Price Discrimination In Practice

Posted on July 28, 2022

Price discrimination occurs when sellers charge different customers different effective prices for the same or closely related product and the differences are not explained entirely by the cost of serving those customers. Healthcare and prescription-drug markets contain several forms of differential pricing, but the term must be used carefully. A hospital's published charge, an insurer's negotiated allowed amount, a pharmacy's cash price, a manufacturer's list price, and the net price after rebates are different figures. A lower price for one purchaser may reflect bargaining power, statutory rebates, volume, distribution arrangements, or a restricted formulary rather than unlawful discrimination. The original essay asks why drug firms provide discounts, why uninsured patients may face high charges, why cash prices sometimes beat insurance prices, and why the Department of Veterans Affairs receives low drug prices. Those questions remain central, but current law and market structure make the answers more complex.

Discounts by Drug Firms

Pharmaceutical manufacturers provide discounts and rebates for several reasons. A lower net price may increase sales volume, secure placement on an insurer's or pharmacy-benefit manager's formulary, encourage hospitals to stock a medicine, satisfy government-program requirements, or respond to competition from alternatives. Manufacturers may also provide patient-assistance or copayment support, although eligibility and effects vary. The economic logic resembles price discrimination because purchasers with different bargaining power and sensitivity to price can face different net prices.

Demand elasticity matters, as the original essay notes. A buyer who can switch easily to another medicine or exclude a product from a formulary has greater bargaining leverage. A patient needing a unique medicine may have little ability to substitute. However, manufacturers do not negotiate directly with every final patient. Wholesalers, pharmacies, insurers, pharmacy-benefit managers, hospitals, government programs, and assistance organizations stand between list price and the amount ultimately paid. (U.S. Government Accountability Office, 2021)

List Price, Gross Price, and Net Price

The list price is a publicly stated amount before discounts, rebates, and concessions. It can affect coinsurance or deductibles in some benefit designs, but it is not necessarily what the manufacturer retains. The net price is the amount remaining after negotiated rebates, statutory rebates, fees, chargebacks, and other concessions. A medicine can therefore have a high list price while its average net price is substantially lower.

This gap creates transparency problems. Patients often see only the amount requested at the pharmacy and may not know whether it reflects the insurer's negotiated rate, deductible, coinsurance, a pharmacy's cash offer, or a manufacturer program. Policymakers evaluating price discrimination should distinguish the party setting each price and the direction in which money later flows.

Why Healthcare Providers Routinely Offer Discounts

Hospitals, physicians, laboratories, and other providers commonly negotiate payment rates with insurance plans. The provider agrees to accept an allowed amount rather than the full published charge in exchange for network participation and access to the insurer's members. The original essay suggests that physicians offer discounts simply because insurance companies are their principal source of income. A more accurate explanation is contractual bargaining: both parties exchange something of value. The insurer offers patient volume and administrative payment arrangements; the provider offers a negotiated rate and network access.

Providers may also offer prompt-pay discounts, income-based financial assistance, charity care, or self-pay packages. These programs are governed by organizational policy and applicable law. Discounts should be transparent and applied consistently so that vulnerable patients are not treated arbitrarily. Routine waiver of required insurance copayments can raise legal and contractual issues when used to induce business or misrepresent the true charge.

Why Uninsured Patients May Face the Highest Charges

Historically, uninsured or self-pay patients often received bills based on a hospital's chargemaster or another undiscounted schedule, while insurers paid negotiated rates substantially below those charges. The original article correctly identifies the bargaining disadvantage: an individual patient does not possess the volume or contracting resources of a large insurer or government program. People without insurance may also lack knowledge about financial-assistance policies or may receive care during an emergency, when comparison shopping is unrealistic.

It is not accurate to say that uninsured patients always pay the highest final price. Many hospitals provide substantial self-pay discounts or charity care, and federal and state rules require certain nonprofit hospitals to maintain financial-assistance policies. The amount initially billed may differ from the amount eventually collected. Nevertheless, the burden of applying, documenting income, and negotiating can fall on a person who is already ill, creating an inequitable process even when assistance exists.

Hospital Price Transparency

United States hospital price-transparency rules require hospitals to publish standard charges, including payer-specific negotiated charges and discounted cash prices, in machine-readable files and provide consumer-friendly information for shoppable services. These disclosures are intended to help patients and researchers compare prices. Compliance and usability have varied, and medical decisions remain difficult to reduce to a single posted number because services, complications, physician bills, and insurance benefits differ.

Transparency is useful only when the information is understandable and accurate. A listed price should identify what is included, whether professional fees are separate, and whether the estimate reflects the patient's insurance status. Posting a complex file without meaningful explanation does not create informed choice.

