Why is Health Care in New York So Unaffordable and What Can be Done to Fix It?

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Executive Summary

In the 1990s, New York State policymakers embraced a market-driven model for regulating hospital prices and planning. Three decades later, health care spending has more than tripled. New Yorkers experience a health care system epitomized by high prices, uneven quality of care, and little transparency about how health care resources are allocated or how much they cost. This situation leads to inequitable access to care for low-income people and people of color, many of whom are disproportionately saddled with medical debt compared to their higher-income and White counterparts.[1]

New York's health care environment has become more expensive and inequitable in the absence of a regulatory structure that can centrally collect, report, and regulate health care pricing and quality data. The long-delayed implementation of a functional All Payer Claims Database has led New York to fall behind many peer states and left policymakers and consumers without State-specific price and quality of care data.

Compounding the information void are a series of decades-old policy decisions to eliminate a comprehensive regulatory framework, such as dismantling the State's hospital all payer rate setting system and community-focused health planning agencies. This regulatory vacuum has failed to stem price increases, secure equitable resource allocation, or ensure high-quality care for New York's patients and employers.

This paper describes the drivers of New York's high-priced health system and outlines promising policy options that can help mitigate its health care affordability, equity, and access predicament. Comprehensive solutions that are not addressed here range from: passing the New York Health Act (a State-based single payer program); adopting global budgeting (like Maryland); restoring hospital rate-setting; and establishing a robust regional health planning infrastructure.

New York's health care landscape confounds policymakers and patients alike, and is characterized by:

- **High hospital and insurance prices.**
    - New York has the second-highest overall health care spending per person ($14,000) in the nation.[2] Hospital care is the single biggest contributor (39 percent) to this spending, rising twice as fast as wages and four times as fast as inflation in the past decade.[3]
    - New York has the second-highest health insurance premiums for family coverage in the nation, with an average annual insurance premium of $26,400.[4]
- **Consolidated hospitals that drive price increases and compromise patient access.**
    - New York's six largest private hospital systems control over 42 percent of inpatient beds and charge a median commercial price that is over four times the Medicare rate.[5]
    - Five out of eight regions in the State have highly consolidated hospital markets, with 53 general hospitals closing in the past 28 years, disproportionately impacting residents of color.[6]

- Consolidation leads to the proliferation of hospital outpatient departments where routine services can cost $1,000 more than the same service at a doctor's office.[7]

- **Quality of care that is incommensurate with New York's high prices.**
  - Despite their high prices, many New York hospitals struggle with quality issues, receiving just one or two stars on the five-star federal quality rating system.[8]
  - Seventy percent of emergency room visits in New York are non-emergent and could be better treated in a primary care setting, over double the national rate.[9]

Immediately, New York policymakers should consider the following range of policy options—many of which have been adopted by other states—to address the unaffordability, lack of access, and low-quality health care, including:

- **Systemic reforms.**
  - Replace New York's dysfunctional planning mechanism with an independent entity like California's Office of Health Care Affordability, which would simultaneously set a benchmark for the growth of health care costs, restrict consolidation, and uphold standards for quality and equity.[10]
  - Implement the long-delayed All Payer Claims Database, which would generate transparent data that could be used by policymakers and consumers alike.

- **Targeted price reforms.**
  - Enact the Fair Pricing Act (S705|A2140) to cap prices for some office-based procedures that are performed in hospital outpatient departments. The bill would generate $1.14 billion in savings for New Yorkers annually, $213 million of which would be saved by consumers through reduced out-of-pocket spending.[11]
  - Create a State Hospital Cost Review Board, like Delaware, to contain hospital spending by setting and enforcing benchmarks for hospital cost growth.[12]

- **Increasing primary care spending.**
  - Enact the Primary Care Investment Act (S1634|A1915A) to replace some expensive hospitalizations with primary care and simultaneously promote better quality and equity of care.

How we got here: The vaccum created by health care deregulation

The origins of New York's expensive, fragmented, and inequitable health care system arise from policymakers' decisions in the 1990s to move from a regulated system of health care pricing and planning to a market-driven financing and planning infrastructure. Historically, New York had a three-prong regulatory framework that supported controlling health care costs and health care planning.

Hospital rate setting. Between the 1960s and the mid-1990s, New York actively regulated payer reimbursement rates to providers.[13] At first, the State only regulated Medicaid and Blue Cross payments, but beginning in 1983, rate regulation was extended to commercial payers and Medicare through a federal Waiver to the Medicare program rules. Massachusetts, Maryland, New Jersey and Washington had similar systems at the time.[14] In New York, this "all payer rate setting system" was called the New York Prospective Hospital Reimbursement Methodology (NYPHRM) and had three goals: (1) control health care costs; (2) aid financially distressed hospitals; and (3) help uninsured individuals access care.[15] Multiple studies found that the program made headway in meeting all three goals, although its order of priorities shifted over time.[16] One evaluation found that under NYPHRM, hospital costs were 13 to 15 percent lower than they would have been otherwise.[17]

Nonetheless, in 1996, the State abolished NYPHRM with the stated goal of promoting competition.[18] The 1996 Health Care Reform Act (HCRA) replaced NYPHRM's all payer rate setting process with a market-driven "negotiated rate" system under which hospitals and insurance companies negotiated provider reimbursements directly. Public goods, such as graduate medical education and hospital charity care, would be funded through the HCRA tax surcharge and no longer through NYPHRM.[19]

Insurance rate de- and then re-regulation. A move to deregulate commercial health insurance premiums in New York occurred nearly simultaneously with the deregulation of hospital prices. Between 1984 and 1995, health insurance premium rates were subjected to a process known as "prior approval," under which the Superintendent of Insurance reviewed and then approved the following year's health insurance premium in advance of it being adopted. In 1996, the State adopted an unregulated system for premium rate review, known as "file and use," whereby carriers simply filed their rates and used them.[20] The file and use system lasted for 15 years until 2010, when "prior approval" was restored in New York State in response to what was seen by the Legislature as excessively high rate increases.[21] Senate Insurance Committee Chair Neil Breslin explained that re-regulation of health insurance premiums was necessary because their rates had increased by 81 percent while real wages had only increased by 11 percent.[22] The same year, prior approval was also adopted nationwide for many health plans under the Affordable Care Act.

Weakened health planning. Beginning in the mid-1990s, the State's mechanisms for health planning were also weakened. Since the late 1940s, New York State had an activist planning approach which surveyed the need for new hospitals. In 1970, the Department of Health's Public Health Council assumed this authority.[23] In 1974, Congress enacted the National Health Planning and Resource Development Act, which created a network of local Health Systems Agencies (HSAs)

responsible for: conducting regional health planning assessments every five years; making recommendations about the need for new institutional services; and distributing federal funds.[24]

From 1975 to 1995, the state's regional HSAs were guided by boards of directors mostly made up of health care consumers.[25] Beginning in 1995, the HSAs were replaced by a series of councils that allowed more members to be physicians or employees of hospitals and nursing homes.[26] In 2005, New York policymakers established the Berger Commission to make recommendations about closing hospital facilities in response to concerns that the State had too many hospital beds. By 2008, nine hospitals closed, eliminating 2,800 beds statewide.[27]

Eventually, in 2010, State policymakers consolidated state health planning into the Public Health and Health Planning Council (PHHPC), which was established to review changes in ownership and the creation of new health facilities in the state.[28] Today, PHHPC is mostly comprised of political appointees who are affiliated with hospitals and other health care industry representatives.[29]

In 2011, New York State enacted a law establishing the creation of an All Payer Claims Database (APCD) to publish a consolidated health care claims database across all payers (commercial, Medicaid, and Medicare) as well as clinical and quality data.[30] As of 2024, 28 states have APCDs, with varying levels of functionality and public access.[31] The APCD websites can be used to: (1) support consumer decision making and respond to surprise billing issues; (2) measure and improve quality of care; and (3) establish state cost benchmarks.[32]

In 2016, New York awarded Optum a $168 million contract to establish its APCD, but as of 2025, New York still does not have a public-facing APCD website that could guide consumers and state policymaking.[33]

The remainder of this paper describes the impact of the health care deregulation trifecta outlined above on health care prices, quality of care, and access to care in New York.

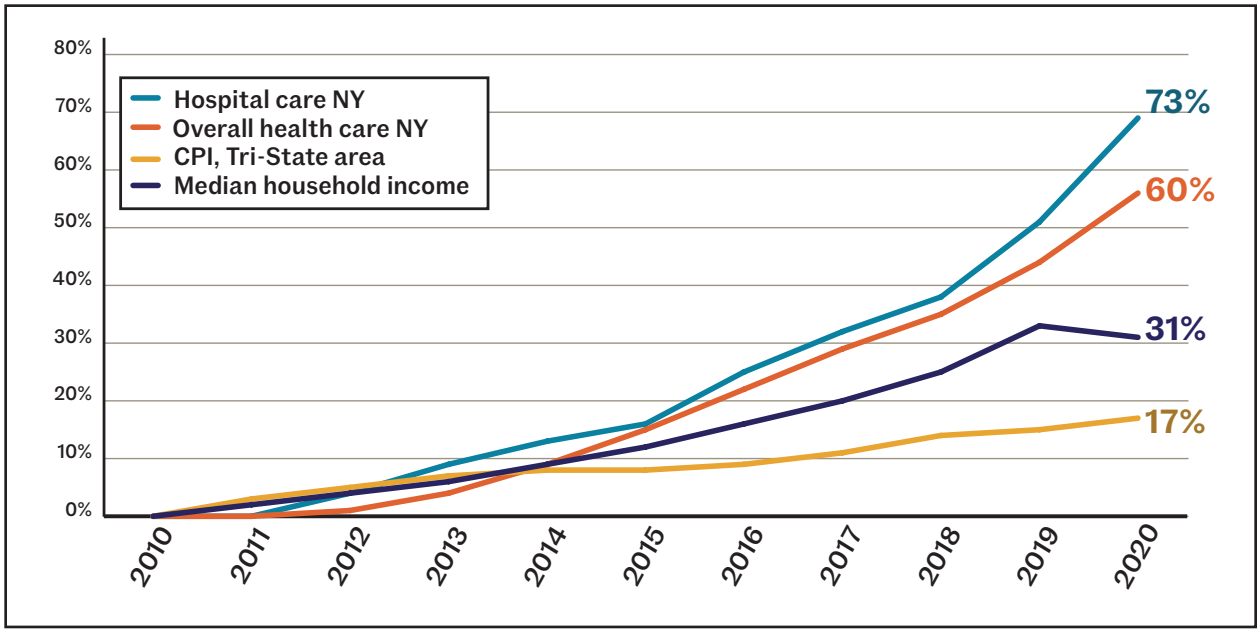
New York's health care costs are expensive and rising quickly

Since New York State eliminated its system for regulating hospital prices in 1996, overall health care spending per person has more than tripled.[34] By 2020, New York's per capita health care spending was $14,000, 37 percent higher than the national average, and the second-highest rate in the nation.[35] As described in the next section, employers and consumers have felt the effects: from 1996 to 2023, average family insurance premiums in New York more than quadrupled, as did family deductibles during a similar time period.

