KINCAID HEALTH

FIDUCIARY GOVERNANCE • ALGORITHMIC ASSURANCE

PBM CONTRACT CLARITY 360 • CONTRACT FIDUCIARY ANALYSIS • 2025 AGREEMENT

Hamilton County and Anthem: *Eight Clauses Carry the Whole Case.*

A forensic reading of the 2025 Anthem administrative services agreement and its Pharmacy Services Schedule. Every finding is tied to quoted contract language. Where the contract is silent, we say so and name the document to request.

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NOVEMBER 6, 2026

100%
Of Medical Drug Rebates retained by Anthem under the agreement's own wording

50%
Of every dollar of network and non-network "savings" paid back to Anthem as a fee

18/100
Composite fiduciary alignment score across 13 provisions and 60 checks

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

SCORE LIFT ROADMAP

How Hamilton County Raises Its Fiduciary Score

The score of 18 out of 100 is not a verdict on the county. It describes the contract the county was offered, and contracts can be amended. Each move below is a specific amendment, drafted in full in Appendix C. Applied in order, three amendments lift the county out of the red-flag band, four reach the midpoint, and the full package reaches the aligned band.

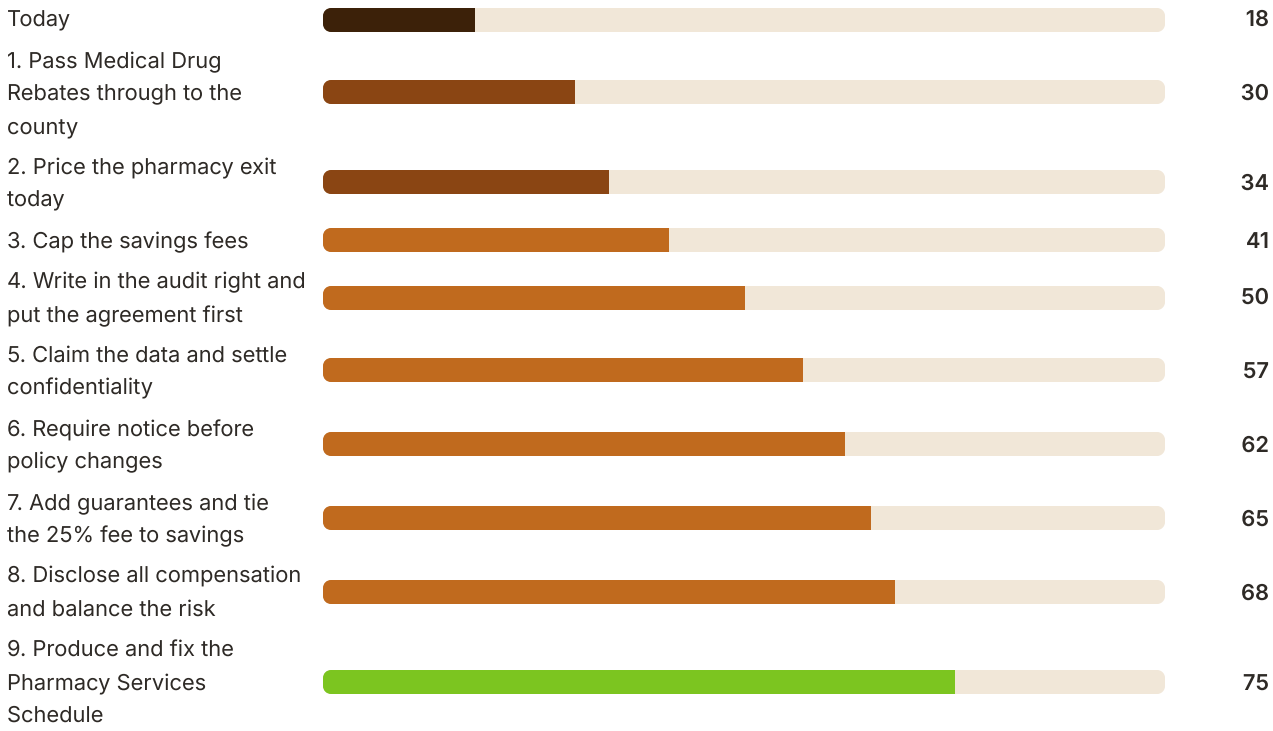
41
Score after the first three amendments: rebates, exit toll, savings fees. Out of the red-flag band

50
Score after adding the audit right and putting the agreement ahead of provider contracts

75
Score with all nine moves, including a fixed Pharmacy Services Schedule. Aligned band (70 and above)

EXHIBIT • COMPOSITE SCORE AFTER EACH AMENDMENT, APPLIED IN ORDER

The first three moves do more than half the work



BANDS: BELOW 40 RED FLAG • 40–69 CONCERN • 70 AND ABOVE ALIGNED. PROJECTED PROVISION SCORES ASSUME THE AMENDMENT IS ADOPTED AS DRAFTED AND ARE ASSESSED ON THE SAME 0 TO 10 SCALE AS APPENDIX B.

#	AMENDMENT	FIXES	WHAT THE CONTRACT MUST SAY	PROVISIONS LIFTED	POINTS	SCORE
1	**Pass Medical Drug Rebates through to the county**	Clause 1	100% pass-through within 90 days, reported by drug and claim	Rebates and Manufacturer Revenue 0.5 to 8.0, Specialty Drug Management 1.0 to 5.0	+12.2	30

2	**Price the pharmacy exit today**	Clause 2	A capped dollar change in medical fees if pharmacy is carved out, plus full data return at exit	Termination and Exit Barriers 2.5 to 8.5	+3.6	34
3	**Cap the savings fees**	Clause 3	An annual dollar cap, measured against a Medicare-based reference rather than billed charges	Spread Pricing 1.5 to 7.0	+6.6	41
4	**Write in the audit right and put the agreement first**	Clause 4	Annual audit of claims, provider pay, rebates and fees, 36-month lookback; county-favorable terms beat provider contracts	Audit Rights and Recovery 2.5 to 8.0, Pricing and Reimbursement 2.5 to 6.0, Claim Adjudication Logic 2.0 to 5.0	+9.4	50
5	**Claim the data and settle confidentiality**	Clause 6	County owns its data; monthly claim-level files; Indiana public records law and the federal gag-clause ban govern	Transparency and Disclosure 1.5 to 7.5, Data Ownership and Access Rights 2.5 to 9.0	+7.4	57
6	**Require notice before policy changes**	Clause 5	60 days' notice, a cost estimate and a right to decline formulary and policy changes	Formulary Control 2.0 to 6.5, Claim Adjudication Logic 5.0 to 7.0	+4.2	62
7	**Add guarantees and tie the 25% fee to savings**	Clause 7	At least 15% of fees at risk; oversight fee paid only from documented net savings	Performance Guarantees 3.0 to 7.5	+3.1	65
8	**Disclose all compensation and balance the risk**	Clause 8	Annual disclosure of all Anthem and affiliate revenue; indemnity for Anthem errors; broker disclosure alongside	Fiduciary and Legal Protections 1.5 to 7.0	+2.8	68
9	**Produce and fix the Pharmacy Services Schedule**	Schedule	Pass-through pharmacy pricing, disclosed network terms, no forced use of affiliated pharmacies	Pharmacy Network Design 2.0 to 7.0, Pricing and Reimbursement 6.0 to 8.0, Specialty Drug Management 5.0 to 7.0	+7.6	75

WHERE TO START

Open the renewal with the first three amendments. Together they add 22 points, and each one 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.

Moves that cost the county nothing

1. Ask for the documents first. A written request for Schedule A, the Pharmacy Services Schedule and 2025 rebate receipts changes no contract term, but it turns every silent check into a scoreable one.
2. Rescore at renewal. PBM Contract Clarity 360 can rescore the amended agreement line by line, so the board sees the number move before it votes.
3. Ask the adviser too. A Kincaid Health Broker Compensation Study shows whether the county's broker is paid in a way that rewards these amendments or the status quo.

Contents

	Score Lift Roadmap	Nine amendments that raise the score from 18 to 75, in order
1	Executive Verdict and Critical Issues	The eight clauses, the evidence map, and all 22 adverse findings ranked
2	Provision 1: Pricing and Reimbursement	6 checks • score 2.5 of 10 • weight 10%
3	Provision 2: Spread Pricing	4 checks • score 1.5 of 10 • weight 12%
4	Provision 3: Rebates and Manufacturer Revenue	6 checks • score 0.5 of 10 • weight 12%
5	Provision 4: Formulary Control	5 checks • score 2.0 of 10 • weight 7%
6	Provision 5: Pharmacy Network Design	5 checks • score 2.0 of 10 • weight 8%
7	Provision 6: Specialty Drug Management	5 checks • score 1.0 of 10 • weight 8%
8	Provision 7: Audit Rights and Recovery	5 checks • score 2.5 of 10 • weight 8%
9	Provision 8: Transparency and Disclosure	5 checks • score 1.5 of 10 • weight 8%
10	Provision 9: Performance Guarantees	4 checks • score 3.0 of 10 • weight 7%
11	Provision 10: Termination and Exit Barriers	4 checks • score 2.5 of 10 • weight 6%
12	Provision 11: Claim Adjudication Logic	4 checks • score 2.0 of 10 • weight 5%
13	Provision 12: Fiduciary and Legal Protections	4 checks • score 1.5 of 10 • weight 5%
14	Provision 13: Data Ownership and Access Rights	3 checks • score 2.5 of 10 • weight 4%
15	Negotiation Playbook	Ordered asks, talking points and a 90-day sequence
16	Appendix A: Contract Evidence Register	All 60 checks with status and contract language
17	Appendix B: Score Calculation Sheet	Provision scores, weights and composite derivation
18	Appendix C: Consolidated Amendment Package	All recommended contract language in one place, ready for counsel
19	Appendix D: Data and Document Request Letter	A ready-to-send request covering every document named in this report
20	Appendix E: Commissioner Briefing and Glossary	A one-page summary for elected officials and plain-language definitions
21	Methodology and Disclaimer	Scoring framework, legal context and limits

HOW TO READ THIS REPORT

Every finding marked Adverse Text quotes the agreement. Every item marked Silent or Pharmacy Schedule is a request, not an accusation. The difference is what lets the county take these findings into a renewal meeting and have them stand.

SECTION 1

Executive Verdict and Critical Issues

Hamilton County's 2025 agreement with Anthem is a medical administrative services agreement with a Pharmacy Services Schedule attached. This edition of PBM Contract Clarity 360 reads it the way a fiduciary should: clause by clause, quote by quote, and only as far as the text will carry. Sixty checks across thirteen provisions were run. Twenty-two of them land on contract language that works against the county, and those twenty-two rest on just eight clauses. Those eight clauses are the case. Everything else is a question the county is entitled to ask and Anthem should be required to answer in writing.

8
Distinct clauses produce every adverse finding in this report

22 of 60
Checks tied to adverse contract language. The other 38 are silences or pharmacy-schedule terms to request

18/100
Weighted composite across 13 provisions. Red flag band (below 40)

Three clauses decide most of the money. First, Anthem keeps all Medical Drug Rebates, the manufacturer payments earned on drugs given in a clinic, infusion center or physician office and billed through the medical plan. Second, Anthem is paid half of the "savings" it reports on network and non-network claims, which rewards a high starting price as much as a low final one. Third, if the county moves its pharmacy benefit to another PBM, Anthem may reset its administrative fees. That reopener is a toll booth on the exit, and it quietly prices every competing PBM bid before one is ever requested.

