PLAN SPONSOR · CONTRACT REVIEWED

# HAMILTON COUNTY

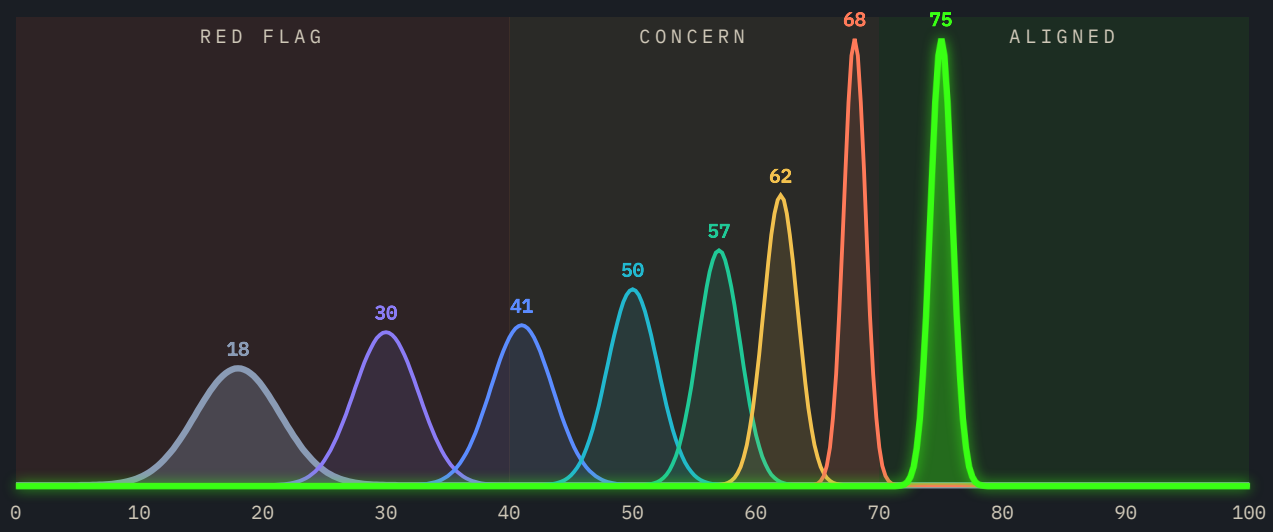
Indiana · Self-funded governmental plan · Anthem administrative services agreement with Pharmacy Services Schedule (CarelonRx) · 13 provisions, 60 checks

## Eight clauses carry the whole case. *Three of them decide the money.*

*The county pays for the savings, keeps none of the medical drug rebates, and is charged more if it shops its pharmacy benefit.*

SCORE PATH · TODAY TO ALIGNED

8 CURVES · TODAY, THEN EACH SET OF AMENDMENTS




Composite fiduciary score, 0–100 (modeled distribution; width reflects terms still unread or silent)

- **Today, as written** — score 18 · ±5.7 (90%)
- **Move 1 · rebates** — score 30 · ±4.3 (90%)
- **Moves 1–3 · exit toll, savings fees** — score 41 · ±4.1 (90%)
- **Moves 1–4 · audit right** — score 50 · ±3.4 (90%)
- **Moves 1–5 · data, confidentiality** — score 57 · ±2.8 (90%)
- **Moves 1–6 · notice of changes** — score 62 · ±2.3 (90%)
- **Moves 1–8 · guarantees, disclosure** — score 68 · ±1.5 (90%)
- **All nine moves** — score 75 · ±1.5 (90%)

**18**
**/100**
RED FLAG band
Composite fiduciary alignment score

**100%**
**of Medical Drug Rebates**
Retained by Anthem under the agreement's own wording

**50%**
**of reported "savings"**
Paid back to Anthem as network and non-network fees

**+57**
**points available**
From nine amendments, reaching the aligned band (75)

# Eight clauses. Twenty-two findings. *One score: 18.*

Sixty checks across thirteen provisions were run against the 2025 Anthem agreement. Twenty-two land on contract language that works against the county, and all twenty-two rest on just eight clauses. The other thirty-eight are silences: questions the county is entitled to ask and Anthem should answer in writing.

