Fact or Fiction?

Evaluating the Evidence on the "Cost Shift"

Office of the Health Care Advocate

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The Office of the Health Care Advocate advocates for all Vermonters through individual consumer assistance and systemic advocacy on health care issues. We work to increase access to high-quality, affordable health care for all Vermonters.

Overview

Many Vermont policy makers, health care entities, and private insurance companies assert that persons with private insurance are subsidizing persons insured by public insurance via "cost shifting." The centrality of the "cost shift" narrative to Vermont health policy leads us to ask two questions:

1. ***Does reliable and objective evidence support the conclusion that the "cost shift" exists?***
2. ***If the "cost shift" exists, how much of an impact does it have on private payer reimbursement rates?***

We found that the "cost shift" lacks empirical support. Given this fact, Vermont policy makers should realign their thinking on the topic. Basing policy decisions on the "cost shift" is inconsistent with the evidence on how private payer reimbursement rates are set.

We proceed in the following manner. First, we define the "cost shift." After that, we discuss how belief in a systemic "cost shift" has impacted Vermont health care policy and regulation. Third, we outline empirical research on the "cost shift" since the early 1990s and summarize the evidence for and against the "cost shift." Lastly, we offer suggestions on how Vermont policy makers' thinking on and approach to the "cost shift" should evolve to align with the evidence on this topic.

What is the "cost shift"?

The core premise of the "cost-shift" is simple and intuitively appealing. It is the idea that hospitals charge private payers more ***because*** public payer reimbursement rates are insufficient to cover costs. Put differently, private payers subsidize the provision of care to patients who are insured by public payers.

Definitions of the "cost shift" vary and academics often define the term using technical economic theory. Two statements by non-academic proponents of the "cost shift," however, capture its essence for the purposes of this paper. The first is by Karen Ignagi, the former president and CEO of America's Health Insurance Plans:

> *"If you clamp down one side of a balloon the other side gets bigger."*[1]

In Ms. Ignagi's analogy, if you clamp down on public payer reimbursement rates, private payer reimbursement rates must inflate.

The second statement is by Don George, the current president and CEO of Blue Cross and Blue Shield of Vermont:

> *"When government reimbursements are insufficient to cover the services a facility provides to Medicare or Medicaid beneficiaries, hospitals charge patients with private insurance enough to cover not only the cost of their services, but the shortfall created by government reimbursements."*[2]

These statements capture the central idea of the "cost shift;" that ***because*** public payer reimbursement rates are below the cost of the services rendered by a hospital, the shortfall in reimbursement must be made up by private payers. For instance, if a service costs $100 and public payers reimburse hospitals only $80, then private payers' reimbursement must include both the cost of the service rendered and the $20 shortfall for a total of $120.[3]

The "cost shift" leads to two different scenarios that result in endless increases in private payer reimbursement rates: 1) public payers fail to keep up with inflation, thus creating a larger and larger deficit between public payer reimbursement rates and the cost of providing services; and 2) the population distribution among payers continually shifts from private payers to public payers in states like Vermont with aging populations. In either case, the "cost shift"

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[1] Austin B. Frakt, *How Much Do Hospital's Cost Shift? A Review of the Evidence*, 89 Milbank Q. 90, 92 (2011), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3160596/.

[2] Kathryn Wagner, *Shock, But No Shift: Hospitals' Responses to Changes in Patient Insurance Mix*, 49 J. Health Econ. 46, 47 (2016), https://epublications.marquette.edu/econ_fac/540/.

[3] Assuming the "cost shift" exists, which is a debated question, the magnitude of the "hydraulic" effect of public payer reimbursement on private payer charges is unclear. For instance, does a $1 dollar under reimbursement from a public payer result in a $1 increase in private-payer charge or an increase of private-payer charge of less than a dollar? *See*, Charpin White, *Contrary to Cost-Shift Theory, Lower Medicare Hospital Payment Rates for Inpatient Care Lead to Lower Private Payment Rates*, 32 Health Aff. 935 (2013) (Finding that a 10%t reduction in Medicare reimbursement rates was associated with a 3.11% *reduction* in private payer reimbursement rates.); Allen Dobson et al., *The Cost-Shift Payment 'Hydraulic': Foundation, History, and Implications*, 25 Health Aff. 22, 31 (2006), https://www.researchgate.net/profile/Namrata-Sen/publication/7367756_The_Cost-Shift_Payment_%27Hydraulic%27_Foundation_History_And_Implications/links/5627bab008ae518e347b286b/The-Cost-Shift-Payment-Hydraulic-Foundation-History-And-Implications.pdf (Arguing for the "cost shift," but noting that public-payer reimbursement rate reductions result in private-payer reimbursement rates increases of a smaller magnitude than the public-payers' reimbursement rate reduction.).

