather Memorial Hospital	Northwell Health
2017	Community Health Systems Inc	UPMC
2017	Lock Haven Hospital; Sunbury Community Hospital and Outpatient Center	UPMC
2017	Pinnacle Health Harrisburg Hospital	UPMC
2017	Hanover Hospital	UPMC
2017	UPMC Kane	UPMC
2017	Sharon Hospital	Health Quest Systems Inc
2017	Porter Medical Center	University of Vermont Health Network
2017	Moses Ludington Hospital	The University of Vermont Health Network Elizabethtown Community Hospital
2017	Southampton Hospital	Stony Brook University Hospital
2018	UPMC Cole	UPMC
2018	St. James Mercy Hospital	University of Rochester Medical Center
2018	The University of Vermont Health Network Elizabethtown Community Hospital; Moses Ludington Hospital	University of Vermont Health Network
2018	South Nassau Communities Hospital	Mount Sinai Health System
2018	TLC Health Network - Lake Shore Hospital	Brooks Memorial Hospital
2019	UPMC Somerset Hospital	UPMC
2019	Massena Memorial Hospital	St Lawrence Health System
2019	Nuvance Health	Health Quest Systems Inc
2019	Stony Brook Eastern Long Island Hospital	Stony Brook University Hospital

Note: *This list was created using a supplemental dataset of hospital mergers described in Cooper et al. (2019).*[56] *For target hospitals/systems, all hospital targets that included more than two hospitals were referred to by a system affiliation. For acquirer hospitals/systems, all acquirers that had a system name were referred to by a system name, and all that did not were referred to by hospital name.*

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