**100%**

### Of Medical Drug Rebates stay with Anthem

Manufacturer payments on drugs given in clinics and infusion centers and billed through the medical plan. The county funds the claims and keeps none of the money they generate. Nationally, 43% of employers receive at least some medical rebates.

**50%**

### Of every reported "saving" is paid back as a fee

On network and non-network claims, Anthem earns half the gap between billed charges and what the plan pays. That rewards a high starting price as much as a low final one. On $1 million of reported savings, $500,000 goes to Anthem.

**Exit toll**

### Carve out pharmacy and Anthem may reset its fees

If the county moves its pharmacy benefit, Anthem may amend the administrative fees, with no cap. That reopener prices every competing PBM bid before one is ever requested.

WHAT THE COUNTY SHOULD DO FIRST

*"Send us Schedule A, a 2025 report of Medical Drug Rebates collected on county claims, and a written cap on any fee change tied to a pharmacy carve-out."*

# Three yardsticks: market, best practice, federal law. *The contract trails all three.*

**18.3**
Composite score, 0–100. Red-flag band is below 40.

**−81.8**
Points lost to a fully protective contract, across 13 provisions

**53%**
Of lost points sit in 5 provisions: rebates, spread, pricing, specialty, transparency

**+25**
Expected points if the 38 silent checks are answered at even odds (90% range +19 to +31)

| PROVISION (RANKED BY POINTS LOST) | SCORE | WEIGHT | POINTS LOST | BEST-PRACTICE STANDARD | HAMILTON COUNTY, AGAINST MARKET OR LAW |
|---|---|---|---|---|---|
| **Rebates and manufacturer revenue** Clauses 1 · 1/6 checks cited | 0.5 | 12% | −11.4 | 100% of all manufacturer revenue, paid within 60 days of quarter-end, with interest if late (PBGH) | 43% of employers receive any medical rebates (PSG 2026); county receives 0% |
| **Spread pricing** Clauses 3, 4, 6 · 3/4 checks cited | 1.5 | 12% | −10.2 | Spread prohibited; pharmacy fees (DIR, GER, BER) returned pro rata (PBGH) | 50% savings fee, at the top of the documented range ("as high as 50%") |
| **Pricing and reimbursement** Clauses 1, 4 · 2/6 checks cited | 2.5 | 10% | −7.5 | Client pays exactly what the pharmacy or provider is paid (pass-through) (PBGH) | Provider contracts the county cannot read govern the price |
| **Specialty drug management** Clauses 1, 4 · 3/5 checks cited | 1.0 | 8% | −7.2 | Specialty list changes on 30 days' written notice; all specialty revenue passed through (PBGH) | Medical-benefit specialty rebates retained in full |
| **Transparency and disclosure** Clauses 1, 6 · 2/5 checks cited | 1.5 | 8% | −6.8 | Disclose all revenue, including payments to the client's advisers (PBGH) | Trade-secret legend on a public body's contract |
| **Pharmacy network design** Clauses 3, 4 · 2/5 checks cited | 2.0 | 8% | −6.4 | Affiliated-pharmacy claims reported separately; network terms disclosed (PBGH) | Pharmacy Services Schedule not in file |
| **Audit rights and recovery** Clauses 6, 8 · 2/5 checks cited | 2.5 | 8% | −6.0 | Auditor of client's choice; ~3-year lookback; PBM pays if errors exceed 5% (PBGH) | No audit clause; contingency fees capped per claim, not per year |
| **Formulary control** Clauses 5 · 1/5 checks cited | 2.0 | 7% | −5.6 | PBM changes discussed 90 days ahead; client may accept, reject or grandfather (PBGH) | Policies apply "as amended from time to time": 0 days required |
| **Performance guarantees** Clauses 7 · 1/4 checks cited | 3.0 | 7% | −4.9 | Money-back guarantees on rebates, discounts, service and adherence (PBGH) | 25% oversight fee with no savings guarantee |
| **Termination and exit barriers** Clauses 2 · 2/4 checks cited | 2.5 | 6% | −4.5 | 60 days' carve-out notice; ASO fee adjustment negotiated and stated (PBGH) | Uncapped fee reopener if pharmacy is carved out |
| **Fiduciary and legal protections** Clauses 1 · 1/4 checks cited | 1.5 | 5% | −4.2 | PBM acts in the client's best interest; advisers unconflicted (PBGH) | No indemnity for Anthem errors; no compensation disclosure |
| **Claim adjudication logic** Clauses 4, 5 · 2/4 checks cited | 2.0 | 5% | −4.0 | Plan terms control; no unilateral policy change without notice (KHiQ) | Provider contracts and amended policies override the plan |
| **Data ownership and access** Clauses None · 0/3 checks cited | 2.5 | 4% | −3.0 | Claim-level data at no charge, directed to the client's designee (PBGH) | No data clause found |