argument asserts that providers will charge private payers ever more over time ***because*** of the need to "make up" the public payer reimbursement shortfall.[4]

In the above scenarios, state government's hands are essentially tied because public payer reimbursement rates lie largely outside of state control.[5] Due to this, privately insured Vermonters, many of whom struggle to pay high deductibles and co-insurance costs even at today's rates, must simply shoulder the growing financial burden of higher premiums or regulators must take the extreme step of allowing hospitals to fail. Neither of these outcomes is sustainable in the long-term nor palatable.

Price Variation does not Prove Causation

The variation in what payers pay for the same service is known as price discrimination. It is important to point out that the "cost shift" is about ***the cause*** of price discrimination by payer type. It is undisputed that reimbursement rates vary by payer type and that there is price discrimination in the reimbursement rates. However, ***variable reimbursement rates are, alone, not evidence of the "cost shift."***

Proponents of the "cost shift" frequently correlate reimbursement rates by payer type with hospital-provided cost data or they graph reimbursement rates by payer type as evidence of the "cost shift." However, descriptive statistics or correlations are not evidence of ***the cause*** of the observed variability in reimbursement rates by payer type. Correlations and descriptive statistics do not, and cannot, speak to causation. ***Such data speak to "what is" not "why it is"***. In other words, correlations and descriptive data may be evidence to consider when describing or understanding a phenomenon but they do not prove the causal relationships behind the phenomenon being examined. [6]

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[4] *See e.g.*, Michael E. Chernew et al., *Public Payment Rates for Hospitals and the Potential for Consolidation-Induced Cost Shifting*, 40 Health Aff. 1277 (2021).

[5] The state could increase Medicaid reimbursement rates. However, this tact is problematic for three reasons. First, as the Vermont population ages, the percentage of the population on Medicaid will presumably decline as more persons will be insured by Medicare thus so too will its relative share of hospital reimbursements. Second, increasing Medicaid reimbursement rates is a substantial political and practical challenge in Vermont. Some observers might say increasing Medicaid reimbursement rates would be a highly unlikely occurrence, at best. Third, as we will outline in this paper, it is unclear that increasing Medicaid reimbursement rates would even decrease private payer reimbursement rates if the "cost shift" is not a causal force behind reimbursement rate setting.

[6] Some readers might correctly assert that in some cases, simple observation can speak to causation. For instance, randomized controlled drug trials allow us to attribute the observed outcome to the effect of the drug.

Vermont's Belief in the "Cost Shift"

It is not surprising that hospitals and private payers advocate for the "cost shift," because it directly aligns with their economic and political interests.[7] There are two primary ways the "cost shift" aligns with the interests of these actors. First, if private payers must reimburse providers for public payer under-reimbursement, then private payer rate increases will be perpetually justified until public payers increase reimbursement rates — an unlikely event.[8] Second, the "cost shift" redirects blame for rising system costs from hospitals and private payers to federal and state governments. For these two reasons, ***charge justification*** and ***blame shifting***, the "cost shift" aligns well with hospital and private payer interests.

What is surprising is that the "cost shift" has become an article of faith for many in Vermont government. For example, the Vermont legislature mandates a "cost shift" analysis.[9] The Executive Branch has been known to express support of the "cost shift" argument, notably during the Shumlin Administration.[10] The Green Mountain Care Board, the Vermont regulatory entity that oversees hospital budgets and commercial insurance rates, frequently points to the "cost shift" in its administrative decisions and public statements as the dominant ***cause*** of rising private health insurance rates and hospital financial instability.[11] That these governmental entities reference the "cost shift" in law, policy, and administrative decisions both

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Similarly, we can measure dropping an object in a vacuum tube to explain the effect of gravity. However, the power of measurement to explain causation in these examples turns on the experimental design and the experimental conditions used. Hospital financial data is not such data.