In the past decade, spending on New York hospital care increased by over 70 percent, driving a similarly high increase in overall health care spending of 60 percent.[36] *See* Figure 1. By comparison, the median New York household income rose by 31 percent. The Consumer Price Index, a measure of inflation experienced by consumers in their daily living expenses, rose by just 17 percent.

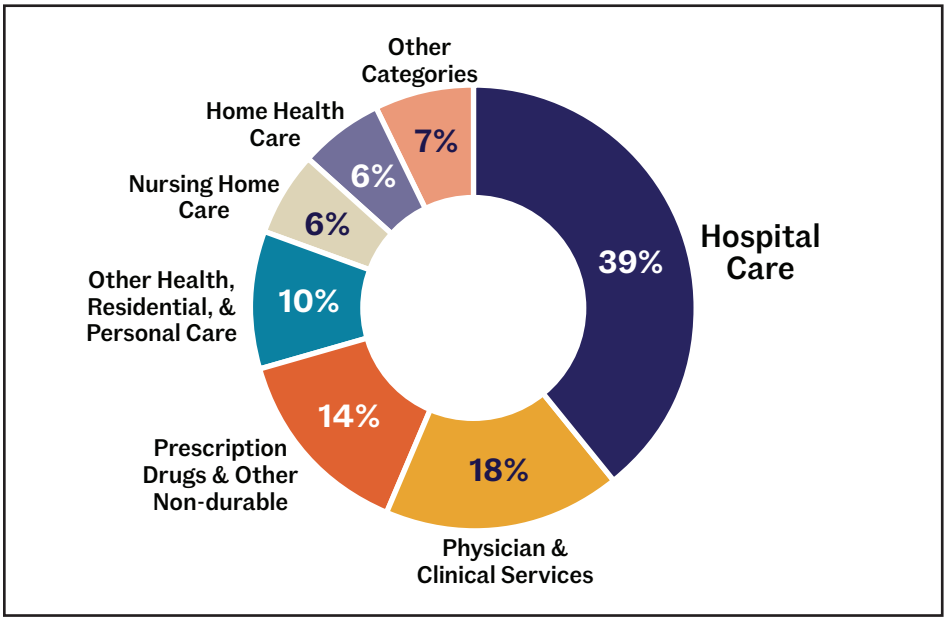
In 2020, hospital care was the single largest component (39 percent) of New York's health care spending.[37] New York's remaining health

Figure 1. Rise in health care expenditures outpaces income and inflation, 2010-2020



Source: CMS Health Expenditures by State of Residence (2022), Census Bureau ACS 5-Year Estimates (2011-2020), Bureau of Labor Statistics Consumer Price Index for NY-NJ-PA (2011-2020)

Figure 2. Distribution of health care spending, NY, 2020



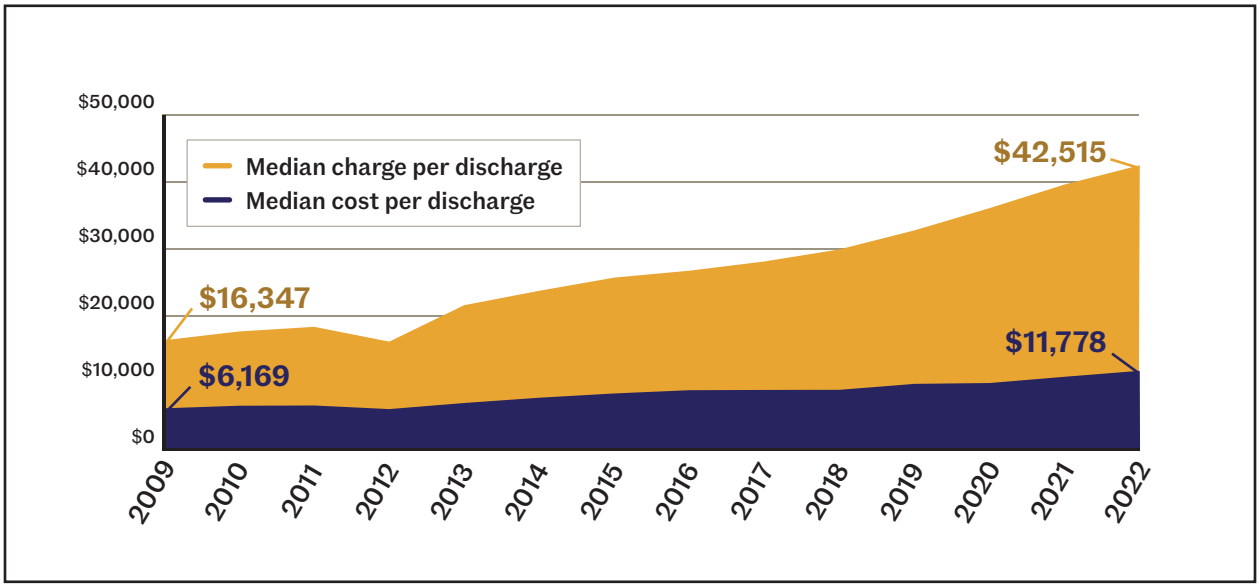
Source: CMS Health Expenditures by State of Residence (2022)

care spending is composed of: physician services (18 percent); prescription drugs and medical products (14 percent); residential care and personal care (10 percent); nursing home and home health care (6 percent each); and other categories.[38] *See* Figure 2.

Hospital prices appear to be a significant driver of the rapid increase in New York's health care spending. For example, in 2009, the median hospital charge for an appendectomy was $16,300.[39] *See* Figure 3. By 2022, the median charge for an appendectomy was over $42,500, a 160 percent increase over 13 years. While the payments received by hospitals can vary substantially among payers, charges serve as a basis for negotiating reimbursement rates.[40]

During the same period, hospital costs did not increase at the same pace as charges. The median amount hospitals spent on an inpatient appendectomy procedure in 2009 was $6,200, increasing by 91 percent to $11,800 in 2022. In other words, the amount hospitals charge has risen substantially faster than the reported cost of providing that same care (160 percent versus 90 percent, respectively).

Figure 3. Hospital-reported charges and costs for inpatient appendectomies, NY, 2009-2022



Source: NYS Department. of Health SPARCS Inpatient De-Identified Files (2009-2022)

High hospital prices adversely affect payers, employers, unions, and patients alike

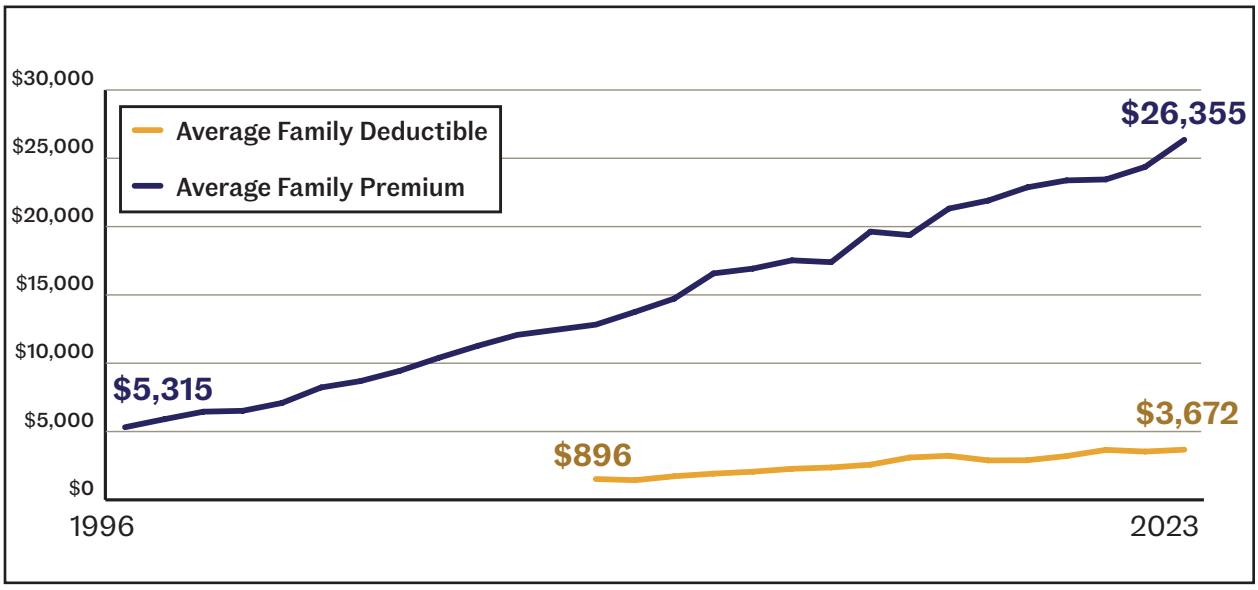
High hospital prices negotiated with insurers impact payers—including employers and unions—as well as consumers.[41] The large portion hospital care makes up of overall health care spending combined with rapidly rising hospital prices drive up insurance premiums. In 2023, the average family premium per employee in New York tied with Massachusetts to be the second most expensive in the nation at $26,400.[42] This rate is more than four times what it was in 1996 ($5,300) before New York moved to deregulate its all payer hospital rate setting mechanism. *See* Figure 4.