None of this requires bad intent to be costly. Each clause is the kind of standard language a carrier offers every client. The point is that a public employer funding its own claims with taxpayer dollars should not accept standard language where the standard favors the vendor. The humane reason matters too: every dollar that leaves the plan as vendor revenue is a dollar not spent on an employee's deductible, a family's premium share, or the county's other services.

WHAT THE COUNTY SHOULD DO FIRST

Request the Schedule A fee exhibits, the Pharmacy Services Schedule, 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. Those four documents turn this report's formulas into the county's own numbers.

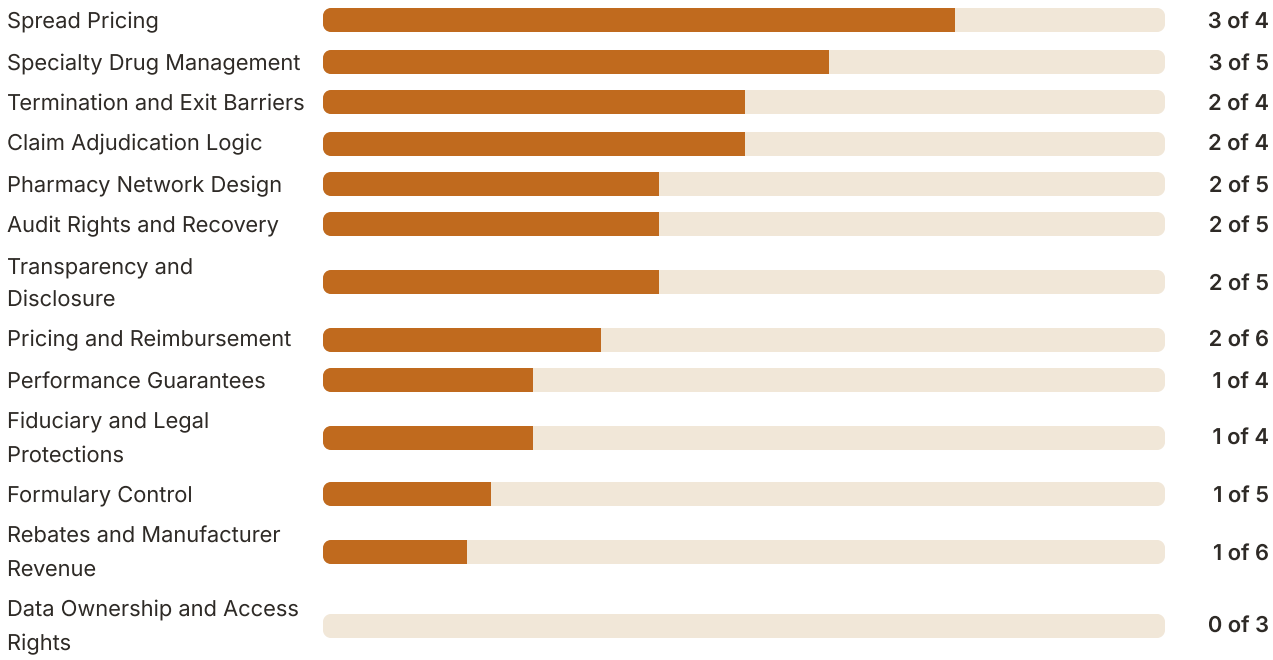
What this contract is, and what it is not

QUESTION	ANSWER FROM THE DOCUMENT	WHY IT MATTERS
Type of agreement	Medical ASO agreement, with pharmacy addressed through a separate Pharmacy Services Schedule	The quoted money sits in medical fee terms (savings fees, Medical Drug Rebates), not in classic pharmacy spread
Pharmacy vendor	Anthem's affiliated PBM, formerly IngenioRx and now CarelonRx	Confirm the current pharmacy contract and any claims processor behind it. The pharmacy schedule was not in the file reviewed

Plan type	Self-funded plan of an Indiana county government	A governmental plan is outside ERISA. Duties reach it through contract, Indiana law and county policy, not ERISA section 404
Federal rules that still apply	Public Health Service Act provisions added by CAA 2021: gag clause prohibition, broker and consultant compensation disclosure, transparency reporting	A federal footing for data and compensation requests even without ERISA
Public records	The agreement carries a trade-secret and federal FOIA confidentiality legend	Indiana's Access to Public Records Act governs county records. A vendor legend does not decide what is public; the statute does

EXHIBIT 1 • CHECKS TIED TO ADVERSE CONTRACT LANGUAGE, BY PROVISION

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



22 OF 60 CHECKS CITE ADVERSE CONTRACT TEXT. THE MEDICAL DRUG REBATE CLAUSE ALONE SUPPORTS 6 OF THEM; THE PROVIDER-CONTRACTS-GOVERN CLAUSE SUPPORTS 5.

The eight clauses, ranked

Ranked by economic weight and by how hard each one makes it for the county to see, measure or leave. Quotations are as extracted from the agreement and should be matched to section numbers in the executed copy before external use. Each clause appears in full in every provision section it affects, so each section can be read on its own.

#	CLAUSE	SEVERITY	CHECKS SUPPORTED	PROVISIONS AFFECTED
1	Anthem keeps every Medical Drug Rebate	High	6	1, 3, 6, 8, 12
2	Carving out pharmacy lets Anthem reset its fees	High	2	10
3	Anthem is paid half of the savings it reports	High	2	2, 5
4	Provider contracts the county cannot see govern the price	High	5	1, 2, 5, 6, 11

5	Anthem's policies apply "as they may be amended from time to time"	Medium	2	4, 11
6	A trade-secret legend on a public body's contract	Medium	3	2, 7, 8
7	A 25% oversight fee on provider performance bonuses	Medium	1	9
8	Contingency fees capped per claim, not per year	Medium	1	7

All 22 adverse findings, ranked by priority

Priority combines the severity of the underlying clause with the economic weight of the provision. Address these in order.

RANK	PROVISION	CHECK	CLAUSE	SEVERITY
1	2. Spread Pricing	Explicit spread or shared-savings clauses	3	High
2	2. Spread Pricing	Implicit spread through reimbursement gaps	4	High
3	3. Rebates and Manufacturer Revenue	Vendor rebate retention rights	1	High
4	1. Pricing and Reimbursement	Specialty drug pricing carve-outs	1	High
5	1. Pricing and Reimbursement	Repricing or retroactive adjustments	4	High
6	5. Pharmacy Network Design	Limited network transparency	4	High
7	5. Pharmacy Network Design	Network savings capture	3	High
8	6. Specialty Drug Management	Specialty carve-out opacity	1	High
9	6. Specialty Drug Management	High-cost claim reimbursement control	4	High
10	6. Specialty Drug Management	Specialty rebates separated from sponsor	1	High
11	8. Transparency and Disclosure	Rebate reporting	1	High
12	10. Termination and Exit Barriers	Bundled renewal lock-in	2	High
13	10. Termination and Exit Barriers	Financial penalty for changing PBMs	2	High
14	11. Claim Adjudication Logic	Retroactive claim adjustment authority	4	High
15	12. Fiduciary and Legal Protections	Conflict-of-interest disclosure	1	High
16	2. Spread Pricing	Spread non-disclosure to plan sponsor	6	Medium
17	7. Audit Rights and Recovery	Data access during audit	6	Medium
18	7. Audit Rights and Recovery	Recovery and fee limits after audit	8	Medium
19	8. Transparency and Disclosure	Proprietary claims used to block pricing disclosure	6	Medium
20	4. Formulary Control	Vendor unilateral formulary and policy authority	5	Medium
21	9. Performance Guarantees	Bonus-driven fee incentives	7	Medium
22	11. Claim Adjudication Logic	Pricing recalculation rules	5	Medium

Pricing and Reimbursement

2.5/10	Red Flag	10%	2 • 0 • 4
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Pricing terms decide what the county pays on every claim, medical and pharmacy. A self-funded plan carries the full cost of each claim, so the pricing method is the plan's largest single economic term. In this agreement the medical side is priced under provider contracts the county cannot see, and the pharmacy side is priced in a schedule that was not in the file.

Where the money moves

Exposure equals (allowed amount the plan funds) minus (amount the provider is actually paid), summed across claims. For pharmacy, the same test runs as (charge to the plan) minus (pharmacy reimbursement plus dispensing fee). The county can compute both once it holds claim-level files with both fields populated.

Significance for a county plan

A county plan is a governmental plan, so ERISA section 404 does not apply directly. The county's duty runs through Indiana law, its own plan documents and its obligations to taxpayers. A prudent sponsor still verifies that it pays only the stated price, and the federal gag clause prohibition in the Public Health Service Act guarantees the county access to the pricing data needed to do it.

ISSUE EVALUATION • 6 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
1.1	AWP, WAC or NADAC benchmark opacity	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
1.2	Spread between reimbursement benchmarks	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
1.3	MAC list control and update rules	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
1.4	Specialty drug pricing carve-outs	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Rebates." Clause 1
1.5	Dispensing fee variability	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
1.6	Repricing or retroactive adjustments	ADVERSE TEXT	"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)." Clause 4

The contract language behind the findings

CLAUSE 1 • PRICING AND REIMBURSEMENT

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 or infusion center, 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 they generate. Retention also removes any reason to steer toward the lowest net-cost product.

THE ASK

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

CLAUSE 4 • PRICING AND REIMBURSEMENT

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 on county claims, and a statement that county-favorable terms in this agreement control.

GAP SUMMARY

The medical pricing method is subordinated to provider contracts, and the most valuable manufacturer revenue on medical drugs stays with Anthem. Pharmacy pricing terms, the usual home of benchmark and MAC language, live in a schedule that must be produced before they can be scored.

RECOMMENDED CONTRACT LANGUAGE

"All pharmacy claims shall be adjudicated on a pass-through basis. Employer shall be charged the amount paid to the dispensing pharmacy for ingredient cost and dispensing fee, plus the disclosed administrative fee, and no other amount. For medical claims, Anthem shall provide claim-level data showing billed charges, allowed amount and amount paid to the Provider, and the terms of this Agreement shall control where they are more favorable to Employer than any Provider contract."

Negotiation talking point

Ask for a claim-level reconciliation for 2025: what each provider and pharmacy was paid, what the county was charged, and the difference. If the two columns match, Anthem should be glad to show it. If they do not, the difference is the finding.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
AWP, WAC or NADAC benchmark opacity	Pharmacy pricing tied to a named, public benchmark (NADAC or WAC) with guaranteed discounts by channel	PHARMACY SCHEDULE In pharmacy schedule
Spread between reimbursement benchmarks	Plan charged exactly what the pharmacy is paid; no difference between benchmarks retained	PHARMACY SCHEDULE In pharmacy schedule
MAC list control and update rules	MAC list disclosed, updated on a stated schedule, and applied identically to plan and pharmacy	PHARMACY SCHEDULE In pharmacy schedule
Specialty drug pricing carve-outs	Specialty pricing and any related manufacturer revenue reported by drug and passed through	ADVERSE TEXT Adverse: Clause 1
Dispensing fee variability	Dispensing fees stated per channel and identical on the plan and pharmacy side	PHARMACY SCHEDULE In pharmacy schedule
Repricing or retroactive adjustments	Retroactive repricing limited to stated windows and reported monthly with original and revised amounts	ADVERSE TEXT Adverse: Clause 4

Questions for Anthem

1. What did Anthem and its PBM pay providers and pharmacies on county claims in 2025, and what was the county charged?
2. Which benchmark prices each pharmacy claim, and where is it written?
3. Is the MAC list used to charge the county the same list used to pay pharmacies?
4. How much Medical Drug Rebate revenue did county claims generate in 2025?
5. Which provider contract terms changed county claim costs in 2025?

