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Medical Industry has a Real Average Wholesale Price (AWP)

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"They're trying to take our health insurance away! We can't let them!" cried Laurie on a long-distance call to her friend who hasn't carried insurance and has been living with pain since Obamacare kicked in.

Republicans ran on a platform of Repeal and Replace, and at least they got rid of the jizyah tax. Meanwhile, as predicted, the healthcare industry is consolidating, demand is growing, and resources are being rationed. Overcharged, by Charles Silver and David Hyman, takes a careful look at what's wrong with this picture. Page after page, egregious examples of waste, fraud, and abuse are illuminated, exposing glaringly obvious room for reform.

A review cannot do justice to the book's 400+ pages of apolitical information. In fact, any two pages selected at random would likely contain enough material for a good article. The text advances the healthcare debate beyond spun rhetorical sound-bites designed to score points for our side.

While the book is by no means comprehensive – the authors decided to write only about instances of fraud involving over $500 million and still had too much material – one's head will soon spin as the costs of unduplicated strategies employed to game the system are laid out.

While it sometimes appears that medical practitioners and establishments these days are in the business of not getting sued, Silver and Hyman see healthcare in America as designed to transfer money to lobbying interests. Health and welfare are secondary.

To start, the healthcare sector comprises slightly less than one-fifth of the US economy, and over $1 trillion a year, or one/third of the sector, is lost to waste, fraud, and abuse. A natural response echoes the old refrain, "What's your problem? Government's the answer." But government's intervention in the healthcare market has amplified and institutionalized waste, fraud, and abuse.

We are told government must intervene because healthcare is essential to the right to life, but so is food, and nobody is asking for food insurance. Since it's on a trajectory toward insolvency, one reasonable reform would be to pattern health insurance after automobile insurance. Auto insurance doesn't pay for day-to-day maintenance costs like fill-ups and oil changes. It does pay for catastrophic loss. Since the poor will always be among us, the authors have no problem with a very thin, public safety net for those who can't afford basic maintenance.

Government is unlikely to make the necessary changes, though, due to a strong lobby. Granted, no politician wants to be known as the guy who pulled the plug on Mom's life support or took the AIDS meds away from Junior. But talk of repealing Obamacare led to pharmaceutical companies diverting millions of dollars more into lobbying activities and donations to candidates.

This was on top of the fact that high-powered pharmaceutical executives are often appointed to key positions in federal regulatory agencies. It's no secret that independent entrepreneurs with a good idea find it difficult to enter the industry due to barriers like FDA approval processes, insurance requirements, and volume minima.

Even large hospitals, deciding it is more humane to allocate limited resources toward healing the sick than building out administrative staffing to process unhelpful but mandatory paperwork, are selling-out in an epidemic of mergers. Small, and even large, insurers are also being squeezed out of the market by department-scale demands for paperwork processing.

While the authors say the problem of third-party payment is secondary, the theme recurs over and over in the text. In simple markets, people trade. If the price is too high, the buyer shops for a better price, motivating the seller to lower his price. In American medicine, people never see the price. They just see their premiums and copays and let the insurance company handle the rest.

Medicare and Medicaid, unfortunately, are designed with a lot of perverse incentives that drive even well-meaning people to make uneconomic choices. The book covers several stories where the incentives drove less-ethical practitioners to scam reimbursement agencies, even when it meant patients would suffer irreversible damage or risk death.

The authors observed that anytime they thought they found a record-breaking medicine markup, they'd turn around and find something even higher. After reading about several examples, one would not even raise an eyebrow over a 1000% markup for a single pill from a billion-dollar company. Insulated from market forces, there's nothing stopping pharmaceutical companies.

They buy patent extensions to own monopolies and then present anybody who questions them with the false dilemma of either paying the markup or causing unnecessary suffering. Companies often claim the high prices are to cover the costs of research and development, when, in fact, much research anymore is conducted with low-risk public funding. The trend continues even though, when the book was published, the average price of a year's supply of a specialty drug was $53,384.