Regulatory efforts to temper insurance premiums through the restoration of prior approval, described above, have been unable to adequately stem these increases for two reasons: (1) prior approval is only used for a small portion of the State's insurance market (individual and small group); and (2) consolidated hospital systems are able to command high reimbursement rates from the carriers. Thus, insurance regulation alone cannot redress New York's health care affordability problem.

The burden of high premiums falls especially hard on workers at small businesses. In 2023, employees at New York firms with fewer than 50 people spent an average of $9,800 annually on family premiums, compared to $6,900 for employees of large businesses.[43] Across the State, employees of small businesses also foot a larger average portion of premium costs compared to workers at bigger firms (39 percent versus 26 percent, respectively).

In addition, high prices burden New Yorkers who buy insurance on the individual market. In 2017 and 2018, the New York State Department of Financial Services (DFS) approved average rate increases of 14 and 17

Figure 4. Increase in average family premiums and deductibles, NY, 1996-2023



Source: AHRQ Medical Expenditure Panel Survey-Insurance Component (1996-2023)

percent, respectively.[44] This pattern of double-digit rate increases briefly ceased during the pandemic, when health care utilization was significantly depressed. However, during the 2024 and 2025 plan years, DFS approved average annual rate increases of 14 and 13 percent, respectively, for individual market health insurance premiums.[45] In the past two years, rate increases well outpaced the average annual rate of inflation for all goods and services (4 percent for both 2023 and 2024) as well as for medical care (-1 percent for both 2023 and 2024) in the Tri-State area.[46]

Employers and unions often try to mitigate this impact of increasing premiums by raising the amount of cost-sharing for patients, often in the form of higher deductibles.[47] New Yorkers have been affected by rapidly increasing deductibles, or the amount the consumer pays before they can use their insurance to pay for care. For example, in 2000, the average deductible in New York was just $900. By 2023, deductibles had increased fourfold to $3,700.[48] *See* Figure 4.

Elevated hospital prices—resulting in substantial increases in insurance premiums, deductibles, and cost-sharing—also lead to a higher medical debt burden.[49] This burden is especially heavy for New Yorkers who are lower-income and/or people of color. A 2023 Urban Institute study found that nationwide, 73 percent of people with medical debt owe at least some of it to hospitals.[50] The same year, a report from Urban Institute found that around 740,000 New Yorkers, or six percent of the adult population, have medical debt.[51] Close to half of New Yorkers with medical debt owe $500 or more, and a third owe at least $1,000. Communities of color, as well as rural upstate regions, are disproportionately burdened. For example, in zip codes where more than half of residents are people of color in Central New York, over a quarter of residents hold medical debt.[52]

The issue of medical debt appears to have worsened over the past decade. New York's health insurance consumer assistance program, Community Health Advocates, documented a 68 percent increase in individuals seeking assistance with medical debt cases between 2018 and 2020.[53] In 2019, nonprofit and State-run hospitals sued 13,886 New Yorkers for unpaid medical bills.[54] These hospital lawsuits often used harmful tactics against patients, including: filing liens against their primary residences; garnishing their wages; and making adverse credit reports.[55] To help abate the harmful toll of medical debt on New Yorkers, State policymakers recently passed a series of medical debt protection laws.[56] However, one of the main causes of medical debt – the price of care—remains unaddressed.

"Elevated hospital prices—resulting in substantial increases in insurance premiums, deductibles, and cost-sharing—also lead to a higher medical debt burden."

The relationship between deregulation, health care consolidation, and rising prices

As described above, two decades ago New York replaced its community-based Health System Agencies' planning processes with what would eventually be known as the Public Health and Health Planning Council (PHHPC). Although New York's PHHPC is charged with regulating hospital mergers, it has not stemmed a significant wave of health care consolidation. From 2011 to the end of 2023, 103 transactions occurred in New York that either involved establishing a new health system or expanding an existing one.[57] By 2022, the six biggest private health systems—Northwell Health, New York-Presbyterian, Mount Sinai, Montefiore Einstein, Catholic Health Long Island, and NYU Langone Health—controlled 42 percent of all inpatient beds in the State.[58]

Figure 5. Level of hospital market concentration in New York's insurance rating regions, 2022

HIGHLY CONCENTRATED (HHI>1800)	NOT HIGHLY CONCENTRATED (HHI ≤1800)
Finger Lakes	Central and Southern Tier
Long Island	North Country and Mohawk Valley
Mid-Hudson	NYC Metro
Capital Region	
Western New York	

Source: DOJ & FTC Merger Guidelines (2023), NASHP Hospital Cost Tool Dataset (2022)

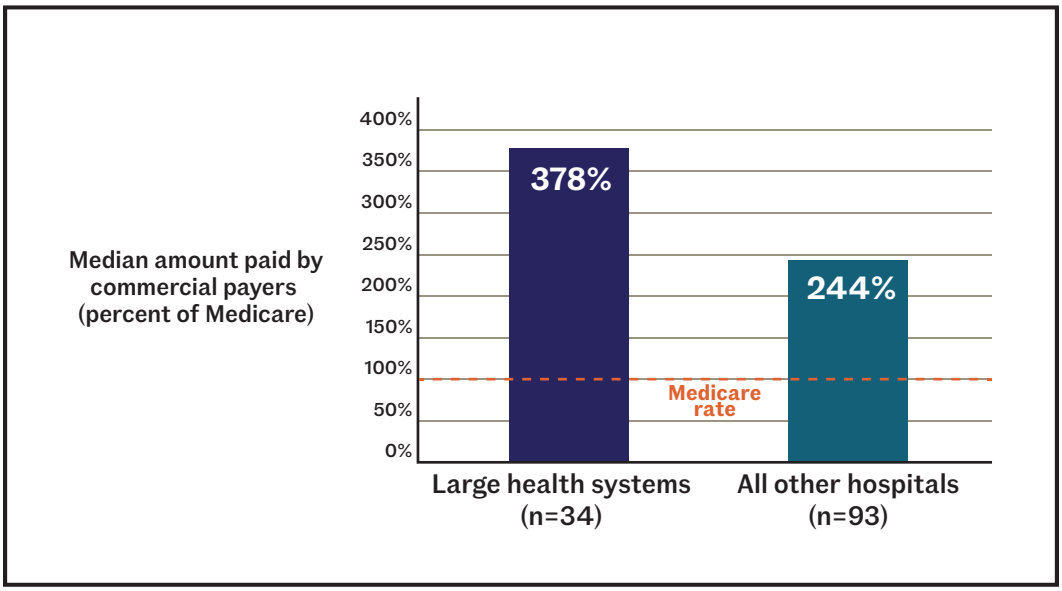
Consolidation has resulted in five out of New York's eight regions meeting the Federal Trade Commission (FTC) threshold for a "highly concentrated" hospital market.[59] *See* Figure 5. The FTC uses the Herfindahl-Hirschman Index (HHI) to measure market concentration. Only three regions are not highly concentrated based on HHI. Two regions – Central and Southern Tier and North Country and Mohawk Valley – are mostly rural. The third region (metropolitan New York City) is still affected by consolidation: half of private hospitals in the City belong to the State's largest private health systems.[60]

Health system consolidation leads to higher prices

Hospital consolidations have led to significant increases in overall health care spending according to many studies around the country.[61] Moreover, studies in New York and other markets have shown that consolidation—and the high prices associated with it—are not linked with better quality of care.[62] The U.S. Department of Health and Human Services states that consolidation in the hospital industry has increased dramatically over the past 30 years: In 1990, 65 percent of metropolitan areas were considered highly concentrated, by 2021, that figure rose to 98 percent.[63]

Hospital mergers and acquisitions concentrate hospitals' market power, enabling them to command higher reimbursement rates from payers. This phenomenon has occurred in New York where the six largest private hospital systems charge much higher prices than the rest of the hospitals in the State. A comparison of these systems' commercial prices with their Medicare rates reveal that they were paid a median commercial price

Figure 6. Median Amount paid by commercial payers for six largest private health systems, NY, 2022