Documents to request

1. Pharmacy Services Schedule with all pricing exhibits
2. Schedule A, Section 3 fee exhibits
3. 2025 claim-level medical and pharmacy files with paid-to-provider fields
4. Current MAC list and update policy

Spread Pricing

1.5/10	Red Flag	12%	3 • 0 • 1
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Spread pricing is the gap between what a plan is charged and what the provider or pharmacy is paid. The contract text reviewed contains no classic pharmacy spread clause. What it does contain is a savings-fee model on medical claims that works on the same logic: Anthem earns a share of the gap between a starting price and the final price.

Where the money moves

Savings fee paid = 50% x reported savings on qualifying claims, subject to any cap. On $1 million of reported savings the fee is $500,000. Because savings are measured from billed charges, a higher starting charge produces a larger fee for the same final payment.

Significance for a county plan

Paying a vendor a percentage of savings it measures itself is a conflict a prudent sponsor should price and cap. The county cannot evaluate the fee without the savings report that drives it, and that report is not a contract exhibit.

ISSUE EVALUATION • 4 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
2.1	Explicit spread or shared-savings clauses	ADVERSE TEXT	"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." Clause 3
2.2	Implicit spread through reimbursement gaps	ADVERSE TEXT	"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)." Clause 4
2.3	Hidden spread through pharmacy clawbacks	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
2.4	Spread non-disclosure to plan sponsor	ADVERSE TEXT	"This document contains confidential and proprietary information, including trade secrets, and commercial and financial information, any and all of which are protected from disclosure under the Freedom of Information Act..." Clause 6

The contract language behind the findings

CLAUSE 3 • SPREAD PRICING

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. On every $1 million of reported savings, $500,000 goes to Anthem.

THE ASK

A flat per-claim fee or an annual cap on all savings-based fees, priced against a Medicare-based reference, plus a monthly report of savings fees by claim.

CLAUSE 4 • SPREAD PRICING

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 on county claims, and a statement that county-favorable terms in this agreement control.

CLAUSE 6 • SPREAD PRICING

MEDIUM

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

> *"This document contains confidential and proprietary information, including trade secrets, and commercial and financial information, any and all of which are 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. The federal FOIA governs federal agencies. County records fall under Indiana's Access to Public Records Act, which has its own trade-secret test.

THE ASK

A clause confirming the county may share the agreement and claims data with auditors, consultants and counsel, and that the Indiana statute governs disclosure.

GAP SUMMARY

The agreement converts medical savings into Anthem revenue at a 50% rate, prices those savings against billed charges, and places the underlying provider terms and the agreement itself behind a confidentiality legend. Each element is defensible alone. Together they make the fee impossible to verify from outside.

RECOMMENDED CONTRACT LANGUAGE

"Savings-based fees, including the Traditional Network Savings Fee and Non-Network Savings Fee, shall be calculated only against the lesser of Billed Charges or [150]% of the Medicare allowable for the service, shall not exceed $[X] in total per plan year, and shall be itemized by Claim in a monthly report to Employer."

Negotiation talking point

The savings fee is not illegal and not hidden; it is in the contract. The question is whether 50% of a number Anthem measures from list price is a fair price for the work. Ask Anthem to show 2025 savings fees by claim and the billed charge each one started from.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Explicit spread or shared-savings clauses	Any shared-savings fee capped in dollars and measured against a Medicare-based reference, not billed charges	ADVERSE TEXT Adverse: Clause 3
Implicit spread through reimbursement gaps	Agreement terms override provider terms where more favorable to the sponsor; reimbursement auditable	ADVERSE TEXT Adverse: Clause 4
Hidden spread through pharmacy clawbacks	Pharmacy clawbacks prohibited or credited to the plan in full	PHARMACY SCHEDULE In pharmacy schedule
Spread non-disclosure to plan sponsor	Claim-level reporting of plan charge versus provider or pharmacy payment, with no confidentiality bar	ADVERSE TEXT Adverse: Clause 6

Questions for Anthem

1. What were total savings fees charged to the county in 2024 and 2025?
2. What starting price is used to measure savings on each claim?
3. What share of savings fees came from out-of-network claims priced from billed charges?
4. Does Anthem or its PBM retain any pharmacy clawbacks or post-sale adjustments?
5. Will Anthem accept an annual dollar cap on all savings-based fees?

Documents to request

1. 2024 and 2025 savings-fee detail by claim
2. Definition of savings and the reference price used
3. Monthly invoices showing savings fees as separate lines

Rebates and Manufacturer Revenue

0.5/10	Red Flag	12%	1 • 4 • 1
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Drug manufacturers pay rebates and fees to the party that controls where their product is used. When the plan funds the drug and the vendor keeps the rebate, the vendor is paid by the manufacturer for spending the plan's money. This agreement states that plainly for medical drugs.

Where the money moves

Medical Drug Rebates kept = rebate-eligible medical drug spend x rebate rate Anthem receives. The rate is not in the contract and must be reported. At an illustrative 10% rate, every $1 million of eligible spend is $100,000 kept by Anthem.

Significance for a county plan

The PBM rebate pass-through rule enacted in early 2026 is written into ERISA and will not reach a county plan directly. A county can still adopt the same standard by contract, and it is the standard taxpayers would expect of public money.

ISSUE EVALUATION • 6 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
3.1	Vendor rebate retention rights	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Rebates." Clause 1
3.2	Delayed rebate remittance timing	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
3.3	Partial rebate pass-through structures	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
3.4	Manufacturer contracting control	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
3.5	Rebate eligibility definitions	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
3.6	Off-invoice and non-rebate manufacturer revenue	SILENT	No governing language found in the agreement text reviewed. Request it in writing.

The contract language behind the findings

CLAUSE 1 • REBATES AND MANUFACTURER REVENUE

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 or infusion center, 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 they generate. Retention also removes any reason to steer toward the lowest net-cost product.

THE ASK

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

GAP SUMMARY

Medical Drug Rebates are retained at 100% by contract. The pharmacy rebate terms sit in the Pharmacy Services Schedule. Nothing reviewed defines rebate timing, eligibility or other manufacturer payments such as administrative fees, so those terms default to Anthem's practice.

RECOMMENDED CONTRACT LANGUAGE

"Anthem shall remit to Employer 100% of Medical Drug Rebates, pharmacy rebates and all other manufacturer payments attributable to Employer's Claims, including administrative fees and price-protection payments, within 90 days of receipt, with a report identifying each drug, Claim count and amount received."

Negotiation talking point

Start with a fact request, not a demand: how much did Anthem collect in Medical Drug Rebates on Hamilton County claims in 2025? The size of that answer sets the stakes for the rest of the renewal.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Vendor rebate retention rights	100% of rebates and manufacturer payments passed through, medical and pharmacy alike	ADVERSE TEXT Adverse: Clause 1
Delayed rebate remittance timing	Remittance within 90 days of receipt, with interest on late payment	SILENT Silent
Partial rebate pass-through structures	Pass-through on actual rebates earned on the sponsor's claims, not pooled or guaranteed minimums alone	PHARMACY SCHEDULE In pharmacy schedule

Manufacturer contracting control	Sponsor informed of manufacturer agreements affecting its formulary and medical drug policy	SILENT Silent
Rebate eligibility definitions	Rebate defined broadly to include all manufacturer revenue, with eligibility rules written into the contract	SILENT Silent
Off-invoice and non-rebate manufacturer revenue	Administrative fees, price protection and data fees from manufacturers disclosed and passed through	SILENT Silent

Questions for Anthem

1. What Medical Drug Rebates did Anthem collect on county claims in 2025?
2. When are pharmacy rebates paid, and how much was passed to the county in 2025?
3. Which manufacturer payments besides rebates does Anthem or its PBM receive?
4. How is a claim judged rebate-eligible?
5. Would Anthem accept 100% pass-through of Medical Drug Rebates at renewal?

Documents to request

1. 2025 Medical Drug Rebate receipts on county claims
2. Pharmacy rebate terms and 2025 rebate reconciliation
3. Definition of rebate and of other manufacturer revenue

Formulary Control

2.0/10	Red Flag	7%	1 • 0 • 4
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

The formulary decides which drugs are covered and at what tier. Whoever controls it controls both member access and the rebates that tier placement earns. This agreement lets Anthem's standard policies govern, as amended from time to time.

Where the money moves

Formulary cost = sum across drugs of (net cost of drug chosen minus net cost of lowest clinically appropriate alternative). The county needs, for each high-spend drug, the tier, the gross cost and the net cost after rebates.

Significance for a county plan

A sponsor that cannot see or approve formulary changes cannot show that coverage decisions serve members rather than rebate economics. Advance notice and a cost estimate are the minimum record a prudent sponsor keeps.

ISSUE EVALUATION • 5 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
4.1	Vendor unilateral formulary and policy authority	ADVERSE TEXT	"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." Clause 5
4.2	Step therapy control	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
4.3	Exclusion list disclosure	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
4.4	Therapeutic substitution discretion	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
4.5	Tier placement incentives	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.

The contract language behind the findings

CLAUSE 5 • FORMULARY CONTROL

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 a contract 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.

GAP SUMMARY

Formulary and clinical policy follow Anthem's standard procedures, which Anthem may amend. The specific formulary terms sit in the pharmacy schedule. The county has no stated approval, notice or cost-impact right.

RECOMMENDED CONTRACT LANGUAGE

"Anthem shall give Employer 60 days' written notice of any formulary change, exclusion, or change to prior authorization or step therapy that affects Employer's members, with the clinical rationale and estimated net cost impact. Employer may decline any change that increases net plan cost without a documented clinical basis."

Negotiation talking point

Ask for a formulary economics report on the top 50 drugs by spend: tier, gross cost, rebate and net cost. That one table shows whether tier placement follows the county's net cost or Anthem's rebate.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Vendor unilateral formulary and policy authority	60 days' notice of formulary and policy changes, with cost estimate and sponsor right to decline	ADVERSE TEXT Adverse: Clause 5
Step therapy control	Step therapy and prior authorization criteria disclosed and based on independent clinical evidence	PHARMACY SCHEDULE In pharmacy schedule
Exclusion list disclosure	Exclusion list published annually with net cost rationale	PHARMACY SCHEDULE In pharmacy schedule
Therapeutic substitution discretion	Substitutions limited to lower net-cost, clinically equivalent options	PHARMACY SCHEDULE In pharmacy schedule

Tier placement incentives	Tier placement driven by net cost after rebates, with an annual net cost report	PHARMACY SCHEDULE In pharmacy schedule

Questions for Anthem

1. Which formulary and policy changes affected county members in 2024 and 2025?
2. What net cost impact did those changes have?
3. Who approves step therapy and prior authorization criteria?
4. Which excluded drugs had lower net cost alternatives?
5. Will Anthem give 60 days' notice and a cost estimate for future changes?

Documents to request

1. Current formulary with tier placement
2. Formulary change log for 2024 and 2025
3. Net cost report for top 50 drugs by spend

Pharmacy Network Design

2.0/10	Red Flag	8%	2 • 0 • 3
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Network design decides where members fill prescriptions and what each pharmacy is paid. When the PBM owns mail or specialty pharmacies, steering members to them can raise plan cost while raising PBM margin. The terms that would show this live in the Pharmacy Services Schedule.