It is no secret that the medical industry has a real average wholesale price (AWP), which is paid to vendors, and what the authors call a Redbook AWP, which is billed to Medicare and Medicaid. Medicare and Medicaid are prohibited by law from negotiating prices, the official reason being the practice could give the government agencies the appearance of playing favorites with private industries.

This created another sky-is-the-limit environment for pricing. Whereas outrageous pricing in a free market signals a no-sale that applies downward pressure, outrageous pricing with Medicare and Medicaid motivates more sales because it translates to a wider profit margin. The General Accounting Office estimated pharmacies reap $0.5 billion more a year from Medicare alone by switching to vendors offering the most outrageous markups. Another anti-market phenomenon

observed in the healthcare industry is that prices rise to meet, rather than decrease to undercut, the competition.

Charities and coupons, marketed as helping the poor with artificially-excessive pricing, don't help in the long run. Big pharmaceutical companies have their own charities, so when they deliver expensive drugs to income-qualified individuals, pharmacies still capture the Medicare or Medicaid reimbursement, and suppliers write off the purchase price for taxes, while charging heavy fees to cover the costs of operating a high-salary office.

Pharmaceutical companies have large legal departments who can figure out how to do this without running afoul of anti-kickback laws. Coupons also work to leverage the markups, as John Graham of the DSS exposed by trying to get coupons with and without insurance.

Like any industry, healthcare is susceptible to bad actors. Cases documented include diluting doses and charging full price, overprescribing treatments to the point of fatally implanting dozens of stents, performing unnecessary and irreversible procedures, and prescribing drugs that may not work.

Overuse of antibiotics, the authors say, is as old as the treatments themselves, with estimates of overprescription running around 50%-100%. Opioid overprescription is but a blip on the radar. Supposedly preventive medicine, in the form of unnecessary X-rays, and a host of operations with results no better than those of placebos, continue to be conducted with a cost of post-operative complications for patients but profits, in the case of arthroscopic knee surgery for arthritis, of $3 billion a year. The cost of unnecessary medical tests is estimated at $200 billion a year.

Sometimes, practitioners have been caught perpetrating nothing short of heists. In those cases, the money could be gone, so the hospital or other organization with which the professional was working ends up paying a settlement, driving up operational costs and creating more demand for malpractice protections. Sometimes research concludes a certain procedure is ineffective, inferior, or even dangerous.

The authors cite a couple case studies when this happened and lobbyists swarmed legislators to protect those procedures and their revenue streams. Although Obamacare was supposed to make the practice of medicine more outcomes-based, it only addressed this by setting up the Patient-Centered Outcomes Research Institute to compare different tests, not the cost-effectiveness of either; and it further forbids any of the institute's findings to be used in actuarial decisions.

Legislators' hands are tied because, quoting the authors with updates, "Between 1998 and 2018, the pharma sector 'donated' $4.0 billion to congressional campaigns – 45% more than the second-largest contributing industry. Hospitals and nursing homes contributed another $1.6 billion. Physicians and other health professionals added still another $1.5 billion." The second-largest contributing industry, incidentally, is insurance, which has contributed $2.8 billion. Guess who pays?

More importantly, while helping those in pain is very important, as with any humanitarian endeavor, leaving that responsibility to government sterilizes charity by putting a wall between the donor and the receiver, thus leaving both blind to natural ties that used to bind. Donors grudgingly pay more taxes and don't see the fruits of their sacrifice.

Receivers come to expect what they view as free money from the government. Another casualty is self-respect. When governments treat their citizens patronizingly, as they do when they build a bureaucratic web so complex, mere mortals need navigators to make sure they don't heal themselves illegally, the population suffers what is known as learned helplessness.

After a careful and reflective review of Overcharged, it is fair to ask how government involvement in other basic human affairs has introduced the same problems. Has homelessness decreased as government assumes increasingly greater responsibility for the real estate market?

Has industry boomed and kept up with technology since government started "picking winners and losers" with economic development incentives? Are communities really feeling those economic multipliers? Those questions, of course, are secondary, since people come with a survival instinct that counters bad policies by creating alternative markets.

The key question is: Is government assuring equal opportunity for all by doing its noncontroversial job of applying laws long on the books against fraud?