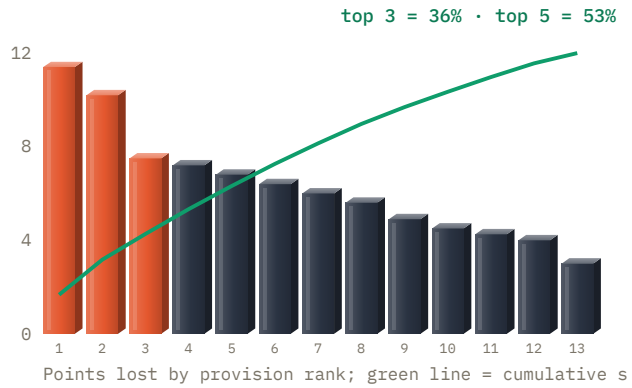
Score 0–10 per provision (10 = fully protective). Points lost = (10 − score) × weight ÷ 10. Standards: PBGH = Purchaser Business Group on Health PBM Common Purchasing Standards (2023); KHiQ = Kincaid Health iQ standard where PBGH is silent.

# Where the gap sits, *and what silence is worth.*

The same thirteen provisions, decomposed: which ones carry the lost points, where the county sits on the terms the market measures, and how much the unread schedules could move the score.

PARETO · WHERE THE 81.8 LOST POINTS SIT

## Three provisions, a third of the gap




MARKET POSITION · QUANTIFIABLE TERMS

## Coral = county · navy tick = market · green = standard

**Medical drug rebates passed to plan**

County: 0% · Market: 43% of employers receive any (PSG 2026) · Standard: 100% (PBGH)

**Savings fee as share of reported savings**

County: 50% · Market: Documented "as high as 50%" (Health Affairs 2025) · Standard: 0% or flat fee (KHiQ)

**Notice before formulary or policy change**

County: 0 days · Market: no survey figure · Standard: 90 days (PBGH)

**Rebate payment timing**

County: None stated · Market: no survey figure · Standard: ≤60 days after quarter (PBGH)

1 · SILENCE HAS A VALUE

38 of 60 checks found no governing language. Modeled at even odds, producing Schedule A and the Pharmacy Services Schedule is worth **+25 points** in expectation (90% range +19 to +31): the cheapest move the county has.

2 · AT THE CEILING, NOT THE MEDIAN

Shared-savings fees have been documented "as high as 50 percent" of the billed-to-paid gap. Anthem's fee **is** 50%, on both network and non-network claims. Medical rebates: 43% of employers receive some; the county's contract guarantees it receives none.

3 · THE FEDERAL FLOOR

As a governmental plan, the county sits outside ERISA, but CAA 2021's gag-clause ban and broker-compensation disclosure apply through the Public Health Service Act. CAA 2026 PBM reforms are largely ERISA-based, and DOL's PBM fee-disclosure rule is still proposed: counsel should confirm reach.