Where the money moves

Network cost gap = (plan cost per claim at affiliated pharmacies minus cost per claim at comparable independent pharmacies) x claims routed. Computable from claim files that identify the dispensing pharmacy.

Significance for a county plan

Without the pharmacy schedule, the county cannot confirm network rates or steering rules. Producing that schedule is the first prudent step, and the county has a federal right to the underlying data.

ISSUE EVALUATION • 5 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
5.1	Preferred pharmacy steering	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
5.2	Differential reimbursement across pharmacies	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
5.3	Mandatory mail-order programs	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
5.4	Limited network transparency	ADVERSE TEXT	"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)." Clause 4
5.5	Network savings capture	ADVERSE TEXT	"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." Clause 3

The contract language behind the findings

CLAUSE 4 • PHARMACY NETWORK DESIGN

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 on county claims, and a statement that county-favorable terms in this agreement control.

CLAUSE 3 • PHARMACY 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. On every $1 million of reported savings, $500,000 goes to Anthem.

THE ASK

A flat per-claim fee or an annual cap on all savings-based fees, priced against a Medicare-based reference, plus a monthly report of savings fees by claim.

GAP SUMMARY

Medical network terms are subordinated to provider contracts and monetized through the savings fee. Pharmacy network design cannot be scored until the schedule is produced.

RECOMMENDED CONTRACT LANGUAGE

"Employer shall receive, on request and at least annually, pharmacy network reimbursement terms by pharmacy type, including any affiliated pharmacy, and claim-level data identifying the dispensing pharmacy. No member shall be required to use an affiliated mail or specialty pharmacy without Employer's written approval."

Negotiation talking point

Ask for 2025 cost per claim by pharmacy type: retail chain, independent, Anthem-affiliated mail and specialty. If affiliated channels cost more per equivalent claim, the network is working for someone other than the county.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Preferred pharmacy steering	No steering to affiliated pharmacies without sponsor approval	PHARMACY SCHEDULE In pharmacy schedule
Differential reimbursement across pharmacies	Reimbursement differences by pharmacy type disclosed annually	PHARMACY SCHEDULE In pharmacy schedule
Mandatory mail-order programs	Mail order voluntary, or mandatory only with sponsor approval and a demonstrated net saving	PHARMACY SCHEDULE In pharmacy schedule
Limited network transparency	Network terms on county claims auditable by the sponsor's auditor	ADVERSE TEXT Adverse: Clause 4
Network savings capture	Network savings measured against a fixed reference and fees on those savings capped	ADVERSE TEXT Adverse: Clause 3

Questions for Anthem

1. Which pharmacies in the network are affiliated with Anthem?
2. What was cost per claim by pharmacy type in 2025?
3. Are any members required to use affiliated mail or specialty pharmacy?
4. How do network reimbursement rates differ by pharmacy type?
5. Will Anthem disclose network terms annually?

Documents to request

1. Pharmacy network listing with affiliated pharmacies identified
2. Cost per claim by pharmacy type for 2025
3. Mail and specialty program rules

Specialty Drug Management

1.0/10	Red Flag	8%	3 • 2 • 0
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Specialty drugs are a small share of claims and a large share of cost. Many are given in clinics and billed through the medical plan, which is exactly where this agreement says Anthem keeps 100% of the rebates.

Where the money moves

Specialty exposure = medical specialty drug spend x retained rebate rate, plus any site-of-care cost difference (hospital outpatient price minus home or physician-office price, times infusions moved).

Significance for a county plan

Specialty management is where clinical judgment and vendor revenue meet. A sponsor should be able to see both the clinical program and the money it generates before approving either.

ISSUE EVALUATION • 5 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
6.1	Site-of-care steering rules	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
6.2	White and brown bagging mandates	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
6.3	Specialty carve-out opacity	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Rebates." Clause 1
6.4	High-cost claim reimbursement control	ADVERSE TEXT	"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)." Clause 4
6.5	Specialty rebates separated from sponsor	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Rebates." Clause 1

The contract language behind the findings

CLAUSE 1 • SPECIALTY DRUG MANAGEMENT

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 or infusion center, 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 they generate. Retention also removes any reason to steer toward the lowest net-cost product.

THE ASK

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

CLAUSE 4 • SPECIALTY DRUG MANAGEMENT

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 on county claims, and a statement that county-favorable terms in this agreement control.

GAP SUMMARY

The highest-cost drugs generate rebates the county never sees, under provider terms the county cannot read, with high-dollar claim review governed by those same provider contracts.

RECOMMENDED CONTRACT LANGUAGE

"Anthem shall report quarterly, by drug, all specialty drugs paid under the medical benefit, including billed, allowed and paid amounts, site of care, and Medical Drug Rebates received. Employer may direct site-of-care programs and may carve out specialty drug management to a vendor of its choice on 90 days' notice without change to other fees."

Negotiation talking point

Ask for the top 25 specialty drugs paid under the medical plan in 2025, with site of care and rebates received. That list is usually short, and it usually carries most of the money.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Site-of-care steering rules	Site-of-care programs directed by the sponsor, with savings reported by drug	SILENT Silent
White and brown bagging mandates	Bagging programs only with sponsor approval and member safeguards	SILENT Silent
Specialty carve-out opacity	Specialty drug spend and rebates reported quarterly by drug, medical and pharmacy	ADVERSE TEXT Adverse: Clause 1
High-cost claim reimbursement control	High-cost claim review under criteria the sponsor can see and audit	ADVERSE TEXT Adverse: Clause 4
Specialty rebates separated from sponsor	Specialty rebates passed through and reported with the claims that earned them	ADVERSE TEXT Adverse: Clause 1

Questions for Anthem

1. Which specialty drugs were paid under the medical plan in 2025, and at what sites of care?
2. What rebates were earned on those drugs?
3. What site-of-care programs apply, and what did they save?
4. How are high-dollar claims reviewed, and under whose criteria?
5. May the county carve out specialty management without repricing other fees?

Documents to request

1. 2025 medical specialty drug report by J-code
2. Site-of-care program terms
3. Medical Drug Rebate receipts by drug

Audit Rights and Recovery

2.5/10	Concern	8%	2 • 3 • 0
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Audit rights are how every other term is enforced. A favorable price the sponsor cannot audit is a promise, not a price. The text reviewed contains a confidentiality legend and per-claim contingency fees on overpayment work, but no full audit clause.

Where the money moves

Recovery value = audited error rate x claims dollars in the lookback period, minus fees charged to find the errors. The per-claim $25,000 cap matters because fees on overpayment recovery reduce what the county actually keeps.

Significance for a county plan

A sponsor that cannot audit cannot show it monitored the vendor. For a county, that record also answers to the state board of accounts and to taxpayers.

ISSUE EVALUATION • 5 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
7.1	Audit scope limits	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
7.2	Lookback window length	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
7.3	Data access during audit	ADVERSE TEXT	"This document contains confidential and proprietary information, including trade secrets, and commercial and financial information, any and all of which are protected from disclosure under the Freedom of Information Act..." Clause 6
7.4	Recovery and fee limits after audit	ADVERSE TEXT	"The fee for Overpayment Identification, Prevention, and Claims Prepayment Analysis Activities will not exceed $25,000.00 per Claim." Also: "Fees paid to Anthem for Claims priced through such tool will not exceed $25,000 per claim." Clause 8
7.5	Vendor-controlled audit method	SILENT	No governing language found in the agreement text reviewed. Request it in writing.

The contract language behind the findings

CLAUSE 6 • AUDIT RIGHTS AND RECOVERY

MEDIUM

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

> *"This document contains confidential and proprietary information, including trade secrets, and commercial and financial information, any and all of which are 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. The federal FOIA governs federal agencies. County records fall under Indiana's Access to Public Records Act, which has its own trade-secret test.

THE ASK

A clause confirming the county may share the agreement and claims data with auditors, consultants and counsel, and that the Indiana statute governs disclosure.

CLAUSE 8 • AUDIT RIGHTS AND RECOVERY

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." Also: "Fees paid to Anthem for Claims priced through such tool will not exceed $25,000 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.

GAP SUMMARY

No audit right was found in the text reviewed. The confidentiality legend can be read to restrict what an auditor receives, and recovery of overpayments carries its own fee.

RECOMMENDED CONTRACT LANGUAGE

"Employer or its designated auditor may audit Claims, Provider reimbursement on Employer's Claims, rebates, and all fees, once per year, with a 36-month lookback, at no charge. Overpayments resulting from Anthem's error shall be refunded in full, with no recovery fee, within 30 days of agreement on the finding."

Negotiation talking point

Ask one question: may the county's chosen auditor review claims, provider reimbursement, rebates and fees for the last three years at no charge? A yes belongs in the contract. A no tells the board what it needs to know.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Audit scope limits	Annual audit right covering claims, provider reimbursement, rebates and fees	SILENT Silent
Lookback window length	Lookback of at least 36 months	SILENT Silent
Data access during audit	Full claim-level data to the sponsor's auditor at no charge, under a standard confidentiality agreement	ADVERSE TEXT Adverse: Clause 6
Recovery and fee limits after audit	Vendor-caused errors refunded in full with no recovery fee	ADVERSE TEXT Adverse: Clause 8
Vendor-controlled audit method	Auditor chosen by the sponsor; sampling and extrapolation methods agreed in advance	SILENT Silent

Questions for Anthem

1. Where in the agreement is the county's audit right written?
2. What lookback period applies?
3. May the county's chosen auditor receive full claim-level data?
4. What fees were charged on overpayment recovery in 2025?
5. Are errors made by Anthem refunded without a fee?

Documents to request

1. Audit provision, if any, in the full agreement
2. 2024 and 2025 overpayment recovery and fee report

Transparency and Disclosure

1.5/10	Red Flag	8%	2 • 2 • 1
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Transparency turns every other term into something the county can check. Here the agreement carries a federal FOIA trade-secret legend, and Medical Drug Rebates are retained without reporting. For a public employer, the confidentiality claim also runs into Indiana's public records law.

Where the money moves

Not a dollar line itself. Transparency is the condition for measuring every dollar line in this report.

Significance for a county plan

Federal law already bars group health plans, including county plans, from accepting gag clauses that block access to cost and quality data. The county should confirm that this agreement does not operate as one.

ISSUE EVALUATION • 5 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
8.1	Proprietary claims used to block pricing disclosure	ADVERSE TEXT	"This document contains confidential and proprietary information, including trade secrets, and commercial and financial information, any and all of which are protected from disclosure under the Freedom of Information Act..." Clause 6
8.2	Ingredient cost disclosure	PHARMACY SCHEDULE	Term sits in the Pharmacy Services Schedule, which was not in the file reviewed. Request the schedule.
8.3	Rebate reporting	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Rebates." Clause 1
8.4	Aggregate-only reporting	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
8.5	Claim-level visibility	SILENT	No governing language found in the agreement text reviewed. Request it in writing.

The contract language behind the findings

CLAUSE 6 • TRANSPARENCY AND DISCLOSURE

MEDIUM

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

> *"This document contains confidential and proprietary information, including trade secrets, and commercial and financial information, any and all of which are 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. The federal FOIA governs federal agencies. County records fall under Indiana's Access to Public Records Act, which has its own trade-secret test.

THE ASK

A clause confirming the county may share the agreement and claims data with auditors, consultants and counsel, and that the Indiana statute governs disclosure.

CLAUSE 1 • TRANSPARENCY AND DISCLOSURE

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 or infusion center, 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 they generate. Retention also removes any reason to steer toward the lowest net-cost product.