[7] *See, e.g.*, Frakt, *supra* note 1; Sherry Gilead, *COVID-19 Overturned the Theory of Medical Cost Shifting by Hospitals*, JAMA F. (June 24, 2021), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2781591; The University of Vermont Medical Center, *Cost Shift Information*, https://d2ubrtwy6ww54e.cloudfront.net/www.uvmhealth.org/assets/migrate_files/act53_cost_shift-uvmmc.pdf.

[8] Jason Lee et al., *Medicare Payment Policy: Does Cost Shifting Matter?*, 22 (Supl. 1) Health Aff. W3-480 (2003), at W3-486.

[9] 18 V.S.A § 9405b(a)(6).

[10] Peter Shumlin, *Why We Should Fix the Medicaid Cost Shift, The* Governor's Blog, archived blog post at https://vermont.preservica.com/Render/render/waybackproxy/20170104223708/http:/governor.vermont.gov/blog/why-we-should-fix-medicaid-cost-shift; Agency of Human Services – Department of Vermont Health Access, *Budget Document – State Fiscal Year 2016*, http://www.vermontbusinessregistry.com/bidAttachments/14110/SFY16%20DVHA%20Budget%20Book%20Part%201.pdf; Agency of Human Service – Department of Vermont Health Access, *2013 Medicaid Cost Shift Report*, https://legislature.vermont.gov/Documents/Reports/296351.PDF.

[11] *See, e.g.*, Vermont Public Radio, *Regulators Say Health Care Reform in Jeopardy Without Increase in State Medicaid Funding* (Aug. 23, 2019), https://www.vpr.org/vpr-news/2019-08-23/regulators-say-health-care-reform-in-jeopardy-without-increase-in-state-medicaid-funding; Green Mountain Care Board GMCB-005-20rr, Blue Cross and Blue Shield of Vermont 2021 Individual and Small Group Filing, Decision at 9 (item 38), https://ratereview.vermont.gov/sites/dfr/files/PDF/Docket%20No.%20GMCB-005-20rr%20Decision%20and%20Order%3B%20BCBSVT%202021%20VISG.pdf; Green Mountain Care Board FY 2022 Hospital Budget Order at 3-4, https://gmcboard.vermont.gov/sites/gmcb/files/documents/FY22%20Budget%20Order-UVMMC.pdf.

presupposes that the "cost shift" is a real phenomenon and, to the extent regulators allow for substantially higher private payer reimbursement rates, it ensures that substantial price discrimination by payer type will continue which, in turn, is justified by the "cost shift."

The "cost shift" argument has taken hold in Vermont despite relatively common-sense alternative explanations of the price discrimination between public and private payers. The reimbursement rate differential might be indicative of overly high private payer reimbursement rates driven by revenue-maximization tendencies or necessitated by unrealized expense reduction opportunities. Also, that public payers under-reimburse (not that there is price discrimination) could be a mirage created by hospitals overstatement of costs to the public and state regulators when these reported costs are, in fact, far different from "true" costs.[12] Given the lack of transparency in hospital cost accounting and the known financial interests of various parties (as organizations and not individual employees), both these explanations are plausible. Our focus in this paper, however, is not the above-mentioned alternative explanations of price discrimination. Rather, it is whether empirical research supports the idea that the "cost shift" is ***the cause*** of price discrimination amongst payers.

A Review of Empirical "Cost Shift" Research

The "cost shift" was first propounded multiple decades ago. Over the years, empirical research on the "cost shift" has evolved significantly. ***Most empirical studies of the "cost shift" have found limited evidence of widespread "cost shifting." Even when "cost shifting" occurs, researchers found that it does not occur at a magnitude to explain a significant amount of variation in reimbursement rates by payer type.*** While it is theoretically possible that the "cost shift" could occur in some circumstances and at sufficient magnitudes to substantially explain payer price variation, the evidence simply does not exist that this is the case in Vermont.

[12] *See* Chapin White & Christopher Whaley*, Prices Paid to Hospitals by Private Health Plans are High Relative to Medicare and Vary Widely: Findings from an Employer-Led Transparency Initiative*, RAND Research Report (2019), https://www.rand.org/pubs/research_reports/RR3033.html; National Academy for State Health Policy (NASHP), Hospital Cost Tool (Updated November 2021), https://www.nashp.org/how-to-complete-nashps-hospital-cost-tool/; Green Mountain Care Board, Presentation by the National Academy for State Health Policy (NASHP), A Look at Vermont Hospitals with NASHP's Hospital Cost Tool, Oct. 21, 2020, http://gmcboard.vermont.gov/sites/gmcb/files/documents/NASHP%20VT%20Hospital%20analysis.pdf.