# The three clauses *that decide the money.*

## 1 REBATES · SPECIALTY · TRANSPARENCY — HIGH

### Anthem keeps every Medical Drug Rebate

> "Anthem shall retain 100% of the Medical Drug Rebates."

**WHAT IT DOES**
Manufacturer rebates on drugs billed through the medical plan, such as infusions and injectables given in a clinic, stay with Anthem in full.

**WHY IT COSTS**
These are often the highest-cost drugs a plan buys. The county funds the claims and receives none of the manufacturer money. It also removes any reason to steer toward the lowest net-cost product.

**THE ASK**
100% pass-through, paid quarterly, with a claim-level report. Until then, an annual report of rebates Anthem collected on county claims.

MODEL LANGUAGE
*"Anthem shall remit to Employer 100% of Medical Drug Rebates and other manufacturer payments attributable to Employer's Claims within 90 days of receipt, with a report identifying each drug, Claim count, and amount received."*

## 2 TERMINATION · EXIT BARRIERS — HIGH

### Carving out pharmacy lets Anthem reset its fees

> "If Employer terminates the Pharmacy Services Schedule with PBM at any time, then Anthem shall have the right to amend the Administrative Services Fees indicated in Section 3 of Schedule A of this Agreement."

**WHAT IT DOES**
Ties the medical fee to keeping Anthem's PBM. Leaving the pharmacy benefit opens the medical price.

**WHY IT COSTS**
An unknown fee increase is a penalty with no ceiling. Every competing PBM proposal must beat its own price and the unknown reopener.

**THE ASK**
State the carve-out fee now, in dollars per employee per month, or cap any change. A fee known in advance is a price; one set afterward is leverage.

MODEL LANGUAGE
*"If Employer terminates the Pharmacy Services Schedule, the Administrative Services Fees shall increase by no more than $[X] per employee per month for the remainder of the then-current term."*

## 3 PRICING · NETWORK DESIGN — HIGH

### Anthem is paid half of the savings it reports

> "Traditional Network Savings Fee... is equal to 50% per Claim... Non-Network Savings Fee... Employer will pay a fee equal to 50% of the difference between the non-Network Provider's Billed Charges and the amount Anthem uses to calculate Plan liability."

**WHAT IT DOES**
On qualifying claims, Anthem earns half the gap between a provider's billed charge and the amount the plan pays.

**WHY IT COSTS**
Billed charges are list prices few people pay. The fee grows with the inflation of the starting number, not the quality of the outcome.

**THE ASK**
A flat per-claim fee or an annual cap on all savings-based fees, plus a monthly report of savings fees by claim.

MODEL LANGUAGE
*"All savings-based fees combined shall not exceed $[X] per plan year, and shall be calculated only against the lesser of Billed Charges or [150]% of Medicare."*

# Three clauses *that make it hard to see.*

4 PRICING · ADJUDICATION · SPECIALTY — HIGH

## Provider contracts the county cannot see govern the price

> "Provider contracts will govern the rights and obligations as between the Parties and Providers (e.g., reimbursement rates and methodologies, filing and Claim adjustment time frames, and high dollar Claim review)."

**WHAT IT DOES**
Where the agreement and a provider contract conflict, the provider contract wins, including on rates, adjustment windows and high-dollar review.

**WHY IT COSTS**
The county funds claims priced under terms it has no right to read. Its own agreement can be overridden by documents outside it.

**THE ASK**
A right to audit provider reimbursement for county claims, and a statement that county-favorable terms in this agreement control.

5 FORMULARY · ADJUDICATION — MEDIUM

## Anthem's policies apply "as they may be amended from time to time"

> "Anthem's standard policies and procedures... as they may be amended from time to time, will be used in the provision of services specified in this Agreement."