THE ASK

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

GAP SUMMARY

The agreement asserts confidentiality over its own terms and provides no rebate reporting on medical drugs. Claim-level reporting obligations were not found.

RECOMMENDED CONTRACT LANGUAGE

"Nothing in this Agreement shall restrict Employer from accessing, using or disclosing cost, quality or Claim data as permitted by Section 2799A-9 of the Public Health Service Act, or from complying with the Indiana Access to Public Records Act. Employer may share this Agreement and its data with its auditors, consultants and counsel."

Negotiation talking point

As a public body, the county decides what is public under Indiana law. Ask Anthem to confirm in writing that the confidentiality legend does not limit the county's data access or its auditors.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Proprietary claims used to block pricing disclosure	Confidentiality terms yield to public records law and federal gag-clause rules	ADVERSE TEXT Adverse: Clause 6
Ingredient cost disclosure	Ingredient cost, dispensing fee and plan charge reported per pharmacy claim	PHARMACY SCHEDULE In pharmacy schedule
Rebate reporting	Rebates reported by drug and quarter, medical and pharmacy	ADVERSE TEXT Adverse: Clause 1
Aggregate-only reporting	Standard reports supplemented by claim-level files on request	SILENT Silent
Claim-level visibility	Monthly claim-level file with billed, allowed and paid amounts	SILENT Silent

Questions for Anthem

1. Does the confidentiality legend limit any county data request or audit?
2. Will Anthem confirm that Indiana's public records law governs disclosure?
3. What claim-level fields are available today?
4. What rebate reporting does the county receive?
5. Will Anthem attest that the agreement contains no gag clause?

Documents to request

1. Confidentiality and data-use sections of the full agreement
2. Standard reporting package and claim-level file layout

Performance Guarantees

3.0/10	Concern	7%	1 • 3 • 0
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Guarantees put vendor money at risk when service falls short. The text reviewed contains no guarantee schedule. It does contain a 25% fee on top of provider performance bonuses, which pays Anthem more when bonuses rise.

Where the money moves

Guarantee value = fees at risk x probability of missing each standard. Bonus-program cost = bonuses paid x 1.25. The county should compare that cost with measured savings for attributed members.

Significance for a county plan

Paying a vendor a percentage of incentive payments, without a savings guarantee, is an arrangement a prudent sponsor documents and tests each year.

ISSUE EVALUATION • 4 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
9.1	Weak or non-binding service standards	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
9.2	Utilization threshold conditions	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
9.3	Bonus-driven fee incentives	ADVERSE TEXT	"Enhanced Personal Health Care Fee. A fee shall be charged for Anthem's oversight of Enhanced Personal Health Care with Providers or Vendors. Such fee shall be 25% of the per attributed Member per month amount charged to Employer for the Provider performance bonus portion..." Clause 7
9.4	Penalty avoidance terms	SILENT	No governing language found in the agreement text reviewed. Request it in writing.

The contract language behind the findings

CLAUSE 7 • PERFORMANCE GUARANTEES

MEDIUM

A 25% oversight fee on provider performance bonuses

> *"Enhanced Personal Health Care Fee. A fee shall be charged for Anthem's oversight of Enhanced Personal Health Care with Providers or Vendors. 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.

GAP SUMMARY

No performance guarantee schedule was found. The one performance-linked term found pays Anthem, not the county.

RECOMMENDED CONTRACT LANGUAGE

"Anthem shall provide performance guarantees for claims accuracy, turnaround, call answer time and reporting timeliness, with at least [15]% of annual administrative fees at risk, measured and paid annually. The Enhanced Personal Health Care Fee shall be payable only to the extent of documented net savings for attributed members."

Negotiation talking point

Ask what Anthem guarantees and what it pays when it misses. Then ask what the Enhanced Personal Health Care program saved in 2025 net of the bonuses and the 25% fee.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Weak or non-binding service standards	Guarantees with at least 15% of fees at risk, measured annually by a third party	SILENT Silent
Utilization threshold conditions	No exclusions that let the vendor avoid penalties when utilization shifts	SILENT Silent
Bonus-driven fee incentives	Vendor fees on incentive programs paid only from documented net savings	ADVERSE TEXT Adverse: Clause 7
Penalty avoidance terms	Penalties paid automatically, without a cure period that erases the miss	SILENT Silent

Questions for Anthem

1. What performance guarantees apply, and what fees are at risk?
2. Which guarantees were missed in 2025, and what was paid?
3. What did the Enhanced Personal Health Care program cost, including the 25% fee?
4. What net savings did it produce for attributed members?
5. Will Anthem tie the oversight fee to documented net savings?

Documents to request

1. Performance guarantee schedule and 2025 results
2. Enhanced Personal Health Care program report

Termination and Exit Barriers

2.5/10	Concern	6%	2 • 2 • 0
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Exit terms decide whether every other right is real. A sponsor that cannot leave cannot negotiate. This agreement lets Anthem reset its medical fees if the county moves its pharmacy benefit.

Where the money moves

Exit toll = (possible fee increase per employee per month) x employees x months remaining. Because the increase is undefined, the toll has no stated ceiling until the county negotiates one.

Significance for a county plan

Bundling a medical fee to a pharmacy contract limits the county's ability to bid each service on its merits. Public procurement favors separable pricing for exactly this reason.

ISSUE EVALUATION • 4 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
10.1	Early termination penalties	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
10.2	Data export restrictions at exit	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
10.3	Bundled renewal lock-in	ADVERSE TEXT	"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." Clause 2
10.4	Financial penalty for changing PBMs	ADVERSE TEXT	"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." Clause 2

The contract language behind the findings

CLAUSE 2 • TERMINATION AND 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 administrative fee to keeping Anthem's PBM. Leaving the pharmacy benefit reopens the medical price.

WHY IT COSTS

An unknown fee increase is a penalty with no ceiling. Every competing PBM proposal must beat both its own price and the unknown reopener, which suppresses competition before it starts.

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. A fee set afterward is leverage.

GAP SUMMARY

Leaving the pharmacy benefit gives Anthem an open-ended right to reprice the medical agreement. Data return terms at exit were not found.

RECOMMENDED CONTRACT LANGUAGE

"Termination of the Pharmacy Services Schedule shall not change the Administrative Services Fees by more than $[X] per employee per month. On termination of any part of this Agreement, Anthem shall deliver complete Claim history in an industry-standard format within 30 days at no charge."

Negotiation talking point

Ask Anthem to price the pharmacy carve-out today, in writing. If the answer is that the fee would be decided later, that is the exit toll, and it belongs at the top of the renewal agenda.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Early termination penalties	Termination for convenience on 90 days' notice with no penalty	SILENT Silent
Data export restrictions at exit	Complete claim history delivered within 30 days of exit at no charge	SILENT Silent
Bundled renewal lock-in	Each service priced separately; ending one does not reprice another	ADVERSE TEXT Adverse: Clause 2
Financial penalty for changing PBMs	Any fee change on carve-out stated in advance and capped	ADVERSE TEXT Adverse: Clause 2

Questions for Anthem

1. What would medical fees be if the county carved out pharmacy at renewal?
2. Is there any early termination fee?
3. What data is delivered at exit, in what format, and at what cost?
4. Do any renewal terms change pricing automatically?
5. Will Anthem cap any fee change tied to a pharmacy carve-out?

Documents to request

1. Termination sections of the full agreement
2. Written quote for medical fees with pharmacy carved out

Claim Adjudication Logic

2.0/10	Red Flag	5%	2 • 2 • 0
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Adjudication rules decide how each claim is priced, adjusted and reprocessed. Here they follow provider contracts and Anthem's amendable standard policies.

Where the money moves

Adjustment exposure = sum of retroactive adjustments and reprocessed claims that increased plan cost, net of those that reduced it. Reportable monthly if required.

Significance for a county plan

A sponsor should be able to trace any change to a claim it funded. Retroactive changes made under documents the sponsor cannot see break that trail.

ISSUE EVALUATION • 4 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
11.1	Retroactive claim adjustment authority	ADVERSE TEXT	"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)." Clause 4
11.2	Reversal discretion without notice	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
11.3	Pricing recalculation rules	ADVERSE TEXT	"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." Clause 5
11.4	Reprocessing visibility	SILENT	No governing language found in the agreement text reviewed. Request it in writing.

The contract language behind the findings

CLAUSE 4 • CLAIM ADJUDICATION LOGIC

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 on county claims, and a statement that county-favorable terms in this agreement control.

CLAUSE 5 • CLAIM ADJUDICATION LOGIC

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 a contract 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.

GAP SUMMARY

Adjustment timeframes come from provider contracts, and pricing rules come from Anthem's amendable policies. No reprocessing report was found.

RECOMMENDED CONTRACT LANGUAGE

"Anthem shall report monthly all retroactive adjustments and reprocessed Claims, with original and revised amounts. Adjustments that increase Employer's cost by more than $[1,000] per Claim shall require notice to Employer before funding."

Negotiation talking point

Ask for 2025 retroactive adjustments and reprocessed claims, with original and final amounts. The net direction of those changes tells the county whose policies are doing the work.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Retroactive claim adjustment authority	Adjudication rules documented and provided to the sponsor	ADVERSE TEXT Adverse: Clause 4
Reversal discretion without notice	Reversals reported monthly with reason codes	SILENT Silent
Pricing recalculation rules	Pricing rules fixed for the contract year unless the sponsor agrees	ADVERSE TEXT Adverse: Clause 5
Reprocessing visibility	Reprocessed claims reported with original and final amounts	SILENT Silent

Questions for Anthem

1. What retroactive adjustments were made to county claims in 2025?
2. What was their net cost effect?
3. Which policy governs claim reprocessing?
4. Is the county notified before a large adjustment is funded?
5. Will Anthem report adjustments monthly?

Documents to request

1. 2025 adjustment and reprocessing report
2. Claims payment policy manual referenced by the agreement

Fiduciary and Legal Protections

1.5/10	Red Flag	5%	1 • 3 • 0
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Legal terms decide who carries risk when something goes wrong. The text reviewed did not include the indemnity, liability or fiduciary sections, so those must be produced. What was found is a conflict: Anthem keeps manufacturer money on drugs the county pays for.

Where the money moves

Not a direct dollar line. Liability caps and indemnity terms decide how much of any loss the county can recover.

Significance for a county plan

ERISA fiduciary status does not apply to a county plan. The relevant questions are whether Anthem discloses its conflicts, whether it indemnifies the county for its own errors, and whether any liability cap is reasonable.

ISSUE EVALUATION • 4 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
12.1	Fiduciary or duty disclaimers	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
12.2	Indemnification balance	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
12.3	Liability limitation terms	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
12.4	Conflict-of-interest disclosure	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Rebates." Clause 1

The contract language behind the findings

CLAUSE 1 • FIDUCIARY AND LEGAL PROTECTIONS

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 or infusion center, 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 they generate. Retention also removes any reason to steer toward the lowest net-cost product.

THE ASK

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

GAP SUMMARY

The conflict is in plain text: retained Medical Drug Rebates. The protections that would balance it were not in the file reviewed. Note that the $25,000 per-claim language is a fee cap, not a liability cap.

RECOMMENDED CONTRACT LANGUAGE

"Anthem shall disclose annually all compensation it or its affiliates receive in connection with Employer's plan, including manufacturer payments and affiliated pharmacy revenue. Anthem shall indemnify Employer for losses caused by Anthem's negligence, error or breach, and any limitation of liability shall not apply to Claim payment errors or data breaches."