Cash Price Versus Insurance Price

The original essay observes that a cash price can be lower than an insurance price. This can occur, especially with generic prescriptions. A pharmacy may offer a low retail cash price or discount-card price, while an insured patient's required payment is based on a plan's negotiated amount, deductible, or copayment structure. During a deductible phase, the patient may pay the negotiated price in full even when a separate cash offer is cheaper.

Using the cash price may have tradeoffs. The payment may not count toward the insurance deductible or out-of-pocket maximum, and the insurer may not receive a claim record needed for medication management. Patients should ask the pharmacist to compare lawful available options and should understand how each choice affects coverage. The existence of a cheaper cash price does not prove that the insurer's entire contract is harmful; contracts negotiate baskets of products, pharmacy networks, services, and risk rather than one transaction in isolation.

The Role of Pharmacy-Benefit Managers

Pharmacy-benefit managers administer prescription benefits for insurers, employers, and government plans. They may negotiate manufacturer rebates, establish pharmacy networks, process claims, and design formularies. Their scale can create bargaining power, but the system is criticized for opaque rebate flows, spread pricing, and incentives tied to list prices. Contract terms determine whether negotiated savings are passed to the plan sponsor or patient.

Formulary placement can influence prescribing and patient access. A medicine with a larger rebate may receive preferred status even when another has a lower list price, although clinical committees and legal standards also affect decisions. Transparency should reveal the economic incentives without

publicly exposing information in ways that eliminate legitimate bargaining.

Do Hospitals Receive Better Drug Prices Than Insurers?

The original essay claims that hospitals generally receive better drug prices because they are direct service providers. There is no universal rule. Hospitals, group-purchasing organizations, wholesalers, insurers, and pharmacy-benefit managers negotiate through different channels. A hospital may receive favorable acquisition pricing for inpatient use, especially through volume contracts or the federal 340B Drug Pricing Program when eligible. An insurer does not usually purchase and store every drug directly; it negotiates reimbursement and rebates within the benefit system.

The relevant comparison depends on the medicine, site of care, purchaser, program eligibility, and definition of price. A hospital's acquisition cost can be low while the amount billed to the patient or insurer is high. Conversely, an insurer may receive a large manufacturer rebate after the claim. Analysts should avoid comparing an acquisition price with a post-rebate net price as though they were identical measures.

The 340B Drug Pricing Program

The 340B program requires participating manufacturers to sell outpatient drugs at discounted prices to eligible safety-net providers. The purpose is to stretch scarce federal resources and support services for vulnerable populations. Eligible organizations include certain hospitals and clinics. The program is distinct from ordinary commercial negotiation and from Medicaid rebates, although coordination rules prevent duplicate discounts.

Debate concerns program growth, contract pharmacies, manufacturer restrictions, patient benefit, and transparency in the use of savings. A discounted acquisition cost does not automatically determine the patient's bill. Policy evaluation should ask whether savings support access and care for intended communities.

Why the Department of Veterans Affairs Receives Low Prices

The Department of Veterans Affairs combines statutory protections, negotiated contracts, formulary management, and large purchasing volume. Manufacturers participating in federal programs may be subject to federal ceiling prices for covered drugs. The VA also uses the Federal Supply Schedule and national contracts to negotiate additional concessions. Its integrated delivery system and national formulary give it leverage because it can direct substantial use toward preferred products when

clinically appropriate. (U.S. Department of Veterans Affairs, 2026)

The original essay attributes VA pricing only to “political authority.” Government authority matters because law establishes mandatory discounts and contracting structures, but the VA’s purchasing model also depends on centralized negotiation, evidence review, utilization management, and the ability to prefer selected medicines. Lower price can involve narrower choice or additional authorization requirements, so comparison with a broad commercial benefit should include access and clinical policy as well as price.

Medicaid Drug Rebates

The Medicaid Drug Rebate Program requires manufacturers to enter rebate agreements so their outpatient drugs can receive Medicaid coverage. For many brand-name medicines, the basic rebate is generally the greater of a specified percentage of the average manufacturer price or the difference between that price and the manufacturer’s best price, with an additional inflation-related rebate when prices rise faster than inflation. Generic and other noninnovator products use a different statutory calculation. (Centers for Medicare & Medicaid Services, 2026)

States may negotiate supplemental rebates in exchange for preferred placement. Medicaid therefore does not simply pay the pharmacy’s initial amount without adjustment; substantial rebates flow later to federal and state governments. The system can create complex incentives and delayed visibility into the true net price.

Would Requiring Medicaid to Receive VA Prices Lower Costs?

The original essay asks what would happen if Medicaid agencies received prices similar to the VA. A direct comparison is difficult because the programs serve different populations and use different legal and purchasing structures. Medicaid has broad coverage obligations and state administration, while the VA operates an integrated health system with a national formulary and direct care infrastructure. Extending one program’s price rules could lower public spending for some medicines, but manufacturers, formularies, market entry, pharmacy reimbursement, and other prices might adjust.