**WHAT IT DOES**
Lets Anthem change operating rules, including clinical and pricing policy, without an amendment.

**WHY IT COSTS**
A contract that can be rewritten by policy memo is a moving target. The county cannot price a term it does not control.

**THE ASK**
60 days' written notice of any material policy change, a cost-impact estimate, and a right to object or exit without penalty.

6 TRANSPARENCY · AUDIT — MEDIUM

## A trade-secret legend on a public body's contract

> "This document contains confidential and proprietary information, including trade secrets... protected from disclosure under the Freedom of Information Act..."

**WHAT IT DOES**
Asserts that the pricing and terms are protected from disclosure.

**WHY IT COSTS**
It chills the county's own analysis and public oversight. Federal FOIA governs federal agencies; county records fall under Indiana's Access to Public Records Act.

**THE ASK**
A clause confirming the county may share the agreement and claims data with its auditors, consultants and counsel, and that APRA governs disclosure.

# Two clauses *that add fees on top.*

7 PERFORMANCE · INCENTIVES

MEDIUM

## A 25% oversight fee on provider performance bonuses

> "Such fee shall be 25% of the per attributed Member per month amount charged to Employer for the Provider performance bonus portion..."

**WHAT IT DOES**

Adds 25% on top of value-based bonus payments the county funds for attributed members.

**WHY IT COSTS**

The county pays the bonus and a quarter more for oversight, with no stated savings guarantee behind either.

**THE ASK**

Program results by year: attributed members, bonuses paid, measured savings. Tie the fee to verified net savings or remove it.

8 AUDIT · FEES

MEDIUM

## Contingency fees capped per claim, not per year

> "The fee for Overpayment Identification, Prevention, and Claims Prepayment Analysis Activities will not exceed $25,000.00 per Claim."

**WHAT IT DOES**

Anthem earns fees for finding overpayments and for pricing claims through a tool, capped only claim by claim.

**WHY IT COSTS**

Ten large claims can carry up to $250,000 in fees. Payment-integrity work the county might expect as core administration becomes a separate revenue line.

**THE ASK**

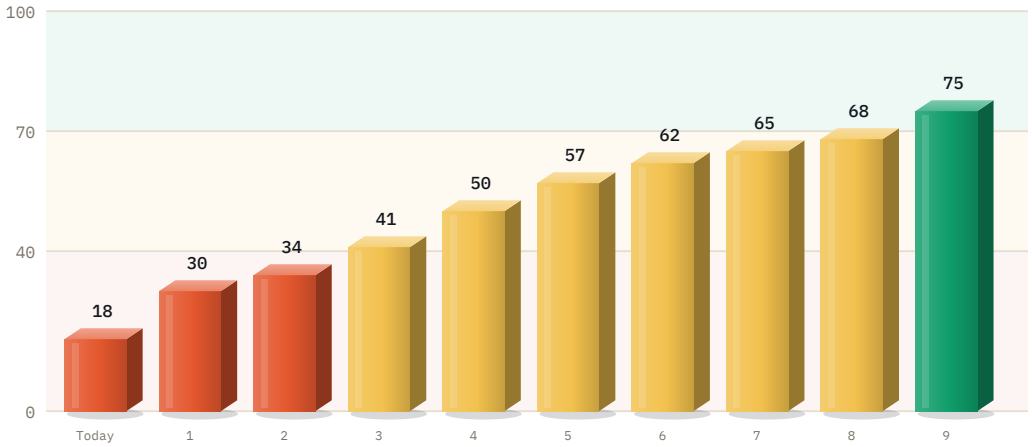
An annual cap, a quarterly fee report, and a rule that errors Anthem itself made are corrected at no charge.

# Nine amendments. *From 18 to 75.*

The score describes the contract the county was offered, and contracts can be amended. The first three moves lift the county out of the red-flag band; the full package reaches the aligned band.