Negotiation talking point

Ask Anthem to list every source of revenue it earns from the county's plan beyond the administrative fee. The CAA 2021 already requires similar disclosure from brokers and consultants; the same standard should apply to the administrator.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Fiduciary or duty disclaimers	Annual disclosure of all vendor and affiliate compensation from the plan	SILENT Silent
Indemnification balance	Indemnity for vendor negligence, error and breach	SILENT Silent
Liability limitation terms	No liability cap on claim payment errors or data breaches	SILENT Silent

Conflict-of-interest disclosure	Written disclosure of conflicts, including retained manufacturer revenue and affiliated pharmacies	ADVERSE TEXT Adverse: Clause 1

Questions for Anthem

1. What compensation do Anthem and its affiliates receive from the county's plan beyond the administrative fee?
2. What indemnity does Anthem provide for its own errors?
3. Is there a limitation of liability, and what does it exclude?
4. What conflicts of interest does Anthem disclose in writing?
5. What compensation does the county's broker or consultant receive in connection with this agreement?

Documents to request

1. Indemnity, limitation of liability and standard-of-care sections
2. Annual compensation disclosure from Anthem and from the county's broker

Data Ownership and Access Rights

2.5/10	Concern	4%	0 • 3 • 0
Provision score	Rating	Weight in composite	Adverse • silent • pharmacy schedule

Why this provision matters

Claims data is the evidence for every finding in this report. The county funds the claims; it should own the record of them. No data ownership, access or portability term was found in the text reviewed.

Where the money moves

Not a dollar line itself. Without data, none of the dollar formulas in this report can be completed.

Significance for a county plan

Federal law protects the county's access to its cost and claims data. A written ownership and delivery clause turns that right into a monthly file.

ISSUE EVALUATION • 3 CHECKS

What the agreement says on each check

REF	CHECK	STATUS	EVIDENCE
13.1	Vendor ownership of claims data	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
13.2	Delayed or incomplete data access	SILENT	No governing language found in the agreement text reviewed. Request it in writing.
13.3	Data portability at exit	SILENT	No governing language found in the agreement text reviewed. Request it in writing.

GAP SUMMARY

The agreement is silent on data ownership, delivery and portability. Silence leaves those terms to Anthem's practice.

RECOMMENDED CONTRACT LANGUAGE

"Employer owns all data relating to its plan and members. Anthem shall deliver complete claim-level medical and pharmacy data monthly, including billed, allowed and paid amounts and rebates, and shall deliver full Claim history within 30 days of termination at no charge."

Negotiation talking point

Ask for monthly claim-level files now, while the relationship is good. A vendor that delivers data freely during the contract rarely becomes difficult at exit.

Market standard versus this agreement

CHECK	WHAT A PROTECTIVE CONTRACT SAYS	THIS AGREEMENT
Vendor ownership of claims data	Sponsor owns all plan data; vendor use limited to administering the plan	SILENT Silent
Delayed or incomplete data access	Monthly claim-level files delivered without charge	SILENT Silent
Data portability at exit	Full data history delivered within 30 days of exit	SILENT Silent

Questions for Anthem

1. Who owns the county's claims data under the agreement?
2. What claim-level data is delivered today, and how often?
3. Does Anthem use or sell county data for any other purpose?
4. What data is delivered at exit, and how fast?
5. Will Anthem deliver a monthly claim-level file at no charge?

Documents to request

1. Data ownership and data-use sections
2. Monthly claim file specification

SECTION 15

Negotiation Playbook

A renewal is won before the meeting starts, by the documents requested in advance. This playbook orders the asks by economic weight and by how much each one unlocks the rest. Open with the exit toll, because a vendor that will price its own exit in writing is a vendor ready to negotiate everything else.

1. **Provision 10: Termination and Exit Barriers**

   Ask Anthem to price the pharmacy carve-out today, in writing. If the answer is that the fee would be decided later, that is the exit toll, and it belongs at the top of the renewal agenda.

   Gap to close: Leaving the pharmacy benefit gives Anthem an open-ended right to reprice the medical agreement. Data return terms at exit were not found.

2. **Provision 3: Rebates and Manufacturer Revenue**

   Start with a fact request, not a demand: how much did Anthem collect in Medical Drug Rebates on Hamilton County claims in 2025? The size of that answer sets the stakes for the rest of the renewal.

   Gap to close: Medical Drug Rebates are retained at 100% by contract. The pharmacy rebate terms sit in the Pharmacy Services Schedule. Nothing reviewed defines rebate timing, eligibility or other manufacturer payments such as administrative fees, so those terms default to Anthem's practice.

3. **Provision 2: Spread Pricing**

   The savings fee is not illegal and not hidden; it is in the contract. The question is whether 50% of a number Anthem measures from list price is a fair price for the work. Ask Anthem to show 2025 savings fees by claim and the billed charge each one started from.

   Gap to close: The agreement converts medical savings into Anthem revenue at a 50% rate, prices those savings against billed charges, and places the underlying provider terms and the agreement itself behind a confidentiality legend. Each element is defensible alone. Together they make the fee impossible to verify from outside.

4. **Provision 6: Specialty Drug Management**

   Ask for the top 25 specialty drugs paid under the medical plan in 2025, with site of care and rebates received. That list is usually short, and it usually carries most of the money.

   Gap to close: The highest-cost drugs generate rebates the county never sees, under provider terms the county cannot read, with high-dollar claim review governed by those same provider contracts.

5. **Provision 1: Pricing and Reimbursement**

   Ask for a claim-level reconciliation for 2025: what each provider and pharmacy was paid, what the county was charged, and the difference. If the two columns match, Anthem should be glad to show it. If they do not, the difference is the finding.

   Gap to close: The medical pricing method is subordinated to provider contracts, and the most valuable manufacturer revenue on medical drugs stays with Anthem. Pharmacy pricing terms, the usual home of benchmark and MAC language, live in a schedule that must be produced before they can be scored.

6. **Provision 7: Audit Rights and Recovery**

   Ask one question: may the county's chosen auditor review claims, provider reimbursement, rebates and fees for the last three years at no charge? A yes belongs in the contract. A no tells the board what it needs to know.

   Gap to close: No audit right was found in the text reviewed. The confidentiality legend can be read to restrict what an auditor receives, and recovery of overpayments carries its own fee.

7 Provision 8: Transparency and Disclosure

As a public body, the county decides what is public under Indiana law. Ask Anthem to confirm in writing that the confidentiality legend does not limit the county's data access or its auditors.

Gap to close: The agreement asserts confidentiality over its own terms and provides no rebate reporting on medical drugs. Claim-level reporting obligations were not found.

8 Provision 13: Data Ownership and Access Rights

Ask for monthly claim-level files now, while the relationship is good. A vendor that delivers data freely during the contract rarely becomes difficult at exit.

Gap to close: The agreement is silent on data ownership, delivery and portability. Silence leaves those terms to Anthem's practice.

9 Provision 4: Formulary Control

Ask for a formulary economics report on the top 50 drugs by spend: tier, gross cost, rebate and net cost. That one table shows whether tier placement follows the county's net cost or Anthem's rebate.

Gap to close: Formulary and clinical policy follow Anthem's standard procedures, which Anthem may amend. The specific formulary terms sit in the pharmacy schedule. The county has no stated approval, notice or cost-impact right.

10 Provision 11: Claim Adjudication Logic

Ask for 2025 retroactive adjustments and reprocessed claims, with original and final amounts. The net direction of those changes tells the county whose policies are doing the work.

Gap to close: Adjustment timeframes come from provider contracts, and pricing rules come from Anthem's amendable policies. No reprocessing report was found.

11 Provision 5: Pharmacy Network Design

Ask for 2025 cost per claim by pharmacy type: retail chain, independent, Anthem-affiliated mail and specialty. If affiliated channels cost more per equivalent claim, the network is working for someone other than the county.

Gap to close: Medical network terms are subordinated to provider contracts and monetized through the savings fee. Pharmacy network design cannot be scored until the schedule is produced.

12 Provision 9: Performance Guarantees

Ask what Anthem guarantees and what it pays when it misses. Then ask what the Enhanced Personal Health Care program saved in 2025 net of the bonuses and the 25% fee.

Gap to close: No performance guarantee schedule was found. The one performance-linked term found pays Anthem, not the county.

13 Provision 12: Fiduciary and Legal Protections

Ask Anthem to list every source of revenue it earns from the county's plan beyond the administrative fee. The CAA 2021 already requires similar disclosure from brokers and consultants; the same standard should apply to the administrator.

Gap to close: The conflict is in plain text: retained Medical Drug Rebates. The protections that would balance it were not in the file reviewed. Note that the $25,000 per-claim language is a fee cap, not a liability cap.

A 90-day sequence

WINDOW	ACTION	OWNER
Days 1–15	Written request for Schedule A, the Pharmacy Services Schedule, the full agreement with section numbers, and 2025 claim-level files	County benefits lead, counsel
Days 15–30	Request 2025 Medical Drug Rebate receipts, savings-fee detail, contingency-fee detail and the Enhanced Personal Health Care report	County benefits lead
Days 30–45	Request a written medical fee quote with pharmacy carved out; request broker and consultant compensation disclosure	County, with advisor

Days 45–60	Fill the formulas in this report with county data; rescore the provisions affected by the pharmacy schedule	Kincaid Health
Days 60–90	Present the amendment package: the model language in Sections 2 to 14, ordered as above	County, counsel, advisor

THE BROKER QUESTION

The CAA 2021 requires brokers and consultants to disclose what they are paid in connection with a group health plan, and county plans are covered. A Kincaid Health Broker Compensation Study sets that figure beside enrollment, so the board can see what advice costs per covered employee and whether the adviser's pay rises with the vendor's.

SECTION 16

Appendix A: Contract Evidence Register

All 60 checks, with the status assigned and the contract language relied on. Quotations are as extracted and should be matched to section numbers in the executed agreement.