We reviewed the existent research to understand whether there is evidence to support the proposition that the "cost shift" underlies price discrimination in reimbursement rates by payer type. To find the relevant research, we first conducted a Google Scholar search for publications (mostly peer-reviewed) that address the "cost shift" or health care price discrimination during a 31-year period, 1990 to 2021, using various search terms and Boolean operators. Additionally, we examined the citations of the articles we identified with the above-mentioned method to identify articles that our Google Scholar searches missed. What we found was literature with consistent findings on whether the "cost shift" exists and, if it does, what the "cost shift's" impact on private payer reimbursement rates was.

Before proceeding with a more detailed explication of our findings, we provide a high-level results summary. First, there is a small amount of academic evidence supporting the "cost shift."[13] Second, there are some theoretical and empirical studies that argue that the "cost shift" occurs but that private payers do not compensate for public payer under-reimbursement on a dollar-for-dollar basis. [14] Third, and in contrast to the two preceding points, the majority of empirical studies find limited to no evidence of the "cost shift."[15] Additionally, there are some theoretical studies that find that the "cost shift" exists but that it could only occur in a limited set of circumstances.[16] In sum, there is insufficient empirical evidence to support a strong and unqualified belief in the "cost shift". ***The question of whether the "cost shift" occurs is, at best, a grey area given current best evidence.***[17]

There was a flurry of research on the "cost shift" in the mid and late-1990s using data from the 1980s and early-1990s.[18] Many researchers in this era found no evidence of a "cost shift." For instance, Morrisey 1996 reviews the empirical research produced during this period and concluded that the then-existent research suggests that the "cost shift" does not exist.[19] We found one research article from this period, Cutler 1998, that found dollar-for-dollar "cost

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[13] *E.g.*, Jack Zwanziger & Anil Bamezai, *Evidence of Cost Shifting in California Hospitals*, 25 Health Aff. 197, 201-202 (2006).
[14] *E.g.*, David M. Cutler, *Cost Shifting or Cost Cutting?: The Incidence of Reduction in Medicare Payments*, 12 Tax Pol'y and the Econ. 1 (1998).
[15] *E.g.*, Frakt, *supra* note 1.
[16] *E.g.*, Chernew et al., *supra* note 4.
[17] The literature is in stark contrast to the stance of some Vermont policy makers and other entities that the "cost shift" is, unambiguously, the driving cause of higher private payer reimbursement rates. It is worth reiterating that the fact that an observed reimbursement rate differential between private and public payers is not proof of the "cost shift." It is evidence of price discrimination, necessary but not sufficient evidence of the cause of the price discrimination.
[18] Frakt, *supra* note 1; Lee, *supra* note 8.8
[19] Michael Morrisey, *Hospital Cost Shifting: A Continuing Debate*, EBRI Issue Brief 180 (1996).

shifting" in the 1980s, but much less substantial "cost shifting" in the 1990s, suggesting that the extent of "cost shifting," when it exists, changes over time, presumably with changes in the health care landscape's structure.[20] However, with the exception of Cutler 1998, most research during the 1990s found scant empirical evidence in support of the "cost shift."

In the early- and mid-2000s, there was again substantial "cost shift" research activity.[21] This research, using newer data, generally found that the "cost shift" does not explain differential reimbursement rates by payer type. Frakt 2011 usefully summarizes "cost shift" research that occurred during this period and concluded that there is little evidence supporting the "cost shift."[22]

Also interesting in this period is White 2013. He analyzed commercial claims and Medicare Cost Report data to explore whether low Medicare inpatient reimbursement rate growth was associated with higher private payer reimbursement rate growth, as is posited by the "cost shift." Although White 2013 found clear evidence of differential reimbursement rates by payer type (i.e., price discrimination), he found that lower Medicare reimbursement rate growth was associated with ***lower*** private payer reimbursement rate growth.[23]

Another study, Dranove et al. 2013, examined whether hospitals raised private-payer charges to offset financial losses resulting from the 2008 stock market collapse using various data sources, including the Medicare Cost Report, CMS impact files, and the American Hospital Association Annual Survey. The authors found that, on average, hospitals did not increase private payer rates to offset losses elsewhere in the organization, suggesting that hospitals do not offset losses, whether from the securities or public payer reimbursement rates, by raising private payer rates.[24]