SCORE LIFT ROADMAP

## The first three moves do more than half the work




Composite score after each amendment, applied in order. Bands: below 40 red flag · 40–69 concern · 70+ aligned.

| # | AMENDMENT | WHAT THE CONTRACT MUST SAY | POINTS | SCORE |
|---|---|---|---|---|
| 1 | **Pass Medical Drug Rebates through to the county** | 100% pass-through within 90 days, reported by drug and claim | +12.2 | 30 |
| 2 | **Price the pharmacy exit today** | A capped dollar change in medical fees if pharmacy is carved out, plus full data return at exit | +3.6 | 34 |
| 3 | **Cap the savings fees** | An annual dollar cap, measured against a Medicare-based reference rather than billed charges | +6.6 | 41 |
| 4 | **Write in the audit right and put the agreement first** | Annual audit of claims, provider pay, rebates and fees; 36-month lookback; county-favorable terms beat provider contracts | +9.4 | 50 |
| 5 | **Claim the data and settle confidentiality** | County owns its data; monthly claim-level files; Indiana APRA and the federal gag-clause ban govern | +7.4 | 57 |
| 6 | **Require notice before policy changes** | 60 days' notice, a cost estimate and a right to decline formulary and policy changes | +4.2 | 62 |
| 7 | **Add guarantees and tie the 25% fee to savings** | At least 15% of fees at risk; oversight fee paid only from documented net savings | +3.1 | 65 |
| 8 | **Disclose all compensation and balance the risk** | Annual disclosure of all Anthem and affiliate revenue; indemnity for Anthem errors; broker disclosure alongside | +2.8 | 68 |
| 9 | **Produce and fix the Pharmacy Services Schedule** | Pass-through pharmacy pricing, disclosed network terms, no forced use of affiliated pharmacies | +7.6 | 75 |