The original claim that manufacturers would simply demand federal compensation or raise all other rates is possible in some form but not an established automatic outcome. Economic effects depend on market competition, exclusivity, research costs, international sales, bargaining rules, and how manufacturers respond. Policy analysis should use evidence and scenario modeling rather than assume a single reaction.

Medicare and Drug-Price Negotiation

The original essay discusses whether Medicare could adopt the VA formulary. Medicare is not identical to the VA because it covers a much larger and more diverse population through private Part D plans, Medicare Advantage, and traditional Medicare arrangements. Part D plans already use formularies and negotiate through sponsors and pharmacy-benefit managers, subject to coverage rules. A single VA-style formulary could increase bargaining power but might reduce access to nonpreferred products unless exceptions and clinical safeguards were designed carefully.

Federal policy changed significantly under the Inflation Reduction Act. Medicare now negotiates Maximum Fair Prices for selected high-expenditure drugs lacking generic or biosimilar competition. The first negotiated prices for selected Part D drugs took effect on January 1, 2026. This is not a universal price for every medicine and does not convert Medicare into the VA model. Selection, negotiation, manufacturer participation, beneficiary access, and future cycles follow statutory procedures administered by the Centers for Medicare & Medicaid Services. (Centers for Medicare & Medicaid Services, 2026)

Ethical Analysis and Biblical Fairness

The original essay introduces a biblical concern for common grace and authentic relationships. An ethical analysis can preserve that concern without replacing economic evidence with religious assertion. Healthcare pricing affects whether people obtain medicines, incur debt, or delay treatment. Principles of justice, compassion, honesty, and protection of vulnerable people support transparent prices, meaningful assistance, and avoidance of exploitation.

Fairness does not necessarily require one identical price for every purchaser. Volume, distribution cost, risk, and public obligations can justify differences. The ethical problem arises when complexity hides excessive charges, patients cannot understand their options, or those with the least bargaining power bear the greatest burden. A just system should evaluate both average efficiency and the experience of people facing illness without financial protection.

Price Discrimination and Innovation

Manufacturers argue that revenue supports research, clinical trials, regulatory work, failed projects, manufacturing, and future innovation. Critics note that pricing can exceed research costs, public funding contributes to discovery, and monopoly protection can limit competition. Differential pricing across countries or purchasers can expand access when lower-income markets receive lower prices, but it can also generate disputes over who finances innovation.

The appropriate balance cannot be determined from list prices alone. Policymakers need reliable

information about net revenue, research investment, manufacturing cost, public support, therapeutic value, and unmet need. Value-based pricing attempts to connect price with health benefit, but measuring value raises ethical questions about disability, age, rarity, and budget impact.

Practical Guidance for Patients

Patients can ask for an estimate, inquire about financial assistance, compare the insurance and cash price of a prescription, request an appropriate lower-cost alternative, and ask whether a manufacturer or public assistance program applies. They should not stop or substitute medicines without discussing clinical suitability with a qualified professional. Hospitals and pharmacies should make these options easier to access rather than placing the full burden on the patient.

Appeals and exceptions may be available when a formulary does not cover the clinically appropriate medicine. Clinicians can help by documenting medical necessity and considering cost during shared decision-making. A prescription that the patient cannot afford is not an effective treatment plan.

Conclusion

Healthcare price discrimination arises through negotiated rates, statutory rebates, formularies, volume purchasing, discounts, and differences in bargaining power. Drug manufacturers discount products to obtain access and volume; providers negotiate with insurers; uninsured patients may face high published charges but can also qualify for self-pay or charity discounts. Cash prescription prices sometimes fall below insured prices, particularly during deductibles, although cash payments may not count toward insurance limits. Hospitals, insurers, pharmacy-benefit managers, Medicaid, the VA, and Medicare operate through different pricing channels, so no purchaser always receives the lowest price. The VA combines statutory and negotiated discounts with a national formulary, Medicaid receives mandatory rebates, and Medicare negotiated prices for its first selected drugs took effect in 2026. Ethical policy should preserve access and innovation while making prices understandable and preventing patients with the least bargaining power from carrying the heaviest burden.

References

Centers for Medicare & Medicaid Services. (2026). *Medicare Drug Price Negotiation Program: Selected drugs and negotiated prices*.

Centers for Medicare & Medicaid Services. (2026). *Medicaid Drug Rebate Program*.

U.S. Department of Veterans Affairs. (2026). *Pharmaceutical prices: Federal Supply Schedule and national contracts*.

U.S. Government Accountability Office. (2021). *Prescription drugs: Department of Veterans Affairs*

paid about half as much as Medicare Part D for selected drugs.

Anderson, G. F. (2007). From “soak the rich” to “soak the poor”: Recent trends in hospital pricing. *Health Affairs, 26*(3), 780–789.