During the early 2000s, Zwanziger & Bamezai 2006 found some empirical evidence of "cost shifting." Although the authors found evidence of "cost shifting" in California from 1997 to

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[20] Cutler, *supra* note 14.14

[21] *E.g.*, Frakt, *supra* note 1; Austin B. Frakt, *The End of Hospital Cost Shifting and the Quest for Hospital Productivity*, 49 Health Services Res. (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3922463/; David Dranove et al., *How Do Hospitals Respond to Negative Financial Shocks? The Impact of the 2008 Stock Market Crash*, NBER Working Paper 18853 (2013), https://www.nber.org/papers/w18853; Jeffrey Strensland et al., *Private-Payer Profits Can Induce Negative Medicare Margins*, 29 Health Aff. 1045 (2010); Wagner, *supra* note 2; Lee, *supra* note;8 White, *supra* note 2; Vivian Y. Wu, *Hospital Cost Shifting Revisited: New Evidence from the Balanced Budget Act of 1997*, 10 Int. J. Health Care Fin. Econ. 61 (2010).

[22] Frakt, *supra* note 1.

[23] White, *supra* note 2.21

[24] Dranove et al., *supra* note 21.21

2001, they note that "cost shifting" is only one factor of many that impacts entities complex reactions to public payer reimbursement rates. Considering this, the authors concluded that policy makers must evaluate this web of responses to differential reimbursement rates, and not turn just to "cost shifting" when making policy decisions.[25]

***In the aggregate, research conducted in the early- and mid-2000s presented little evidence of a "cost shift" on a national scale*.** Generally, researchers found that it is unclear how hospitals respond to public and private payer reimbursement differentials and that there are multiple possible reasons for their responses, of which the "cost shift" may be one. Moreover, the response of an individual hospital depends on the specifics of that hospital's market power, how much market power it has already exercised, and the goals of the hospital (i.e., whether the hospital seeks to fully exercise its market power).

More contemporary studies also found limited empirical evidence of a substantial or pervasive "cost shift." The majority of materials we reviewed question whether the "cost shift" exists or explore whether market regulation based on the "cost shift" is justified.[26] For instance, the Colorado Department of Health Care Policy and Finance 2020 found that longitudinal data from 2009 to 2018 from various sources conflicted with the "cost shift" argument.[27] The report noted that, if the "cost shift" argument was true, that various interventions should have lowered hospital private payer rates. However, despite these interventions being implemented, hospital private payer rates did not decline. This was interpreted as evidence that the "cost shift" either did not occur or that "cost shifting" had a minimal impact on private payer reimbursement rates.[28] Similarly, a recent RAND study looking at claims data from various All-Payer Claims Databases found no association between private payer allowed charge amount and case-mix adjusted discharges for patients insured by public payer thus supporting the proposition that the "cost shift" does not occur.[29]

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[25] Zwanziger & Bamezai, *supra* note 13.13

[26] *E.g.*, Colorado Dept. of Health Care Policy and Fin., *Colorado Hospital Cost Shift Analysis* (2020), https://hcpf.colorado.gov/sites/hcpf/files/Colorado%20Hospital%20Cost%20Shift%20Analysis%20Report-January%202020.pdf. *See also*, Gilead, *supra* note (7Although we do not agree with the author's logic leading to the conclusion regarding COVID-19, the author provides a useful summary of recent "cost-shift" research).

[27] Colorado Dept. of Health Care Policy and Fin., *supra* note 26, at 11.

[28] *Id* at 67.

[29] Christopher Whaley, Brian Briscombe, Rose Kerber, *Prices Paid to Hospitals by Private Health Plans: Findings from Round 4 of an Employer-Led Transparency Initiative*, RAND Research Report (2022), at 18, https://www.rand.org/pubs/research_reports/RRA1144-1.html.