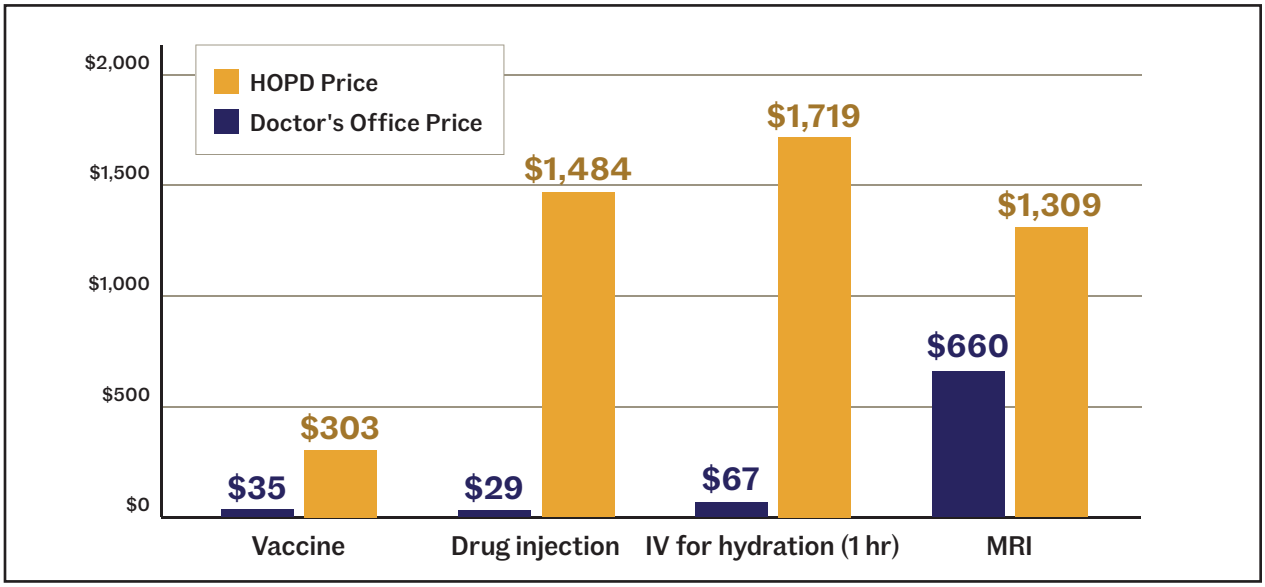
Source: RAND Health Care Hospital Price Transparency Study Round 5

close to four times the rate for Medicare in 2022, well over what is received by the State's other hospitals.[64] *See* Figure 6. Medicare rates are designed to allow hospitals to make a modest profit, accounting for local cost of living, inflation, and severity of illness.

Higher prices have helped the State's largest private health systems flourish while smaller hospitals struggle. In 2022, 14 out of the 36 hospitals in New York's six biggest health systems had an operating profit margin of over 10 percent.[65] Over half had at least a 6 percent operating profit margin, well above the 3 percent Fitch Ratings considers healthy for nonprofit hospitals to meet their obligations.[66] These returns are especially strong considering the financial pressure placed on hospitals during the COVID-19 pandemic, as well as the high levels of spending required to retain health care workers post-pandemic.[67]

Hospital-driven price inflation impacts the cost of routine services, which are increasingly shifting from doctors' offices to hospital-owned outpatient departments (HOPDs). In the last two decades, health systems' acquisitions of physician practices have accelerated along with hospital merger activities.[68] HOPDs often charge much more despite providing similar quality of care. For example, Medicare pays four times more for many procedures provided in an HOPD versus a physician's office.[69] The Congressional Budget Office estimates that Medicare will pay an excess of $39 million more for certain drug administration services in 2025 as a result of the move to HOPDs.[70] Another analysis found that adopting payment policies to cap these fees (known as site-neutral policies) for Medicare would yield savings of up to $471 billion over the next 10 years.[71]

Figure 7. Average aggregate price of outpatient services at hospital outpatient departments vs. independent doctor's offices, NY, 2022



Source: 32BJ Health Fund analysis of claims data

In New York, an analysis of claims data conducted by 32BJ Health Fund shows that the same procedure can cost over $1,000 more at an HOPD compared to a doctor's office.[72] *See* Figure 7. Patients who receive care at an HOPD instead of in a physician's office are often met with higher medical bills in the form of copays, deductibles, and coinsurance.

Newly released data from the New York State Health Insurance Program (NYSHIP), the State employee plan, confirms the substantial price differentials across hospitals in the State for outpatient procedures provided in HOPDs. For example, NYSHIP covered almost 37,000 visits for outpatient hospital screening mammography in the 2023 plan year. The allowed amount (payment) for this service ranged from $129 at Vassar Brothers Medical Center to $1,383 at New York Presbyterian Hudson Valley Hospital—a difference of more than $1,000.[73]

Finally, emerging research has found that hospital consolidations result in higher health insurance premiums, which leads employers to lay off employees because they cannot afford to pay for health coverage. This research estimates the average hospital merger that raises health care prices by at least 5 percent leads to the loss of 203 jobs and $32 million in lost wages.[74]

> ***"Hospital-driven price inflation impacts the cost of routine services, which are increasingly shifting from doctors' offices to hospital outpatient departments. In the last two decades, health systems' acquisitions of physician practices have accelerated along with hospital merger activities."***

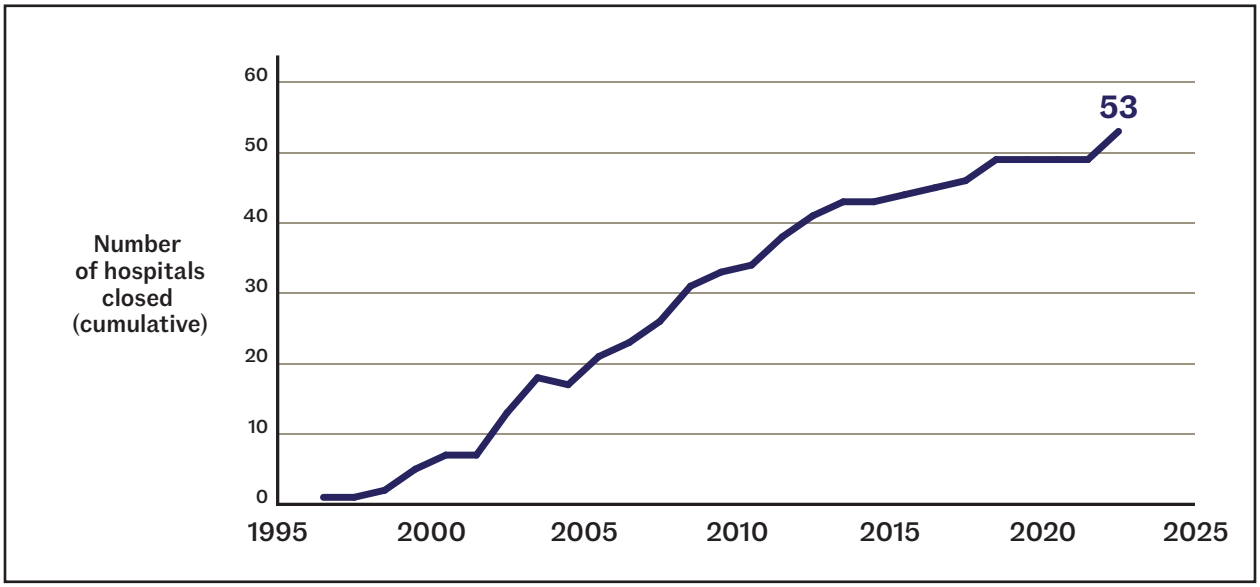
The deregulatory vaccum enabled hospital closures that deepened health inequities

Deregulation has also hastened the pace of hospital closures over the last two decades. As the State's large health systems have grown larger, small hospitals have struggled to survive. From 1997 through 2024, 53 short-term acute care hospitals out of over 200 in New York closed, removing around 8,000 beds from the State's health care system (roughly 16 percent).[75] *See* Figure 8. During a similar time frame, over 9,600 beds were lost due to closures and consolidations (altogether 18 percent of the State's total beds). *See* Appendix B, Table 2. Out of the 53 closures, 49 hospitals had fewer than 400 beds.[76]According to one news account, State data indicates that there has been a total loss of 20,000 beds between 2000 and 2020, including the downsizing and closures of specialized hospitals.[77]

These closures have not been equitably distributed across the State's population. Since 1997, one or more hospitals have closed in 26 out of 62 New York counties.[78] The median share of residents of color in the closure counties is 21 percent compared to just 12 percent in the non-closure counties.[79] *See* Figures 9 & 10. Income and insurance status do not explain these differentials. For example, the percentage of individuals without insurance was higher in the closure counties than the non-closure counties (5 percent versus 4 percent).[80] Similarly, the counties with closures had higher incomes than those without ($72,200 versus $69,100).[81] *See* Figure 9.

The unequal distribution of hospital closures statewide has contributed to disparities in access to care. Since 1997, New York City alone has seen 20 hospital closures, many of them in counties where more than half of residents are people of color. [82] *See* Figure 10. The onset of the COVID-19 pandemic illustrated the disparate impact these closures had on low-income residents and communities of color.

