KINCAID IQ

KINCAID RX DEFENSE PBM CONTRACT X-RAY IQ INTELLIGENCE SERIES

THE HUMAN COST LEDGER — NO. 01

The Refill Was Rationed. The Bonus Was *Not.*

A federal agency found $7.3 billion in markups on the cheapest drugs in the system. The proxy statements show, to the dollar, where it went. One of these two numbers came with a receipt.

Jeremiah F. Shrack • Kincaid IQ • Rx Defense PBM Contract X-Ray

> A patient splits a tablet in half to make the prescription last to the next paycheck. That is not a metaphor. It is a dosing decision made at a kitchen table, by someone who was told they had a benefit. Two thousand miles away, a compensation committee approves a number with four commas in it. The connection between those two events is not moral. It is arithmetic — and only one of the two parties was ever shown the math.

We are told the Pharmacy Benefit Manager exists to lower drug costs through scale. That is the brochure. The structure tells a different story, and for once we do not have to infer it. In January 2025 the Federal Trade Commission published the receipts.

The three companies that sit between every American and their medication — CVS Caremark, Express Scripts, and OptumRx, vertically integrated with CVS Health, Cigna, and UnitedHealth respectively — together administer roughly **80% of all prescriptions filled in the United States.** They do not compete for your attention. You have no relationship with them. You cannot fire them. And yet they decide which drug you get, where you fill it, and what you pay at the window.

> *The system did not fail the patient. It performed exactly as engineered. The patient was simply not the beneficiary of the engineering.*

The Mechanics of a Transfer Nobody Voted For

FOUR STEPS FROM THE PHARMACY COUNTER TO THE PROXY STATEMENT

THE MARKUP WITH A ZIP CODE

MECHANISM 01

The most aggressive markups land on the cheapest drugs — and only at pharmacies the PBM happens to own.

The FTC examined 51 specialty generic drugs across 882 National Drug Codes dispensed from 2017 to 2022. These are not exotic compounds. Many are generics used to treat HIV, cancer, and multiple sclerosis — drugs whose acquisition cost is low. The FTC found the Big Three marked them up by hundreds, and in many cases **thousands of percent** — but specifically when dispensed through their own affiliated specialty pharmacies. The markup was not a function of the drug. It was a function of who owned the counter.

Source: *FTC Second Interim Staff Report on Prescription Drug Middlemen, January 14, 2025.*

THE $7.3 BILLION LINE ITEM

MECHANISM 02

A single category, a five-year window, and a figure that has to land somewhere.

The FTC quantified the excess revenue — the amount collected above the drugs' estimated acquisition cost — at **more than $7.3 billion** across 2017–2022, from specialty generics alone. The agency was careful and conservative: this is one slice of one drug category. The same report documented that pharmacies affiliated with the Big Three captured **68% of all specialty dispensing revenue by 2023, up from 54% in 2016.** The funnel is not widening by accident. It is being engineered to point inward.

Reading note: *$7.3 billion is not a fine. It is not a settlement. It is revenue the structure was built to produce, collected while patient and employer drug spending rose every year.*

THE DISCLOSURE ASYMMETRY

MECHANISM 03

One side of this transaction is documented to the penny. The other side never gets a statement.

Here is the quiet absurdity. When the money arrives at the top, it is disclosed with extraordinary precision. Federal securities law requires it. Every dollar of executive compensation appears in an SEC proxy statement, itemized into base salary, stock awards, option awards, and non-equity incentive. The patient who funded the upstream margin receives no such document. **She gets a copay and a silence.** The system that cannot tell a plan participant what their drug actually cost can tell shareholders the CEO's bonus to the last dollar.

The tell: *Opacity in this market is not a technology problem. The capacity for precise accounting plainly exists. It is simply pointed in one direction.*

THE PAY RATIO IS THE CONFESSION

MECHANISM 04

The disclosed numbers are not the scandal. They are the audit trail.

For 2024, the chief executive of UnitedHealth Group was reported at **$26.3 million** in total compensation — the highest among major health-plan CEOs. Cigna's chief executive was reported at **$23.25 million**, against a CEO-to-median-worker pay ratio of **279 to 1.** In 2025, with a returning chief executive and a one-time equity award, the UnitedHealth figure was reported near **$60.9 million.** None of this is hidden. That is the point. The compensation is the most transparent number in the entire pharmacy supply chain. It is the one figure the system was willing to print.