REF	PROVISION	CHECK	STATUS	EVIDENCE
1.1	Pricing and Reimbursement	AWP, WAC or NADAC benchmark opacity	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
1.2	Pricing and Reimbursement	Spread between reimbursement benchmarks	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
1.3	Pricing and Reimbursement	MAC list control and update rules	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
1.4	Pricing and Reimbursement	Specialty drug pricing carve-outs	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Clause 1
1.5	Pricing and Reimbursement	Dispensing fee variability	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
1.6	Pricing and Reimbursement	Repricing or retroactive adjustments	ADVERSE TEXT	"Provider contracts will govern the rights and obligations as between the Parties and Providers (e.g., reimbursement rates and methodologies, filing and Claim adjustment..." Clause 4
2.1	Spread Pricing	Explicit spread or shared-savings clauses	ADVERSE TEXT	"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..." Clause 3
2.2	Spread Pricing	Implicit spread through reimbursement gaps	ADVERSE TEXT	"Provider contracts will govern the rights and obligations as between the Parties and Providers (e.g., reimbursement rates and methodologies, filing and Claim adjustment..." Clause 4
2.3	Spread Pricing	Hidden spread through pharmacy clawbacks	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
2.4	Spread Pricing	Spread non-disclosure to plan sponsor	ADVERSE TEXT	"This document contains confidential and proprietary information, including trade secrets, and commercial and financial information, any and all of which are protected..." Clause 6
3.1	Rebates and Manufacturer Revenue	Vendor rebate retention rights	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Clause 1
3.2	Rebates and Manufacturer Revenue	Delayed rebate remittance timing	SILENT	Not found in text reviewed
3.3	Rebates and Manufacturer Revenue	Partial rebate pass-through structures	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
3.4	Rebates and Manufacturer Revenue	Manufacturer contracting control	SILENT	Not found in text reviewed
3.5	Rebates and Manufacturer Revenue	Rebate eligibility definitions	SILENT	Not found in text reviewed
3.6	Rebates and Manufacturer Revenue	Off-invoice and non-rebate manufacturer revenue	SILENT	Not found in text reviewed
4.1	Formulary Control	Vendor unilateral formulary and policy authority	ADVERSE TEXT	"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 Clause 5

4.2	Formulary Control	Step therapy control	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
4.3	Formulary Control	Exclusion list disclosure	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
4.4	Formulary Control	Therapeutic substitution discretion	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
4.5	Formulary Control	Tier placement incentives	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
5.1	Pharmacy Network Design	Preferred pharmacy steering	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
5.2	Pharmacy Network Design	Differential reimbursement across pharmacies	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
5.3	Pharmacy Network Design	Mandatory mail-order programs	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
5.4	Pharmacy Network Design	Limited network transparency	ADVERSE TEXT	"Provider contracts will govern the rights and obligations as between the Parties and Providers (e.g., reimbursement rates and methodologies, filing and Claim adjustment..." Clause 4
5.5	Pharmacy Network Design	Network savings capture	ADVERSE TEXT	"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..." Clause 3
6.1	Specialty Drug Management	Site-of-care steering rules	SILENT	Not found in text reviewed
6.2	Specialty Drug Management	White and brown bagging mandates	SILENT	Not found in text reviewed
6.3	Specialty Drug Management	Specialty carve-out opacity	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Clause 1
6.4	Specialty Drug Management	High-cost claim reimbursement control	ADVERSE TEXT	"Provider contracts will govern the rights and obligations as between the Parties and Providers (e.g., reimbursement rates and methodologies, filing and Claim adjustment..." Clause 4
6.5	Specialty Drug Management	Specialty rebates separated from sponsor	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Clause 1
7.1	Audit Rights and Recovery	Audit scope limits	SILENT	Not found in text reviewed
7.2	Audit Rights and Recovery	Lookback window length	SILENT	Not found in text reviewed
7.3	Audit Rights and Recovery	Data access during audit	ADVERSE TEXT	"This document contains confidential and proprietary information, including trade secrets, and commercial and financial information, any and all of which are protected..." Clause 6
7.4	Audit Rights and Recovery	Recovery and fee limits after audit	ADVERSE TEXT	"The fee for Overpayment Identification, Prevention, and Claims Prepayment Analysis Activities will not exceed $25,000.00 per Claim." Also: "Fees paid to Anthem for..." Clause 8
7.5	Audit Rights and Recovery	Vendor-controlled audit method	SILENT	Not found in text reviewed
8.1	Transparency and Disclosure	Proprietary claims used to block pricing disclosure	ADVERSE TEXT	"This document contains confidential and proprietary information, including trade secrets, and commercial and financial information, any and all of which are protected..." Clause 6
8.2	Transparency and Disclosure	Ingredient cost disclosure	PHARMACY SCHEDULE	In Pharmacy Services Schedule (not in file)
8.3	Transparency and Disclosure	Rebate reporting	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Clause 1

8.4	Transparency and Disclosure	Aggregate-only reporting	SILENT	Not found in text reviewed
8.5	Transparency and Disclosure	Claim-level visibility	SILENT	Not found in text reviewed
9.1	Performance Guarantees	Weak or non-binding service standards	SILENT	Not found in text reviewed
9.2	Performance Guarantees	Utilization threshold conditions	SILENT	Not found in text reviewed
9.3	Performance Guarantees	Bonus-driven fee incentives	ADVERSE TEXT	"Enhanced Personal Health Care Fee. A fee shall be charged for Anthem's oversight of Enhanced Personal Health Care with Providers or Vendors. Such fee shall be 25% of..." Clause 7
9.4	Performance Guarantees	Penalty avoidance terms	SILENT	Not found in text reviewed
10.1	Termination and Exit Barriers	Early termination penalties	SILENT	Not found in text reviewed
10.2	Termination and Exit Barriers	Data export restrictions at exit	SILENT	Not found in text reviewed
10.3	Termination and Exit Barriers	Bundled renewal lock-in	ADVERSE TEXT	"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..." Clause 2
10.4	Termination and Exit Barriers	Financial penalty for changing PBMs	ADVERSE TEXT	"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..." Clause 2
11.1	Claim Adjudication Logic	Retroactive claim adjustment authority	ADVERSE TEXT	"Provider contracts will govern the rights and obligations as between the Parties and Providers (e.g., reimbursement rates and methodologies, filing and Claim adjustment..." Clause 4
11.2	Claim Adjudication Logic	Reversal discretion without notice	SILENT	Not found in text reviewed
11.3	Claim Adjudication Logic	Pricing recalculation rules	ADVERSE TEXT	"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 Clause 5
11.4	Claim Adjudication Logic	Reprocessing visibility	SILENT	Not found in text reviewed
12.1	Fiduciary and Legal Protections	Fiduciary or duty disclaimers	SILENT	Not found in text reviewed
12.2	Fiduciary and Legal Protections	Indemnification balance	SILENT	Not found in text reviewed
12.3	Fiduciary and Legal Protections	Liability limitation terms	SILENT	Not found in text reviewed
12.4	Fiduciary and Legal Protections	Conflict-of-interest disclosure	ADVERSE TEXT	"Anthem shall retain 100% of the Medical Drug Clause 1
13.1	Data Ownership and Access Rights	Vendor ownership of claims data	SILENT	Not found in text reviewed
13.2	Data Ownership and Access Rights	Delayed or incomplete data access	SILENT	Not found in text reviewed
13.3	Data Ownership and Access Rights	Data portability at exit	SILENT	Not found in text reviewed

SECTION 17

Appendix B: Score Calculation Sheet

Each provision receives a score from 0 to 10, where 10 means the agreement fully protects the county on that provision. Scores are assigned by the analyst from the evidence in Appendix A, giving the most weight to adverse text and less to silence, since silence can be cured by a request. Weights reflect each provision's economic weight and sum to 100%.

#	PROVISION	ADVERSE	SILENT	PHARMACY	SCORE	WEIGHT	SCORE × WEIGHT	RATING
1	Pricing and Reimbursement	2	0	4	2.5	10%	25.0	Red Flag
2	Spread Pricing	3	0	1	1.5	12%	18.0	Red Flag
3	Rebates and Manufacturer Revenue	1	4	1	0.5	12%	6.0	Red Flag
4	Formulary Control	1	0	4	2.0	7%	14.0	Red Flag
5	Pharmacy Network Design	2	0	3	2.0	8%	16.0	Red Flag
6	Specialty Drug Management	3	2	0	1.0	8%	8.0	Red Flag
7	Audit Rights and Recovery	2	3	0	2.5	8%	20.0	Concern
8	Transparency and Disclosure	2	2	1	1.5	8%	12.0	Red Flag
9	Performance Guarantees	1	3	0	3.0	7%	21.0	Concern
10	Termination and Exit Barriers	2	2	0	2.5	6%	15.0	Concern
11	Claim Adjudication Logic	2	2	0	2.0	5%	10.0	Red Flag
12	Fiduciary and Legal Protections	1	3	0	1.5	5%	7.5	Red Flag
13	Data Ownership and Access Rights	0	3	0	2.5	4%	10.0	Concern
	Total	**22**	**24**	**14**		**100%**	**182.5**	

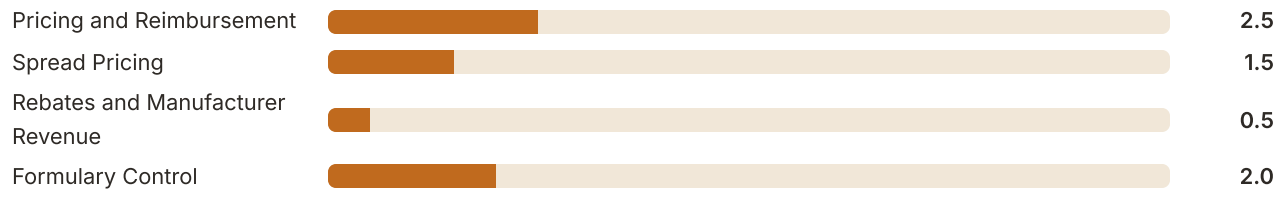
COMPOSITE DERIVATION

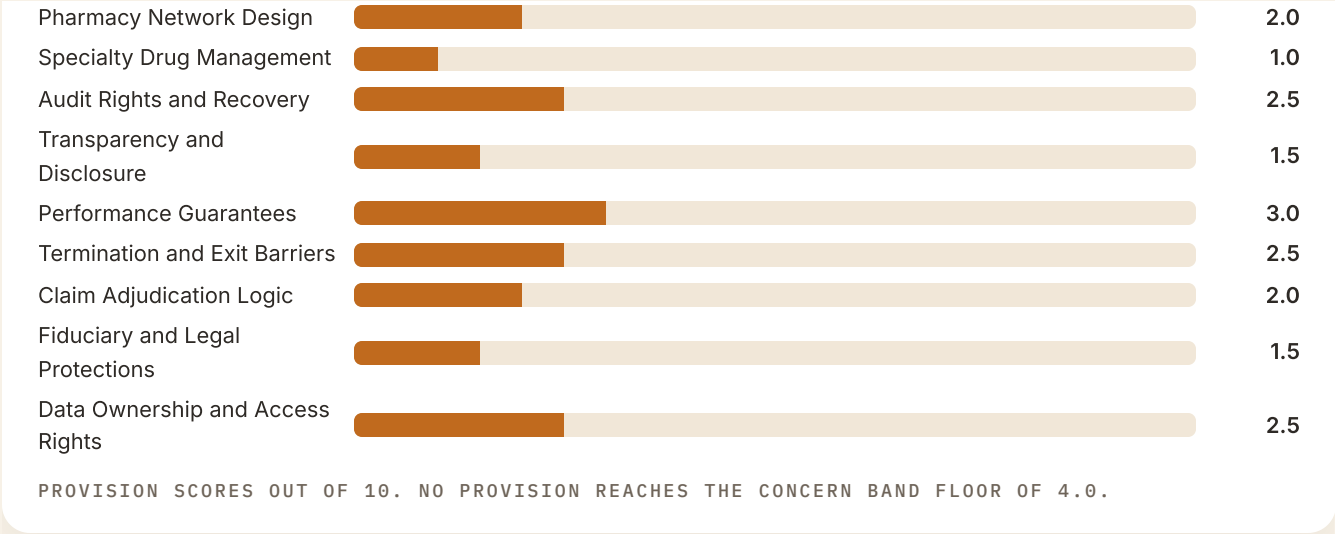
Composite = Σ(score × weight) ÷ 100 × 10

```
(2.5 × 10) + (1.5 × 12) + (0.5 × 12) + (2 × 7) + (2 × 8) + (1 × 8) + (2.5 × 8) + (1.5 × 8) +
(3 × 7) + (2.5 × 6) + (2 × 5) + (1.5 × 5) + (2.5 × 4)
= 182.5
182.5 ÷ 100 × 10 = 18.25, reported as 18/100
```

BANDS: 0–39 RED FLAG • 40–69 CONCERN • 70–100 ALIGNED. FIVE PROVISIONS CANNOT BE FULLY SCORED UNTIL THE PHARMACY SERVICES SCHEDULE IS PRODUCED; THEIR SCORES SHOULD BE REVISITED THEN.