Figure 8. Cumulative number of hospital closures, NY, 1997-2023



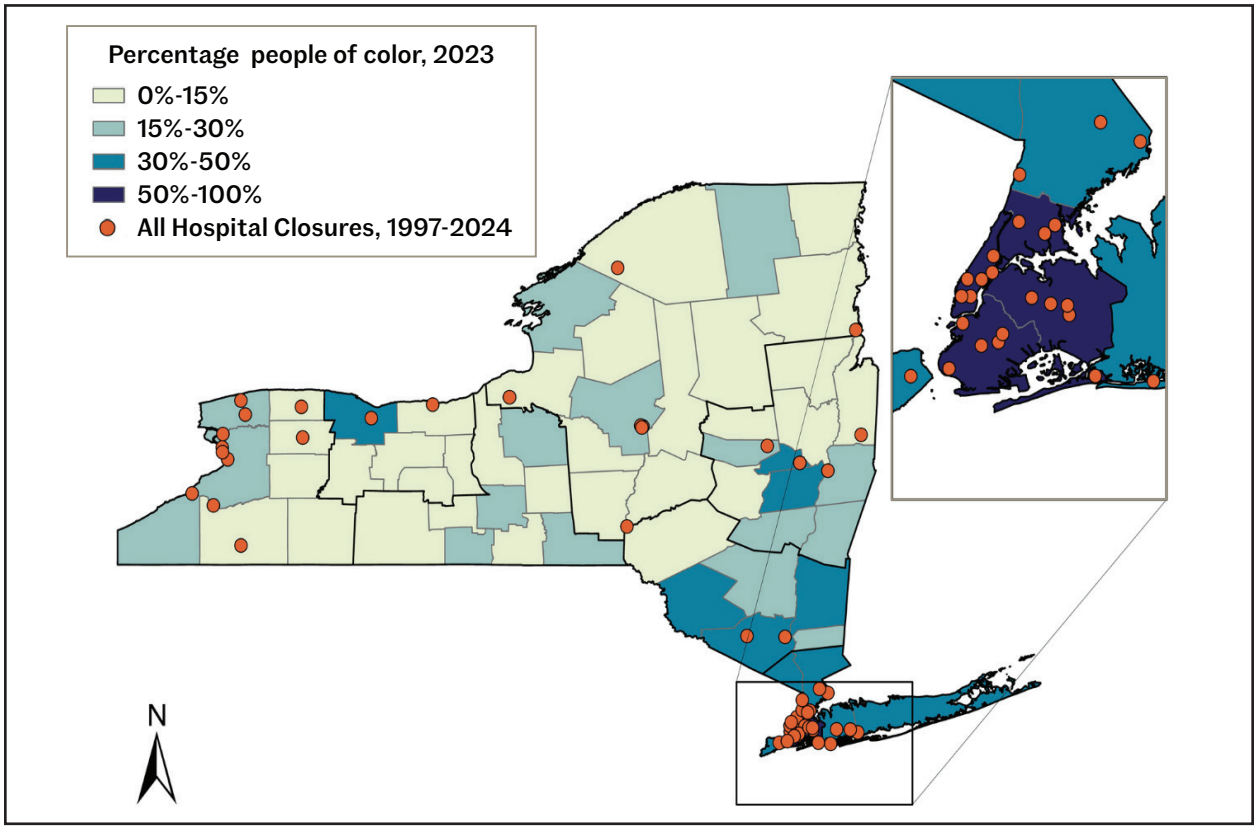
Sources: CMS and American Hospital Association data (2000); NYS Department of Health NYS Health Care Reform Act and Health Profiles data (2024)

Figure 9. Resident characteristics in counties with no hospital closures versus counties with at least one hospital closure, NY, 1997-2024

	Counties with no hospital closure	Counties with at least one hospital closure
Median share of people of color	12%	21%
Median household income	$69,100	$72,200
Median share of uninsured residents	4%	5%
Median share of rural population	59%	32%

Source: Census Bureau ACS 5-Year Estimates (2023)

Figure 10. Hospital closures, NY, 1997-2024



Sources: U.S. Census Bureau ACS 5-Year Estimates, 2023; CMS and American Hospital Association data (2000); NYS Department of Health NYS Health Care Reform Act and Health Profiles data (2024)

Early in the pandemic, Queens had almost twice the rate of COVID-19 cases as Manhattan (22 versus 12 cases per 1,000 residents).[83] However, in the wake of the closure of five hospitals in Queens between 2004 and 2012, the borough had only a quarter as many hospital beds as Manhattan (1.5 versus 6.4 beds per 1,000 residents).

Access to care in other regions of the State has also declined over time. For example, 11 hospitals in Western New York have closed since 1997.[84] Western New York covers over 10 times the geographical area of New York City and is served by fewer hospitals (19 total).[85] Similarly, the Finger Lakes region had only 11 hospitals but witnessed two hospital closures over the last two and a half decades. In addition, closures in rural areas create transportation challenges for low-income and older people.[86]

Closures are conducted without the benefit of the State's Health Equity Impact Assessment law and do not require public notice. Hospitals seeking to acquire other hospitals or consolidate with other providers often evade the Health Equity Impact Assessment law by initially claiming there will be no loss of services, as demonstrated by Northwell's recent acquisition of three Hudson Valley hospitals.[87] Recently, Governor Hochul vetoed the Local Input in Community Healthcare Act, which would have required notification and engagement of community members as well as a Health Equity Impact Assessment in advance of a closure. Existing law merely requires notice to the public after a closure already has occurred.[88]

In the case of consolidations, the Department of Health and PHHPC members appear to concur with the acquiring hospitals' statements that mergers are necessary to rescue financially distressed small hospitals that might otherwise close and would improve the quality of care.[89] But advocates contend that small hospitals are sometimes converted to provide different types of care or even shut down entirely post-merger. Further, a body of research indicates hospital mergers do not lead to improved quality of care and instead appear to be associated with lower patient satisfaction.[90]

An additional concern is that the acquisition of a smaller hospital by a large system may infuse the newly acquired institution with undesirable practices. For example, all of New York's six largest private health systems score below average on inclusivity, or how well patients represent a hospital's surrounding community in terms of race, education, and income.[91] On both racial and income inclusivity, the hospitals in the largest systems averaged 2.6 out of 5 stars compared to 2.9 stars for all hospitals in the State. On educational inclusivity, large health systems averaged only 2.3 stars compared to 2.8 stars statewide.

"New York's hospitals rate poorly on multiple aspects of care measured by CMS, including: mortality; safety of care; readmissions; timely and effective care; and patient experience."

High hospital prices have not secured high quality care

New York hospitals lag behind the rest of the United States in terms of quality despite their high prices. In July 2024, the Centers for Medicare and Medicaid Services (CMS) rated New York hospitals an average of 2.4 out of 5 stars for overall quality of care, lower than the average of 3.1 stars for hospitals nationwide.[92]

Nearly 60 percent (72 hospitals) received just 1- or 2-star ratings, and only 19 percent (24 hospitals) of New York hospitals received 4- or 5-star quality ratings. *See* Figure 11. Nationwide, 40 percent of hospitals have a 4- or 5-star rating, indicating that New York hospitals struggle to provide high-quality care. New York hospitals also perform poorly according to other rating systems.[93] *See* Appendix C for a complete list of hospitals and their ratings.

New York's hospitals rate poorly on multiple aspects of care measured by CMS, including: mortality; safety of care; readmissions; timely and effective care; and patient experience. For each of these measures, many New York hospitals are rated among the bottom third of hospitals nationwide.[94] *See* Appendix C.

For patient experience, New York hospitals averaged 2.6 out of 5 stars compared to 3.3 stars nationwide.[95] For timely and effective care, 40 percent of hospitals performed poorly.[96] For safety of care, which measures complications and surgery-related infections, 38 percent of hospitals performed poorly. And 20 percent of New York hospitals had higher mortality rates than most hospitals nationwide, based on deaths for conditions such as heart attacks and strokes.

For readmissions in particular—including measures such as excess days in acute care and rate of readmissions after a discharge—over half of the hospitals in New York scored in the bottom third nationwide. Out of 108 New York hospitals with risk-adjusted data on readmissions, 57 hospitals (including 14 in large health systems) had among the highest readmissions nationwide.[97]

Department of Health data indicates that preventable hospitalizations disproportionately impact New Yorkers of color.[98] From 2019 to 2021, Black New Yorkers had over two times the number of preventable hospitalizations per 10,000 residents compared to White New Yorkers (189 versus 82). Latino New Yorkers also had significantly more preventable hospitalizations than their White counterparts (114 versus 82).

Substantial financial investments—without repercussions for failure—in New York's hospitals have not yielded appreciable improvements in readmissions. In 2014, CMS approved $6.4 billion for New York's Delivery System Reform Incentive Payment (DSRIP) program with the goal of reducing avoidable Medicaid hospitalizations for both emergency and inpatient care by 25 percent over five years.[99] But this investment missed its mark. By 2020, preventable readmissions dropped 18 percent and avoidable emergency department visits decreased by just 4 percent.[100]

Figure 11. CMS quality ratings for hospitals, NY, 2024

Overall quality rating	*1 star*	*2 stars*	*3 stars*	*4 stars*	*5 stars*
Number of hospitals	32	40	30	14	10

Source: CMS hospital datasets (2024)

New York lags behind other states in policies to address costs, equity, and quality

As described above, New York's current regulatory environment is ill-equipped to control health care costs, improve access to care, or meet national quality benchmarks. Other states, and some pending legislation in New York, offer the following three types of promising solutions, described in turn: (1) system-wide approaches; (2) targeted price controls; and (3) primary care investment-based solutions. *See* Figures 12-14.

System-wide approaches tackle multiple issues at once

Figure 12. State models for system-wide approaches

Policy Goal	New York Initiative(s)	Other State-based Initiatives
All Payer Claims Databases make health care cost and pricing data transparent, enabling policymakers and consumers to take informed decisions	New York's All Payer Claims Database is still not available and only 8 percent of hospitals are fully compliant with federal transparency requirements.	**Colorado's all payer claims database,** established in 2012, regularly publishes data and maintains a user-friendly tool to compare prices for different services.[101] In addition, over 60 percent of the state's hospitals fully complied with federal transparency requirements.[102]
Restricting hospital mergers and acquisitions	New York's industry-dominated Public Health and Health Planning Council readily approves mergers and lacks oversight over closures and most downsizing.	**California** has an independent **Office of Health Care Affordability (OHCA)** that assesses and coordinates with other state agencies to address market consolidation and improve consumer affordability.[103] The **Oregon Health Authority's (OHA) Health Care Market Oversight (HCMO)** program reviews proposed mergers, acquisitions, and other health care business deals to ensure they support health equity, lower costs, increased access, and better care. It has the authority to recommend rejecting large-scale merger proposals.[104]
Health care cost growth benchmarks	New York recently received CMS approval to participate in the AHEAD program, which requires that states set an all payer cost growth target. New York has no other cost growth benchmarks.	**California's OHCA** has set a 3.5 percent annual statewide health care spending growth target for 2025, with the goal of reaching 3 percent by 2029.[105] The **Massachusetts Health Policy Commission** oversees and can modify the established cost growth benchmark of 3.6 percent, subject to legislative review.[106]

Many states are moving forward with system-wide approaches to establish comprehensive approaches to collecting data, regulating consolidation and controlling prices. *See* Figure 12.