Source: *SEC proxy filings as compiled by Fierce Healthcare, Modern Healthcare, and Becker's, 2024–2026.*

> *The pharmacy can tell you, to four decimal places, the MAC reimbursement on a generic statin. It cannot tell you what your plan paid for it. The proxy statement can tell you the CEO earned $26,341,000 and not a dollar more. We have built the most precise accounting machine in the history of healthcare and aimed all of its precision at the ceiling.*

Why This Is a Structural Problem, Not a Villain Problem

It is tempting to reach for outrage at individuals. Resist it; the individuals are interchangeable and the structure is not. No single executive designed this. What was designed — deliberately, over two decades of consolidation and vertical integration — is a set of incentives in which the entity that decides which pharmacy you use also owns that pharmacy, sets its price, and reports the resulting margin upward as performance. The patient's cost exposure is not a side effect of that system. **It is the input.**

An economist would call this a misalignment of incentives. A systems engineer would call it doing exactly what it was optimized to do. The machine is not broken. It is operating at specification. The tragedy is that the specification was written by the party on the receiving end of the margin, and ratified by plan sponsors who were never given the schematic.

THE LITIGATOR TAKE

"The disclosure asymmetry is not a defense. In a fiduciary context, it is the exposure."

Strip away the populist framing and what you have is a textbook ERISA problem. A plan sponsor is a fiduciary under **ERISA §404**, obligated to act with prudence and in the sole interest of participants. The arrangements documented by the FTC — affiliated-pharmacy steering, spread on the cheapest drugs, margin reported upward — raise the question every fiduciary-breach case turns on: *did the responsible party understand what they were paying for, and could they have?*

The answer "we relied on the PBM's representations" is not the shield people think it is. Under **§408(b)(2)**, a service arrangement is only exempt from prohibited-transaction rules if the compensation is reasonable and adequately disclosed. When one side reports its take to the

SEC to the dollar and the other side cannot reconstruct the cost of a single claim, "adequately disclosed" becomes a contested fact.

If these structures are borne out in discovery, the question is not whether there is exposure. It is who carries it, and how a court quantifies a harm that landed, one half-tablet at a time, on people who never saw the contract.

— Composite perspective, senior ERISA fiduciary-breach counsel

WHAT RX DEFENSE DOES ABOUT IT

The Rx Defense PBM Contract X-Ray reads the schematic the patient never saw.

The compensation number is disclosed because the law forces it into the light. The margin that funds it stays in the dark because the contract was engineered to keep it there. Rx Defense exists to close that gap — to give the fiduciary the same precision the proxy statement gives the shareholder, before the harm compounds for another plan year.

It operates on the Administrative Services Agreement itself — the document where the steering, the spread, and the definitional sleight-of-hand actually live — and renders it legible at the clause level.

X-RAY Forensic, clause-level decomposition of the ASA — surfacing affiliated-pharmacy steering, definitional carve-outs, and the reconciliation mechanics that quietly retract the guarantees a sponsor was sold.

TRACE Maps each contract term to its participant-level consequence — converting "thousands of percent" from an FTC headline into the specific dollars leaving a specific plan and the specific patients exposed to them.

EVIDENCE Produces a fiduciary-grade, SHA-256 evidence manifest a named ERISA fiduciary can put in front of a board, a broker, and if it comes to it, counsel — documentation that finally points the precision downward.

A NOTE ON STEWARDSHIP

The dignity of the person is not a residual line item.

Catholic social teaching has held for more than a century that the economy exists to serve the person, not the person the economy. In *Rerum Novarum*, Leo XIII insisted that human labor and human need are not commodities to be priced at whatever the market will bear. *Centesimus Annus* reaffirmed the priority of labor over capital — the principle that the worker, and here the patient, is the end and not the means. A pharmacy benefit is, at its root, a promise made to working people: that the cost of staying alive will be borne together. When the architecture of that promise is engineered so that the sickest and the poorest become the funding source for the largest compensation packages in American healthcare, something has been inverted that no efficiency argument can set right. The half-tablet at the kitchen table is not a market signal. It is a person. The first obligation of anyone who touches this system — sponsor, broker, fiduciary, founder — is to remember whose money it was, and whose health it bought.

The transparency is coming whether the industry chooses it or not. The FTC has published two interim reports and continues to litigate. Settlements are beginning to reshape the standard offering. State legislatures are moving. The disclosure asymmetry that protected the margin for twenty years is the one thing regulators are best equipped to dismantle, because they already know how to demand a proxy statement. The only open question is whether plan sponsors read their own contracts before a court reads it for them. The receipts exist. The patient was always entitled to a copy.

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This article analyzes publicly documented market structure, incentives, and legal exposure under ERISA. It cites the FTC's interim staff reports (2024–2025) and executive compensation figures disclosed in SEC proxy filings. It does not allege that any named company or individual has violated any law. Nothing herein constitutes legal, financial, or actuarial advice. Plan sponsors and fiduciaries should consult qualified ERISA counsel regarding their specific arrangements.