Rating bands by provision





PROVISION SCORES OUT OF 10. NO PROVISION REACHES THE CONCERN BAND FLOOR OF 4.0.

SECTION 18

Appendix C: Consolidated Amendment Package

The recommended language from Sections 2 to 14, collected for counsel. Bracketed values are negotiating variables for the county to set. Each clause is drafted to stand alone so the county can trade them individually.

AMENDMENT 1 • PROVISION 10: TERMINATION AND EXIT BARRIERS

"Termination of the Pharmacy Services Schedule shall not change the Administrative Services Fees by more than $[X] per employee per month. On termination of any part of this Agreement, Anthem shall deliver complete Claim history in an industry-standard format within 30 days at no charge."

AMENDMENT 2 • PROVISION 3: REBATES AND MANUFACTURER REVENUE

"Anthem shall remit to Employer 100% of Medical Drug Rebates, pharmacy rebates and all other manufacturer payments attributable to Employer's Claims, including administrative fees and price-protection payments, within 90 days of receipt, with a report identifying each drug, Claim count and amount received."

AMENDMENT 3 • PROVISION 2: SPREAD PRICING

"Savings-based fees, including the Traditional Network Savings Fee and Non-Network Savings Fee, shall be calculated only against the lesser of Billed Charges or [150]% of the Medicare allowable for the service, shall not exceed $[X] in total per plan year, and shall be itemized by Claim in a monthly report to Employer."

AMENDMENT 4 • PROVISION 6: SPECIALTY DRUG MANAGEMENT

"Anthem shall report quarterly, by drug, all specialty drugs paid under the medical benefit, including billed, allowed and paid amounts, site of care, and Medical Drug Rebates received. Employer may direct site-of-care programs and may carve out specialty drug management to a vendor of its choice on 90 days' notice without change to other fees."

AMENDMENT 5 • PROVISION 1: PRICING AND REIMBURSEMENT

"All pharmacy claims shall be adjudicated on a pass-through basis. Employer shall be charged the amount paid to the dispensing pharmacy for ingredient cost and dispensing fee, plus the disclosed administrative fee, and no other amount. For medical claims, Anthem shall provide claim-level data showing billed charges, allowed amount and amount paid to the Provider, and the terms of this Agreement shall control where they are more favorable to Employer than any Provider contract."

AMENDMENT 6 • PROVISION 7: AUDIT RIGHTS AND RECOVERY

"Employer or its designated auditor may audit Claims, Provider reimbursement on Employer's Claims, rebates, and all fees, once per year, with a 36-month lookback, at no charge. Overpayments resulting from Anthem's error shall be refunded in full, with no recovery fee, within 30 days of agreement on the finding."

AMENDMENT 7 • PROVISION 8: TRANSPARENCY AND DISCLOSURE

"Nothing in this Agreement shall restrict Employer from accessing, using or disclosing cost, quality or Claim data as permitted by Section 2799A-9 of the Public Health Service Act, or from complying with the Indiana Access to Public Records Act. Employer may share this Agreement and its data with its auditors, consultants and counsel."

AMENDMENT 8 • PROVISION 13: DATA OWNERSHIP AND ACCESS RIGHTS

"Employer owns all data relating to its plan and members. Anthem shall deliver complete claim-level medical and pharmacy data monthly, including billed, allowed and paid amounts and rebates, and shall deliver full Claim history within 30 days of termination at no charge."

AMENDMENT 9 • PROVISION 4: FORMULARY CONTROL

"Anthem shall give Employer 60 days' written notice of any formulary change, exclusion, or change to prior authorization or step therapy that affects Employer's members, with the clinical rationale and estimated net cost impact. Employer may decline any change that increases net plan cost without a documented clinical basis."

AMENDMENT 10 • PROVISION 11: CLAIM ADJUDICATION LOGIC

"Anthem shall report monthly all retroactive adjustments and reprocessed Claims, with original and revised amounts. Adjustments that increase Employer's cost by more than $[1,000] per Claim shall require notice to Employer before funding."

AMENDMENT 11 • PROVISION 5: PHARMACY NETWORK DESIGN

"Employer shall receive, on request and at least annually, pharmacy network reimbursement terms by pharmacy type, including any affiliated pharmacy, and claim-level data identifying the dispensing pharmacy. No member shall be required to use an affiliated mail or specialty pharmacy without Employer's written approval."

AMENDMENT 12 • PROVISION 9: PERFORMANCE GUARANTEES

"Anthem shall provide performance guarantees for claims accuracy, turnaround, call answer time and reporting timeliness, with at least [15]% of annual administrative fees at risk, measured and paid annually. The Enhanced Personal Health Care Fee shall be payable only to the extent of documented net savings for attributed members."

AMENDMENT 13 • PROVISION 12: FIDUCIARY AND LEGAL PROTECTIONS

"Anthem shall disclose annually all compensation it or its affiliates receive in connection with Employer's plan, including manufacturer payments and affiliated pharmacy revenue. Anthem shall indemnify Employer for losses caused by Anthem's negligence, error or breach, and any limitation of liability shall not apply to Claim payment errors or data breaches."

SECTION 19

Appendix D: Data and Document Request Letter

A template for the county to send on its own letterhead. It asks only for documents and data; it makes no allegation. Adjust the response date to the renewal calendar.

[Date]

[Anthem account executive]
Anthem Blue Cross and Blue Shield

Re: Hamilton County 2025 Administrative Services Agreement, request for documents and plan data

In preparation for renewal, and consistent with the county's rights under the agreement, Section 2799A-9 of the Public Health Service Act and the Indiana Access to Public Records Act, Hamilton County requests the following within 30 days:

1. Pharmacy Services Schedule with all pricing exhibits
2. Schedule A, Section 3 fee exhibits
3. 2025 claim-level medical and pharmacy files with paid-to-provider fields
4. Current MAC list and update policy
5. 2024 and 2025 savings-fee detail by claim
6. Definition of savings and the reference price used
7. Monthly invoices showing savings fees as separate lines
8. 2025 Medical Drug Rebate receipts on county claims
9. Pharmacy rebate terms and 2025 rebate reconciliation
10. Definition of rebate and of other manufacturer revenue
11. Current formulary with tier placement
12. Formulary change log for 2024 and 2025
13. Net cost report for top 50 drugs by spend
14. Pharmacy network listing with affiliated pharmacies identified
15. Cost per claim by pharmacy type for 2025
16. Mail and specialty program rules
17. 2025 medical specialty drug report by J-code
18. Site-of-care program terms
19. Medical Drug Rebate receipts by drug
20. Audit provision, if any, in the full agreement
21. 2024 and 2025 overpayment recovery and fee report
22. Confidentiality and data-use sections of the full agreement
23. Standard reporting package and claim-level file layout

24. Performance guarantee schedule and 2025 results
25. Enhanced Personal Health Care program report
26. Termination sections of the full agreement
27. Written quote for medical fees with pharmacy carved out
28. 2025 adjustment and reprocessing report
29. Claims payment policy manual referenced by the agreement
30. Indemnity, limitation of liability and standard-of-care sections
31. Annual compensation disclosure from Anthem and from the county's broker
32. Data ownership and data-use sections
33. Monthly claim file specification

Please provide data files in a machine-readable format with a field dictionary. Where a document is considered confidential, please identify the specific provision relied on so that the county can evaluate it under Indiana law. The county may share these materials with its auditors, consultants and counsel.

Thank you for your help. Please direct questions to [county contact].

Sincerely,
[Name, title]
Hamilton County

SECTION 20

Appendix E: Commissioner Briefing and Glossary

ONE-PAGE BRIEFING FOR ELECTED OFFICIALS

The county funds its own health claims. Three contract terms send part of that money to the administrator.

1. **Medical Drug Rebates.** Drug makers pay rebates on clinic-administered drugs the county pays for. The contract lets Anthem keep all of them.
2. **Savings fees.** Anthem is paid half of the savings it reports on many claims, measured from billed charges that few payers actually pay.
3. **Pharmacy exit toll.** If the county moves its pharmacy benefit, Anthem may raise its medical fees by an amount the contract does not limit.

Composite score: 18 of 100 (red flag). **Evidence:** 22 of 60 checks rest on adverse contract language; the rest are requests. **Ask of the board:** authorize staff and counsel to request the documents in Appendix D and to negotiate the amendments in Appendix C at renewal.

Glossary

Administrative services only (ASO)	The county pays its own claims; Anthem processes them for a fee.
Billed charges	A provider's list price before discounts. Rarely the amount actually paid.
Medical Drug Rebate	A manufacturer payment on a drug billed through the medical plan, such as an infusion given in a clinic.
Pharmacy benefit manager (PBM)	The company that runs the prescription drug benefit: network, formulary, claims and rebates.
Pharmacy Services Schedule	The part of this agreement covering the PBM. Not in the file reviewed.
Savings fee	A fee equal to a share of the difference between a starting price and the price paid.
Spread pricing	Charging the plan more than the provider or pharmacy is paid and keeping the difference.
Formulary	The list of covered drugs and the tier each sits on.
MAC list	Maximum allowable cost list used to price generic drugs.
NADAC	A federal survey of what pharmacies pay to acquire drugs.
Gag clause	A contract term that blocks a plan from seeing or sharing cost and quality data. Prohibited by federal law.
Governmental plan	A plan sponsored by a public employer. Not governed by ERISA.
Carve-out	Moving one service, such as pharmacy, to a different vendor.
Lookback	How far back an audit may examine claims.

SECTION 21

Methodology and Disclaimer

Scoring framework

PBM Contract Clarity 360 evaluates 13 provisions against 60 defined checks. Each check receives one of three statuses: adverse text (quoted language works against the sponsor), silent (no governing language found), or pharmacy schedule (the term belongs in a schedule not in the file). Only adverse text is presented as a finding. Provision scores run from 0 to 10 and are combined using economic weights that sum to 100%.

Dollar figures

This edition states dollar exposure as formulas and, where labeled, illustrative scenarios. No figure is presented as the county's loss until the county's own claims, fee and rebate data are applied. Hamilton County does not file a Form 5500, so participant and spend figures must come from county records.

Legal context

The county's plan is a governmental plan and is not governed by ERISA. Public Health Service Act provisions added by the Consolidated Appropriations Act, 2021 (including the gag clause prohibition and broker and consultant compensation disclosure) apply to non-federal governmental plans. The PBM reforms enacted in early 2026 are written largely into ERISA; counsel should confirm which, if any, reach a county plan. County records are subject to the Indiana Access to Public Records Act.

Use of software

Contract text was extracted and matched to checks with software assistance, then reviewed by an analyst. Every adverse finding cites the quoted language it relies on.

Scope and limits

This review covers the administrative services agreement as provided. Schedule A, the Pharmacy Services Schedule, provider contracts, amendments and side letters were not in the file and may change these conclusions. Oral representations and business practices were not evaluated.

This report is for informational purposes and is not legal advice. Kincaid Health is not a law firm. Quotations should be verified against the executed agreement, and any contract change should be reviewed by the county's counsel before it is proposed or signed.

Jeremiah Franklin Shrack

Founder, CEO and Chairman, Kincaid Health

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SOURCES

Hamilton County 2025 Anthem administrative services agreement, as extracted. Public Health Service Act sections 2746 and 2799A-9, added by the Consolidated Appropriations Act, 2021. Indiana Access to Public Records Act, Ind. Code 5-14-3. Elevance Health announcement renaming IngenioRx as CarelonRx.