All Payer Claims Database (APCD). New York legislators, researchers, and consumers lack essential information about health care costs and prices that could help them redress affordability, access, and quality concerns. In 2011, New York was a leader in enacting APCD legislation. Fourteen years and $159 million later, New York has no APCD, lagging behind dozens of its peer states.[107] Across the country, 28 states have established APCDs with varying levels of success and transparency.[108] While many states allow researchers to request data extracts and custom reports, a process that can take months, only 11 states (CO, FL, GA, IN, ME, MD, MA, MN, NH, RI, and VT) have public-facing portals that provide a one-stop shop for consumers to look up hospital prices by procedure. Eight states (CA, CT, DE, MA, OR, RI, VT, and WA) use data from their APCD to inform health care cost growth benchmarking efforts.[109]

A robust APCD could also help consumers ascertain hospital prices.[110] Many New York hospitals do not comply with federal price transparency rules. A recent Patient Rights Advocate report found that most New York hospitals (88 out of 96 reviewed) do not fully comply with a federal requirement to publish prices for common services by payer and health plan.[111] By contrast, Colorado's APCD publishes data for policymakers and consumers alike. This transparency may help explain why 60 percent of Colorado hospitals comply with the federal transparency rules, compared to just 8 percent in New York.[112]

Regulating hospital consolidation. As described above, New York's current regulatory infrastructure (the Department of Health and PHHPC) have failed to slow the pace of hospital mergers and consolidation. The PHHPC lacks sufficient independence from the hospital industry: it is chaired by a senior official at the State's largest private health system and most members work in the health care industry.[113] The likelihood that mergers and acquisitions will result in higher prices is not a factor that is considered in the existing approval process. Moreover, there is no independent or public process to review hospital closures or veiled forms of consolidation, such as management services contracts in which a hospital pays a health system or larger hospital to oversee its operations. These transactions are routinely approved by DOH staff in a non-public process.[114]

Other states are leading the way with independent system-level approaches that control costs while safeguarding access and quality of care. In 2022, California established an Office of Health Care Affordability (OHCA) in the Health Care Quality and Affordability Act which has three main functions: (1) regulate health system consolidation (mergers and acquisitions); (2) set health care cost growth limits; and (3) promote high-value care by establishing quality and equity benchmarks.[115] To achieve these goals, OHCA publishes data on health care spending and collaborates

with the staff in charge of California's functional APCD. In contrast to New York, OHCA's Health Care Affordability Board members are independent and cannot receive compensation from health care organizations.

Similarly, the Oregon Health Authority's (OHA) Health Care Merger Oversight program has a review process for mergers that considers potential impacts on health care prices, quality, equity, and access.[116] The OHA also can recommend rejecting large-scale mergers, setting it apart from other states. In 2017, Oregon enacted a law that limits how much insurers can pay hospitals on behalf of its State employee health plans, which cover over 290,000 people. The State sets in-network and out-of-network limits at 200 and 185 percent of Medicare, respectively. In an audit of 2021 claims data, the state's average reimbursement decreased from 215 percent of Medicare to 163 percent of Medicare following the implementation of reference-based pricing, leading to $112.7 million in savings.[117]

Health care cost growth benchmarks. At least nine states, including California and Massachusetts, have entities that set and enforce health care cost growth benchmarks.[118] California's OHCA has set a 3.5 percent cost growth benchmark for 2025. Massachusetts' Health Policy Commission has likewise established a 3.6 percent cost growth benchmark. Importantly, New York recently joined CMS's Advancing All Payer Health Equity Approaches and Development (AHEAD) program. The AHEAD states must set specific targets for Medicare and all payer cost growth as well as investment in primary care.[119] However, primary care advocates are concerned that New York will set an ineffectually low primary care spending benchmark, discussed below.[120]

Targeted reforms help control prices at hospitals and outpatient departments

Figure 13. State models targeting pricing reforms

Policy Goal	New York Initiative(s)	Other State-based Initiatives
Making pricing consistent at hospital outpatient departments	In 2023, New York banned facility fees for preventive services only. The recently introduced Fair Pricing Act would set a price cap on hospital outpatient departments.	**Maine** prohibits facility fees for a broader range of care provided in hospital outpatient departments.[121] **Connecticut** does not allow facility fees for many common outpatient services related to diagnosing and treating illnesses unless they are provided in an emergency department.[122]
Hospital cost growth benchmarks	New York does not regulate hospital cost growth.	The **Diamond State Hospital Cost Review Board in Delaware** is tasked with reviewing and regulating hospital budgets to support the State in its health care cost growth benchmark.[123] The **Office of the Health Insurance Commissioner** in **Rhode Island** limits the amount that hospital prices can increase to no more than inflation plus one percent, enforced through prior approval.[124]

States are also moving forward with an array of targeted interventions that seek to control costs at specific sites of care in lieu of or in addition to system-wide reforms. *See* Figure 13.

Site-neutral payment reform. Over the past few decades many procedures have shifted from an inpatient setting to an outpatient setting in hospital outpatient departments (HOPDs) and doctors' offices. However, the reimbursement payments for the same procedure provided in an HOPD is typically much higher than when it is provided in a doctor's office. Efforts to curb these higher HOPD charges are known as "site-neutral" payment reform.

New York policymakers have introduced a site-neutral bill called the Fair Pricing Act (FPA) (S705|A2140). The FPA would establish price caps for a set of routine services. Brown University researchers estimate that the Fair Pricing Act would save New Yorkers $1.14 billion annually ($213 million of which would be saved by consumers through reduced out-of-pocket spending) by eliminating this form of overpayment for routine services.[125]

Currently, New York State only has limited protections against excessive fees, known as "facility fees." In 2022, New York passed legislation banning facility fees for preventive care and requiring hospitals to notify patients about facility fees not covered by insurance before they are charged.[126] Other states (Connecticut and Maine) ban facility fees for a wider range of services, including diagnoses and treatments, at HOPDs.[127] Colorado and Washington annually report facility fees and require providers to notify patients in advance of their imposition.[128]

Benchmarks for hospital costs. Unlike other states, New York has no regulatory authority to control hospital costs. For example, Delaware's Diamond State Hospital Cost Review Board is tasked with reviewing and regulating hospital budgets. Hospitals submit financial information to the Board which determines whether the State's hospital budget benchmark is being met. Hospitals that exceed the benchmark must develop a Performance Improvement Plan that identifies causes of spending growth and strategies to address them. The Board can reduce the hospital's budget for the following year when a hospital fails to improve. The Board supports the State's broader health care cost growth benchmark, which applies to sites of care beyond hospitals. Other states, including Indiana and Oregon, have also taken action to require hospitals to submit details about their finances with penalties for hospitals that do not comply.[129]

In Rhode Island, the Office of the Health Insurance Commissioner controls hospital costs through its prior approval process as part of a set of affordability standards for all commercial insurers in the State. The Commissioner enforces annual price inflation caps equal to the Medicare price index plus 1 percent for inpatient and outpatient services.[130] A study of Rhode Island affordability standards found that total spending growth decreased, driven by lower prices consistent with the adoption of price controls.[131]

Investing in primary care to improve quality, access, and equity

Figure 14. State models for investing in primary care

Policy Goal	New York Initiative(s)	Other State-based Initiatives
Primary Care Spending Benchmarks	The Primary Care Investment Act would require insurers to gradually increase spending on primary care to at least 12.5 percent.	**Rhode Island** requires insurers to dedicate at least 10.7 percent of their annual medical spending to primary care, which is enforced through prior approval.[132] **Delaware** law uses a similar enforcement mechanism with a stairstep approach, requiring health plans to reach 11.5 percent in 2025.[133] **Oregon** requires insurers to spend at least 12 percent of their annual medical expenditures on primary care. If this target is not reached, insurers must submit a plan for increasing spending on primary care.[134]

Many states are establishing firm benchmarks and study commissions to increase primary care spending. *See* Figure 14.

Primary care investments and benchmarks. As described above in the discussion of DSRIP, New York has a poor track record of investing in hospitals to control costs and improve patient outcomes. By contrast, there is strong evidence that investing in low-cost primary care reduces high-cost hospitalizations. Without adequate primary care, minor health problems can lead to an increase in: chronic and acute disease; emergency department visits; and overall health care spending.[135] Investing in primary care has been shown to reduce overall health care costs and is the only part of the health system proven to lengthen lives and reduce inequities at the population level.[136]

Nationally, primary care accounts for approximately 35 percent of all health care visits each year, yet only about 5 to 7 percent of all health care expenditures are for primary care.[137] New York-specific data is not available in the absence of a State APCD. However, research indicates that an increase of one primary care physician per 10,000 people can generate 11 percent fewer hospital visits.[138] In addition, 70 percent of emergency department visits in New York have non-emergency medical issues or could be treated by a primary care provider, a percentage that has remained stable over time and is over double the national rate.[139]

At least 17 states have taken action to explore, measure, or increase investment in primary care.[140] Several states, including Connecticut, Delaware, Hawaii, Oklahoma, Oregon, and Rhode Island, have specifically required increased

primary care investment. *See* Figure 14. Rhode Island and Delaware enforce primary care investment benchmarks through prior approval.[141] Following the implementation of these benchmarks, Oregon and Rhode Island both successfully increased the number of per capita primary care providers, suggesting that investment in primary care also reduces strain on the workforce.[142]

New York's Primary Care Investment Act (S1634|A1915A) would require measuring and reporting the percentage of insurance carriers' overall health care spending on primary care.[143] Insurers that dedicate less than 12.5 percent of their spending to primary care would be mandated to increase this share by 1 percent each year until they reach a target of at least 12 percent.