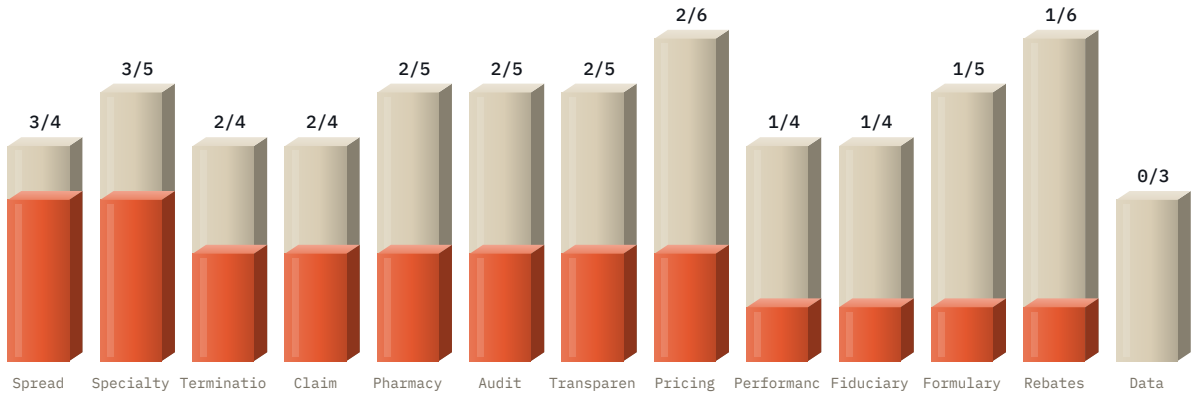
# Thirteen provisions *at a glance.*

| # | PROVISION | CLAUSES | EVIDENCE | SCORE | WEIGHT | STATUS |
|---|---|---|---|---|---|---|
| 1 | **Pricing and reimbursement** | 1, 4 | 2/6 | **2.5** | 10% | ADVERSE TEXT |
| 2 | **Spread pricing** | 3, 4, 6 | 3/4 | **1.5** | 12% | ADVERSE TEXT |
| 3 | **Rebates and manufacturer revenue** | 1 | 1/6 | **0.5** | 12% | ADVERSE TEXT |
| 4 | **Formulary control** | 5 | 1/5 | **2.0** | 7% | ADVERSE TEXT |
| 5 | **Pharmacy network design** | 3, 4 | 2/5 | **2.0** | 8% | REQUEST SCHEDULE |
| 6 | **Specialty drug management** | 1, 4 | 3/5 | **1.0** | 8% | ADVERSE TEXT |
| 7 | **Audit rights and recovery** | 6, 8 | 2/5 | **2.5** | 8% | SILENT |
| 8 | **Transparency and disclosure** | 1, 6 | 2/5 | **1.5** | 8% | ADVERSE TEXT |
| 9 | **Performance guarantees** | 7 | 1/4 | **3.0** | 7% | SILENT |
| 10 | **Termination and exit barriers** | 2 | 2/4 | **2.5** | 6% | EXIT TOLL |
| 11 | **Claim adjudication logic** | 4, 5 | 2/4 | **2.0** | 5% | ADVERSE TEXT |
| 12 | **Fiduciary and legal protections** | 1 | 1/4 | **1.5** | 5% | SILENT |
| 13 | **Data ownership and access** | None | 0/3 | **2.5** | 4% | SILENT |
| | **Composite** | 8 clauses | 22/60 | **18.25** | 100% | RED FLAG |

Composite = Σ(score × weight) ÷ 10 = 18.25. Adverse text: quoted language works against the county. Silent: no governing language found; request it. Request schedule: the term lives in the Pharmacy Services Schedule, which was not in the file reviewed.

WHERE THE EVIDENCE ACTUALLY IS

**Pricing, rebates and network findings rest on a handful of clauses. Data rights rest on none.**




Coral: checks citing contract text. Tan: total checks. The Medical Drug Rebate clause alone supports 6 f

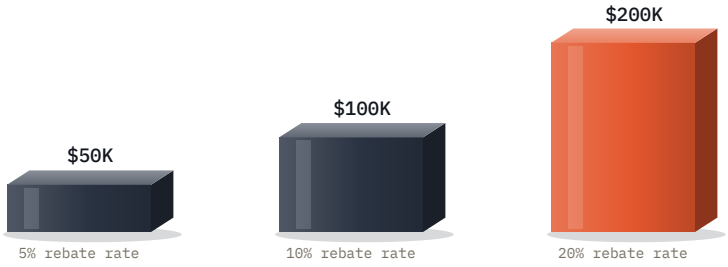
# Sizing the money *without guessing.*

The county does not publish a Form 5500, so participant and spend figures must come from its own claims reports. Two clauses can be sized with arithmetic alone once those figures are in hand.

| CLAUSE | FORMULA | DATA THE COUNTY HAS OR CAN DEMAND |
|---|---|---|
| **Savings fees (Clause 3)** | 50% × reported network and non-network savings, less any cap | Anthem savings reports for 2024 and 2025; fee lines on monthly invoices |
| **Medical Drug Rebates (Clause 1)** | Rebate-eligible medical drug spend × rebate rate actually received by Anthem | Medical pharmacy claims by J-code; Anthem's rebate receipts on county claims |
| **Carve-out reopener (Clause 2)** | Possible fee increase per employee per month × employees × months left in term | Schedule A fees; enrolled employees; remaining contract term |
| **Contingency fees (Clause 8)** | Sum of overpayment and pricing-tool fees, against the $25,000 per-claim cap | Quarterly fee detail by claim |

ILLUSTRATIVE ONLY · MEDICAL DRUG REBATES KEPT PER $1 MILLION OF REBATE-ELIGIBLE MEDICAL DRUG SPEND

### The rate is an assumption until Anthem reports it. The direction is not.




Rates shown are scenarios, not findings. Replace with Anthem's reported rebate receipts on county claims.