Perhaps most interestingly, some recent research on the "cost shift" moves past previous debates on whether the "cost shift" has empirical or theoretical justification, and instead examines the local conditions that may lead to payer reimbursement rate differentials having a meaningful effect on hospital solvency. For instance, Chernew et al. 2021 examines how provider reimbursement rates impact hospital market structure in a region. Chernew et. al. 2021 may be particularly relevant to the Vermont context given the large share of public payer patients relative to private payer patients and the financial health of Vermont's hospitals. It is important to note, however, that Chernew et al. 2021 does not identify raising private payer reimbursement rates as a viable solution to the issue of hospital financial condition; rather, they identify hospital consolidation regulation as the policy lever that gets at the root cause of the rate differentials between payers.[30]

Another interesting study in recent years is Darden 2018. He found that the extent to which hospitals raise private payer reimbursement rates because of public payer reimbursement rates depends on the relative market dominance of a given hospital relative to a given insurer and the hospital's payer mix.[31] Darden found that the "cost shift" plays a more important role in rising reimbursements and health care costs where hospitals have a payer mix with many private payer patients relative to public payer patients.[32]

In summary, based on our review of the evidence, we conclude that the "cost shift" argument lacks sufficient supporting evidence to merit being used in policy decisions. We note, however, that in very specific instances the "cost shift" could occur at magnitudes that are policy relevant. Local conditions in Vermont potentially could present such circumstances, but at present there is no empirical evidence to confirm or deny whether this is the case. Absent such evidence, continued belief in the "cost shift" is unwarranted and inconsistent with evidence-based policy practice.

Responding to the Best-Evidence

Vermonters should view the "cost shift" with a high degree of skepticism considering current evidence, because ascribing Vermont's health care issues to the "cost shift" aligns with the financial interests of hospitals and private payers, and because policy decisions that rely

[30] Chernew et al., *supra* note 4.
[31] Michael Darden et al., *Who Pays in Pay for Performance? Evidence From Hospital Pricing*, NBER Working Paper 24304 (2013), at 8, https://www.nber.org/papers/w24304/.
[32] *Id.* at 6, 18.

on the "cost shift," given the lack of evidence of it, harms Vermonters. Again, the most-current evidence does not support the conclusion that public payer reimbursement rates are ***the cause of*** high private payer reimbursement rates. Is it possible that a "cost shift" is occurring in limited ways in Vermont because of Vermont's unique health care landscape, shaped as it is by a lack of hospital competition, the state's largely rural nature, and/or regulation of hospital net patient revenue? Yes. But to the best of our knowledge, such research does not exist.

Why does it matter if Vermont policy adopts the "cost shift" as the driving force behind high private payer insurance rates and hospital financial conditions? One reason is that if Vermont designs policy interventions to address the "cost shift," those interventions are likely to have unintended and potentially negative effects, particularly on consumers.

More importantly, uncritical acceptance of the legitimacy of the "cost shift" undermines the ability of Vermont policy makers to effectively intervene in the health care system. Policy interventions that are intended to make health care more affordable for consumers and employers and strengthen the health care system are unlikely to succeed if they are directed at a non-existent cause. Further, if we accept that the "cost shift" plays a dominant role in Vermont, then, absent federal policy changes, there are few actions Vermont policy makers can take that would dramatically improve hospital financial sustainability or affordability for Vermonters.[33] This, in turn, excuses state policy makers from designing and implementing interventions to address Vermont's most pressing health care problems: affordability and sustainability.

This raises a valid question: what reform steps should Vermont government implement given the current state of knowledge on the "cost shift?" We suggest the following:

- *Recognize, in regulation and policy documents, that correlation is not causation, and that the existence of price variation is necessary but not sufficient evidence of the "cost shift."*
- *Like Colorado, commission a reliable and accurate study of whether, given specific Vermont conditions, the "cost shift" impacts hospital solvency and to what extent, if any, the "cost shift" affects private payer reimbursement rates. By reliable, we simply mean a*

[33] Of course, Vermont might choose to increase Medicaid reimbursement rates partially from the state's coffers. It is unclear, however, whether such an increase would have a long-term impact given Vermont's aging population and, thus, the share of patients that are likely to have Medicare.

study produced by a reliable source free from known financial interests in furthering the idea of the "cost shift". Further, unlike past analyses of the "cost shift" in Vermont, the study's methods should not presuppose the existence of the "cost shift" or suggest that price discrimination is, by itself, proof of the "cost shift."

- *Pending the results of the study recommended above, policy makers should exercise caution and restraint ascribing health care system financial issues to the "cost shift." The "cost shift," if it exists at all in Vermont, is likely just one cause of the issues impacting Vermont's health care system.*
- *In the absence of adequate evidence that the "cost shift" occurs in Vermont, lawmakers and regulators should push back on entities that use the "cost shift" to justify increases to the cost of care, allowed charges, or premium rates, especially if advancing or defending the existence of the "cost shift" is in the proponents' financial interests.*

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