"Health care costs are a major driver of New York's affordability crisis. By adopting one or more of the policy options described above, policymakers have the opportunity to make a meaningful difference in their constituents' lives to secure a more affordable and equitable New York."

Conclusion: How policymakers can better control health care costs, promote quality, and improve access and equity

The roots of New York's health care affordability crisis lie in a series of measures taken in the 1990s to de-regulate hospital and insurance price setting as well as health planning systems. As a result, New York has record high prices, a cascade of inequitable hospital closures, and poor health outcomes. Patients suffer from inequitable access to care and medical debt burdens. Truly comprehensive interventions include restoring hospital rate setting, regional health planning, global budgeting, and/or passing the New York Health Act to implement a single-payer health care system.

Short of these broader reforms, there are several policy solutions that have been adopted by other states that policymakers can take now to address New York's health care affordability crisis.

First, adopt system-wide reforms. The State should replace PHHPC with an independent entity like California's Office of Health Care Affordability (OHCA) to: assess market consolidation; set limits on health care spending growth; and promote high-value care. An independent New York Office of Health Care Affordability could help address consolidation and inequitable hospitals closures, slow health care spending growth, and address long-term structural issues that have reduced access to care, especially for New Yorkers who are low-income or people of color.

A functional, public-facing APCD is essential to achieving this goal. New York should follow the lead of at least eight states that have APCDs that inform health care cost growth benchmarks and the 11 states that permit consumer price comparisons.[144]

Second, impose targeted pricing reforms. Absent establishing a system-wide entity to redress New York's health care affordability crisis, the State could adopt price caps on hospital outpatient departments by enacting the Fair Pricing Act (S705|A2140). This law would ensure that the same price is charged for the same routine service across different sites of care, saving New Yorkers $1.14 billion ($213 million for consumers) annually.

The State should explore a hospital-specific cost review entity such as the Diamond State Hospital Cost Review Board in Delaware, which sets limits on cost growth specifically for hospitals.

Finally, establish a primary care spending target. The Primary Care Investment Act (S1634|A1915A) would improve patient outcomes and reduce preventable hospital care. In doing so, it could also help address health inequities such as disproportionately high rates of preventable hospitalizations for New Yorkers of color and low-income New Yorkers.

Health care costs are a major driver of New York's affordability crisis. By adopting one or more of the policy options described above, policymakers have the opportunity to make a meaningful difference in their constituents' lives to secure a more affordable and equitable New York.

Appendix A: Notes on methodology

For most comparisons over time that appear in this report, no adjustment has been made for inflation (e.g., average family premiums in 1997 versus 2023). In some cases, change in the general and/or medical consumer price index (CPI) is presented over a similar time period for reference. The annual rate of change in CPI is calculated based on the average of CPI across all months for each year.

Analyses of New York's hospitals and health systems usually are based on 2022 Medicare Cost Reports filed by hospitals. CSS accessed Medicare Cost Report data compiled by the National Academy of State Health Policymakers (NASHP) as well as the RAND Corporation. Health systems with multiple facilities often file a single Medicare Cost Report (e.g., NYU Langone Hospitals). CSS used the 2022 NASHP data, which contains health system identifiers from the AHRQ 2021 Compendium of U.S. Health Systems, to analyze the State's largest health systems. Not all hospitals are required to file Medicare Cost Reports. For consistency, CSS does not include military hospitals in final tallies in this report that do not rely on NASHP or RAND Corporation data.

CSS used NASHP data to define the largest private systems based on bed size, excluding public system NYC Health and Hospitals Corporation. The hospitals belonging to New York's six largest private health systems are:

- **Northwell Health:** Community Memorial Hospital, Glen Cove Hospital, Huntington Hospital, Lenox Hill Hospital, Long Island Jewish Medical Center, Maimonides Medical Center, Mather Hospital, Nassau University Medical Center, North Shore University Hospital, Northern Westchester Hospital, Peconic Bay Medical Center, Phelps Memorial Hospital Center, Plainview Hospital, South Shore University Hospital, Staten Island University Hospital
- **New York Presbyterian Hospital**: New York Presbyterian Hospital, New York Presbyterian Hudson Valley, New York-Presbyterian/Queens
- **Mount Sinai Health System**: Mount Sinai Health System-Beth Israel, Mount Sinai Hospital, Mount Sinai St. Luke's Roosevelt Hospital, New York Eye and Ear Infirmary, South Nassau Communities Hospital
- **Montefiore Medical Center**: Montefiore Medical Center, Montefiore New Rochelle Hospital, Montefiore Nyack Hospital, St. Luke's Cornwall Hospital, The Mount Vernon Hospital, White Plains Hospital
- **Catholic Health:** Good Samaritan Hospital, Mercy Medical Center, St. Charles Hospital, St. Catherine of Siena Medical Center, St. Francis Hospital, St. Joseph Hospital
- **NYU Langone Health:** NYU Langone Hospitals (including NYU Langone Hospital - Brooklyn, NYU Langone Hospital - Long Island, NYU Langone Orthopedic Hospital, and Rusk Rehabilitation at Tisch Hospital).

The analysis of health system transactions, hospital facility and unit closures, and the numbers of beds lost between 1997-2024 and 2000-2024 was conducted for CSS by Patty HasBrouck (Madison Healthcare Advisors) and Lois Uttley. Data sources include the Health Markets Insights Database, the NYS Department of Health, and individual hospital websites. For geographic analyses, CSS defined the eight regions of New York based on New York's standardized insurance rating regions. In addition, throughout the report, median values are presented whenever data is greatly skewed.

Health care costs, charges, and commercial prices

For the charges and costs in Figure 3, appendectomy procedures were identified using APR-DRG code 225 in 2009 to 2017 SPARCS de-identified inpatient discharge data. For data from 2018 to 2022, due to a change in the coding system, appendectomies were identified using APR-DRG codes 233 and 234. Due to the large variation in costs and charges, CSS calculated median values for each year.

In Figure 6, CSS used the RAND 5.0 transparency study of 2020-2022 medical claims data to determine relative price data. CSS calculated relative commercial prices for inpatient and outpatient facility care by dividing "total private allowed amount" by "simulated Medicare allowed amount" for each hospital for which RAND data was available. Critical access hospitals were excluded from this analysis because they are reimbursed differently by Medicare.

Economic impacts of high premiums and deductibles

CSS reports average family premiums per person from AHRQ. AHRQ calculates average family premiums (Figure 4) by dividing the total amount New York employers and employees pay for family premiums (counting only private-sector firms that offer health insurance) by the number of employees with such coverage. Similarly, the average family deductible only accounts for employees at private firms that offer a health insurance plan with a deductible.

Consolidation and operating profits

CSS used 2022 data from NASHP and the RAND Corporation to identify health systems, sort hospitals into regions, and calculate regional market share based on percentage of inpatient discharges. Market shares were squared and combined to find the HHI for each region pursuant to Federal Trade Commission methodology.

Operating profit for hospitals in the state's six largest health systems comes from NASHP data. Operating profit margin includes costs closely related to hospital-based patient care (medical equipment, nurses' salaries) as well as other associated expenses (research, depreciation of capital assets).

Hospital closures, affected communities, and inclusivity

For figures 9 and 10, CSS drew demographic information from 2023 U.S. Census data. People of color are defined as all non-White and Hispanic (including White Hispanic) individuals. Share of rural population is the number of rural residents in each county divided by the total number of residents. CSS geocoded the addresses of hospital closures using QGIS. Counties with at least one hospital closure (and accompanying demographic information) were identified using ArcGIS Pro and shapefiles from the NYS GIS Clearinghouse.

The number of hospital closures in each region of New York (as well as NYC alone) was calculated using a similar method in ArcGIS Pro. Comparison of the geographic area of NYC versus Western New York was

also made using ArcGIS Pro. The number of open hospitals in each region is based on 2022 NASHP data.

To calculate overall and detailed average inclusivity grades, CSS matched health system data from NASHP with ratings from the 2024 Lown Hospital Index.

Hospital quality of care

For Figure 11, CMS only calculates overall quality star ratings for hospitals for which sufficient data is available. *See* Appendix C for a complete list of hospitals by overall quality star rating. CMS's overall quality star rating is based on five "measure groups" that address different aspects of care: patient experience, patient safety, mortality, safety of care, readmissions, and timely and effective care. While star ratings are not available for measure groups, CSS uses the patient experience rating from CMS's Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which is published on the CMS Care Compare portal.

For the other four measure groups, CSS followed CMS's methodology and combined data for 37 individual indicators from the appropriate spreadsheets in the "Hospitals – All Datasets" zip file. CSS then calculated the nationwide average and standard deviation for each individual indicator. Using these figures, a normalized score on each indicator was generated for each hospital. When necessary, direction of the score was adjusted so that higher scores corresponded with better performance. For each measure group, all available indicator scores were averaged to generate an overall score. Hospitals which did not report data for any indicators in a measure group did not receive a measure group score.

CSS calculated the 30th percentile score nationwide for each measure group. All hospitals which did not receive an overall quality score from CMS in July 2024 were then removed from the dataset. Among the remaining hospitals, the number that scored below the 30th percentile threshold for any given measure group was divided by the total number of hospitals with sufficient data.

