Even at this stage, the principal–agent problem arises in yet another odd form. Although one could describe the insurer as the principal – given that the insurer pays much of the cost – patients can work directly with pharmaceutical companies to change what *they* pay while still pushing the bulk of the cost onto the insurer. Many pharmaceutical companies provide co-pay "coupons" or "rebates" directly to patients. These incentives discount the patient's out-of-pocket costs for drugs at the point of sale, perhaps influencing the patient to purchase expensive drugs while shifting all cost (and risk) onto insurers. Thus, to paraphrase Stephen Hawking, it is principals and agents all the way down.[68]

The economic implications of such coupons are an ongoing subject of debate in pharmaceutical pricing. Massachusetts was the only state to have banned these coupons until its law was repealed (for drugs without generic equivalents) in 2012, and federal health insurance (including Medicare, Medicaid, and veterans' benefits) users are ineligible for coupon benefits under antikickback laws.[69]

If the description of the process was confusing, that is because it is. There is a complete disconnection at every step of the process. Patients require drugs, have little idea about cost, and will only pay a small percentage of it anyway, sharply affecting their ability to respond to price. Doctors also do not respond to price, given that they are tasked with a mandate of efficacy and face no financial consequence for their prescription habits. Insurers and PBMs attempt to reduce their costs by making deals with wholesalers and pharmaceutical companies, which influence the actions of doctors, pharmacists, and patients. Those insurers and PBMs, however, face the majority of the cost for the drug despite having little to no influence over its prescription by the doctor and purchase by the patient. If you were for some reason looking for a reason to feel bad for insurance companies, there it is. But perhaps you should feel only a little bad; this completely decoupled chain of pricing information and responsibility eventually leads to higher premiums, low price sensitivity, and an opportunity for pharmaceutical companies to take advantage of the complexity by raising prices for everyone.

[68] Stephen Hawking, A Brief History of Time (1988).

[69] *See* David Schultz, *Drug Coupons: A Good Deal for the Patient, but Not the Insurer*, Kaiser Health News (Oct. 1, 2012), http://khn.org/news/drug-coupons/ (noting laws preventing those on federal health insurance from using coupons and detailing the debate over co-pay rebates); Karen Weintraub, *Mass., 50th State, Now Allows Drug Coupons: What You Need to Know*, WBUR (July 16, 2012, 9:40 AM), http://commonhealth.wbur.org/2012/07/drug-coupons-massachusetts (covering repeal of Massachusetts's drug coupon law); *see also* Charles Ornstein, *Are Copay Coupons Actually Making Drugs More Expensive?* ProPublica (Jun. 30, 2016), www.propublica.org/article/are-copay-coupons-actually-making-drugs-more-expensive?utm_campaign=sprout&utm_medium=social&utm_source=twitter&utm_content=1467295822; Johnson, *Secret Rebates, Coupons, and Exclusions*, *supra* note 63.