WHAT THIS CONTRACT IS, AND WHAT IT IS NOT

| QUESTION | ANSWER FROM THE DOCUMENT | WHY IT MATTERS |
|---|---|---|
| **Type of agreement** | Medical ASO agreement with a separate Pharmacy Services Schedule | Medical fee terms are where the quoted money sits |
| **Pharmacy vendor** | Anthem's affiliated PBM, formerly IngenioRx, now CarelonRx | The pharmacy schedule itself was not in the file reviewed |
| **Plan type** | Self-funded plan of an Indiana county government | Outside ERISA; fiduciary standards reach it through contract, Indiana law and county policy |
| **Federal rules that apply** | CAA 2021 gag-clause ban, broker and consultant compensation disclosure, transparency reporting | A federal footing for data and compensation requests even without ERISA |
| **Public records** | Contract carries a trade-secret and FOIA legend | Indiana's Access to Public Records Act governs county records; the county decides |

# The negotiation playbook, *in order.*

1. **Open with the exit toll.** Ask Anthem to price the pharmacy carve-out in dollars today. If the answer is "we would decide later," that is the finding.

2. **Move Medical Drug Rebates to the county.** Ask for 100% pass-through. As a fallback, a split with a floor and a quarterly claim-level report.

3. **Cap the savings fees.** Annual dollar cap, priced against a Medicare-based reference rather than billed charges.

4. **Put policy changes on notice.** 60 days' notice, a cost estimate and a penalty-free exit for material changes.

5. **Write in the audit right.** Claims, provider reimbursement, rebates and fees; three-year lookback; auditor of the county's choosing; Anthem errors corrected at no charge.

6. **Claim the data.** County ownership of claims data, monthly claim-level files, and full history within 30 days of termination at no charge.

7. **Resolve confidentiality under Indiana law.** APRA governs; the county may share with auditors, consultants and counsel.

8. **Ask who else is paid.** Request the CAA 2021 broker and consultant compensation disclosure. A Kincaid Health iQ Broker Compensation Study places that figure against enrollment so the board can see what advice costs per covered person.

WHERE TO START

*Open the renewal with the first three amendments. Together they add 23 points, and each is a single sentence of contract language. If Anthem accepts them, the remaining moves are routine. If it refuses, the refusal itself is the most useful finding the county will have.*

**Method and limits.** PBM Contract Clarity 360 scores 13 provisions against 60 defined checks, each provision 0 to 10, weighted by economic weight to a 0–100 composite. Adverse text is presented as a finding; silences are presented as requests. Dollar figures appear only as formulas or labeled scenarios. The cover distribution and the "+25 points" estimate are modeled: each silent check is treated as an even-odds unknown, and widths shrink as amendments resolve provisions. This review covers the administrative services agreement as provided; Schedule A, the Pharmacy Services Schedule, provider contracts and side letters were not in the file and may change these conclusions. Because the plan is governmental, ERISA does not govern it directly. Benchmarks: PBGH PBM Common Purchasing Standards (2023); PSG 2026 Trends in Specialty Drug Benefits (medical rebates, as reported); Handorf, Monahan and Watts, Health Affairs (2025), on shared-savings fees; Mintz PBM policy update (Oct. 2026) on CAA 2026 and the proposed DOL rule. Quotations are as extracted and should be matched to section numbers in the executed copy before external use. Not legal advice; Kincaid Health iQ is not a law firm. Prepared by Jeremiah Franklin Shrack, Founder, CEO and Chairman, Kincaid Health iQ.

# KINCAID HEALTH iQ

FIDUCIARY GOVERNANCE • ALGORITHMIC ASSURANCE

## Every clause of your PBM contract, *read for the people who pay for it.*

### PBM Contract Clarity 360

Thirteen provisions, sixty checks, every finding tied to quoted contract language, benchmarked against market data, best-practice standards and federal law.

### Kincaid Health iQ Broker Compensation Study

What your adviser is paid, every way it is paid, set beside enrollment and national peer benchmarks.


Jeremiah Franklin Shrack

Founder, CEO and Chairman, Kincaid Health iQ

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