Appendix B: Hospital closure tables

Table 1: NYS Hospital Closures, 1997-2024

Statewide Total	**53**
NYC Total	**20**
Rest of State Total	**33**

HOSPITAL NAME	YEAR CLOSED
Bronx (3)	
Our Lady of Mercy Med Ctr/ Florence Durso Pavilion	2004
Union Hospital of the Bronx	1997
Westchester Square Medical Center	2013
Kings (5)	
Kingsbrook Jewish Medical Center	2023
Long Island College Hospital	2014
St. Mary's Hospital of Brooklyn	2005
The Caledonian Hospital	2003
Victory Memorial Hospital	2006
New York (6)	
Beth Israel Medical Center/ Herbert and Nell Singer	2004
Cabrini Medical Center	2008
Manhattan Eye Ear & Throat Hospital	2007
North General Hospital	2010
St. Vincent's Hospital/Manhattan	2010
St. Vincent's Midtown Hospital	2007
Queens (5)	
Mary Immaculate Hospital	2009
Peninsula Hospital Center	2012
St. John's Queens Hospital	2009
St. Joseph's Hospital of Flushing	2004
The New Parkway Hospital	2008
Richmond (1)	
Doctor's Hospital of Staten Island	2003
Cattaraugus (2)	
Salamanca Hospital District Authority	2000
Tri-County Memorial Hospital	2009
Chautauqua (1)	
Lakeshore Hospital	2014
Delaware (1)	
Tri-Town Regional Hospital	2018
Erie (4)	
DeGraff Memorial Hospital	2019
Millard Fillmore Gates Circle Hospital	2012
Our Lady of Victory Hospital	1999
Sheehan Memorial Hospital	2012
Essex (1)	
Moses Ludington Hospital	2017

Genessee (1)

United Memorial Medical Center/ Bank Street Division	2000

Monroe (1)

Genesee Hospital	2001

Montgomery (1)

Amsterdam Memorial Hospital	2009

Nassau (3)

Island Medical Center	2003
Long Beach Medical Center	2012
Massapequa General Hospital	2000

Niagara (2)

Eastern Niagara Hospital - Lockport	2023
Eastern Niagara Hospital - Newfane	2019

Oneida (3)

Faxton-St. Lukes Healthcare- Faxton Division	2004
Faxton-St. Lukes Healthcare- St. Lukes Campus	2023
St. Elizabeth Medical Center	2023

Orange (2)

Cornwall Hospital	2016
Orange Regional Medical Center - Middletown Campus	2011

Orleans (1)

Lakeside Memorial Hospital	2013

Oswego (1)

Albert Lindley Lee Memorial Hospital	2009

Rensselaer (1)

Samaritan Hospital - St. Mary's Campus	2019

Schenectady (1)

St. Clares Hospital - McClellan Division	2008

St. Lawrence (1)

E.J. Noble Hospital/Samaritan	2013

Suffolk (1)

Brunswick Hospital Center	2005

Washington (1)

Mary McClellan Hospital	2003

Wayne (1)

Myers Community Hospital	2002

Westchester (3)

New York United Hospital Medical Center	2004
St. Agnes Hospital	2003
Yonkers General Hospital	2001

Table 2: Staffed Hospital Beds 2000 to 2024 by County

	Staffed Beds in 2000	Bed Loss Through Closure	Bed Loss (Gain) Through Other Restructure	Estimated Staffed Beds in 2024	% Change
NEW YORK STATE	**51,528**	**8,046**	**1,617**	**41,865**	**-18.8%**
NEW YORK CITY	**22,277**	**4,154**	**369**	**17,754**	**-20.3%**
Bronx	3,412	345	68	2,999	-12.1%
Kings	5,532	1,367	167	3,998	-27.7%
New York	8,990	1,125	312	7,553	-16.0%
Queens	3,312	1,200	(192)	2,304	-30.4%
Richmond	1,031	117	14	900	-12.7%
REST OF STATE	**29,251**	**3,892**	**1,248**	**24,111**	**-17.6%**
Cattaraugus	257	66	5	186	-27.6%
Chautauqua	481	42	213	226	-53.0%
Delaware	92	60	(31)	63	-31.5%
Erie	2,670	380	172	2,118	-20.7%
Essex	64	15	24	25	-60.9%
Genessee	126	65	(50)	111	-11.9%
Monroe	1,523	305	(543)	1,761	15.6%
Montgomery	172	51	21	100	-41.9%
Nassau	5,436	425	148	4,863	-10.5%
Niagara	513	205	(10)	318	-38.0%
Oneida	761	609	(401)	553	-27.3%
Orange	678	350	(340)	668	-1.5%
Orleans	112	61	12	39	-65.2%
Oswego	199	67	0	132	-33.7%
Rensselaer	376	201	(97)	272	-27.7%
Schenectady	571	166	34	371	-35.0%

	Staffed Beds in 2000	Bed Loss Through Closure	Bed Loss (Gain) Through Other Restructure	Estimated Staffed Beds in 2024	% Change
St. Lawrence	570	25	343	202	-64.6%
Suffolk	2,248	192	274	1,782	-20.7%
Washington	47	47	0	0	-100.0%
Wayne	162	32	29	101	-37.7%
Westchester	3,024	528	469	2,027	-33.0%
ALL COUNTIES WITH NO HOSPITAL CLOSURE	**9,169**	**N/A**	**1,248**	**7,921**	**-13.6%**

Appendix C: CMS Overall Quality Star Ratings for New York Hospitals

The following New York hospitals received five stars according to CMS' July 2024 overall quality ratings: Hospital for Special Surgery, John T. Mather Memorial Hospital, New York-Presbyterian Hospital, Northern Dutchess Hospital, Northern Westchester Hospital, Northwell Hospital Glen Cove, NYU Langone Hospitals, St. Anthony Community Hospital, St Francis Hospital – The Heart Center, and White Plains Hospital Center.

The following hospitals received four stars: Cayuga Medical Center at Ithaca, Claxton-Hepburn Medical Center, Corning Hospital, Guthrie Cortland Regional Medical Center, Jones Memorial Hospital, Lenox Hill Hospital, New York-Presbyterian/Queens, North Shore University Hospital, Huntington Hospital, Southside Hospital, Massena Hospital, St. Charles Hospital, St. Peter's Hospital, and SUNY/Stony Brook University Hospital.

The following hospitals received three stars: Auburn Community Hospital, Bon Secours Community Hospital, Brooks-TLC Hospital System, Inc., Clifton Springs Hospital and Clinic, Garnet Health Medical Center Catskills, Garnet Health Medical Center, Good Samaritan Hospital of Suffern, Hudson Valley Hospital Center, Kaleida Health, Long Island Jewish Medical Center, Mercy Medical Center, Mount Sinai Beth Israel, Mount Sinai Hospital, Mount Sinai St. Luke's Roosevelt Hospital, Mount St. Mary's Hospital & Health Center, Newark-Wayne Community Hospital, Oneida Health Hospital, Oswego Hospital, Peconic Bay Medical Center, Phelps Hospital, Plainview Hospital, Putnam Hospital Center, Samaritan Hospital of Troy, Samaritan Medical Center, Saratoga Hospital, Sisters of Charity Hospital, St. Catherine of Siena Hospital Medical Center, University Hospital SUNY Health Science Center, UPMC Chautauqua at WCA, and Vassar Brothers Medical Center.

The following hospitals received two stars: Adirondack Medical Center – Saranac Lake, Albany Medical Center Hospital, Aurelia Osborn Fox Memorial Hospital, Bassett Healthcare, Bellevue Hospital Center, Canton-Potsdam Hospital, Champlain Valley Physicians Hospital, Chenango Memorial Hospital, St. Joseph Hospital (Catholic Health LI), Cobleskill Regional Hospital, Columbia Memorial Hospital, Crouse Hospital, Ellis Hospital, Elmhurst Hospital Center, Erie County Medical Center, Geneva General Hospital, Glens Falls Hospital, Highland Hospital, Kenmore Mercy Hospital, Mercy Hospital of Buffalo, Montefiore Medical Center, Mount Sinai South Nassau, Mohawk Valley Health System, Nathan Littauer Hospital, Niagara Falls Memorial Medical Center, Nicholas H. Noyes Memorial Hospital, Nyack Hospital, Our Lady of Lourdes Memorial Hospital, Rochester General Hospital, St. James Mercy Hospital, St. Joseph's Hospital Health Center, St. Joseph's Medical Center, St. Luke's Cornwall Hospital, St. Mary's Healthcare, Strong Memorial Hospital, United Health Services Hospitals, Inc., United Memorial Medical Center, Unity Hospital, Woodhull Medical & Mental Health Center, Wyoming County Community Hospital.

The following hospitals received one star: Arnot Ogden Medical Center, Bronx Health System, Brookdale Hospital Medical Center, Brooklyn Hospital Center – Downtown Campus, F. F. Thompson Hospital, Flushing Hospital Medical Center, Good Samaritan Hospital Medical Center, Harlem Hospital Center, HealthAlliance Hospital Mary's Avenue Campus, Jacobi Medical Center, Jamaica Hospital Medical Center, Kings County Hospital Center, Lincoln Medical & Mental Health Center, Long Island Community Hospital, Maimonides Medical Center, Metropolitan Hospital, Montefiore New Rochelle Hospital, Nassau University Medical Center, New York Community Hospital of Brooklyn, Olean General Hospital, Queens Hospital Center, Richmond University Medical Center, Rome Memorial Hospital, Inc., South Brooklyn Health, St. Barnabas Hospital, St. Elizabeth Medical Center, St. John's Episcopal Hospital at South Shore, St. John's Riverside Hospital, Staten Island University Hospital, SUNY/Downstate University Hospital of Brooklyn, Westchester Medical Center, and Wyckoff Heights Medical Center.

Similar to the NASHP data (see Appendix A), multiple facilities in the same health system may receive a single CMS quality score.

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