SJVIA PHARMACY OVERVIEW

CONSULTANTS REPORT ON PHARMACY

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Executive Summary

SJVIA pharmacy strategy — Board-level view; appendix contains supporting detail

$40M	$235	$9.3M	$5.6M	$1.6M+	2027
Annualized pharmacy spend (pre-rebate)	Annual pharmacy PMPM	Gross AOM annual run-rate	Estimated net AOM cost after modeled rebate	Generic unit-cost pricing minimum projected savings	Decision window: model, validate, preserve options

What the Board needs to know

- Q2 2026 increased versus both Q2 2025 and Q1 2026, primarily from Fresno and higher-cost drug mix, not higher claim volume.
- GLP-1 and specialty drugs remain the key pharmacy cost drivers; AOMs alone are a material budget issue.
- CarelonRx reported higher Q1 program savings than EmpiRx, but the methodologies differ and do not prove lower net plan cost.

Immediate stance

Validate net cost, rebate treatment, configuration accuracy, and renewal economics before benefit or PBM decisions.

AOM strategy if coverage changes

- If AOMs are excluded, member alternatives should be defined before the change: FDA-approved cash/self-pay pathways, physician-led weight management, lifestyle/nutrition support, bariatric surgery evaluation, and carefully positioned telehealth/cash-pay compounded GLP-1 pathways where legally available and clinically appropriate.
- Position compounded GLP-1s as a member-directed cash-pay alternative, not as an employer-sponsored replacement for FDA-approved AOM coverage.

AOM vs bariatric surgery

AOMs are an ongoing pharmacy cost; bariatric surgery is a medical-benefit pathway for clinically eligible members and should be evaluated as part of obesity strategy, not as a one-for-one replacement.

Generic price-per-pill opportunity

- The model applies to generics: fixed dollar-per-unit pricing by GCN rather than AWP discount or PBM-controlled MAC economics.
- SJVIA analysis shows approximately $1.62M–$1.73M annual projected savings, driven primarily by generic pricing improvement with no pharmacy network or benefit reduction required.
- Only a limited number of PBMs participate because the model reduces their pricing discretion and requires transparent, auditable unit-cost accountability.

RFP implication

The RFP must evaluate objective unit pricing for generics separately from traditional brand/specialty AWP discounts, rebates, admin fees, and clinical management.

Board takeaway

SJVIA does not need to decide today. The recommendation is to validate net cost, define member alternatives if AOM coverage changes, pursue the generic unit-pricing savings opportunity, and preserve competitive PBM options for the 2027 renewal.

Sources: SJVIA Jan–Jun 2026 claims; SJVIA pricing assessment; USI pharmacy analysis. Values are pre-rebate unless noted.

Appendix A: High-Level Financial Picture

APPENDIX

Board-level summary from Jan–May / Jan–Jun 2026 pharmacy experience

$40.0M	$235	60,596	8,893	$1.9K
Annualized pharmacy spend (pre-rebate)	Annual pharmacy PMPM	Paid claims Jan–May	Utilizing members (encrypted IDs)	Average cost per utilizer Jan–May

Jan–May 2026 plan cost mix

Why this matters

Pharmacy spend is concentrated in GLP-1 and specialty therapies. The renewal conversation should focus on governance, clinical criteria, net cost, and vendor accountability.

Board takeaway

Pharmacy spend is concentrated in high-cost categories. The value is in targeted oversight and net-cost management, not broad utilization metrics.

Source: SJVIA Jan–May 2026 paid pharmacy claims analysis. Values are pre-rebate and rounded.

Appendix B: Quarter-over-Quarter Pharmacy Trend

APPENDIX

Q2 2025 vs Q2 2026 and Q1 2026 vs Q2 2026; plan cost is pre-rebate

$10.88M
Q2 2026 plan cost

+$1.10M
Q2 2026 vs Q2 2025
+11.2% YoY

+$1.33M
Q2 2026 vs Q1 2026
+13.9% QoQ

-846
Claim count change
Q1 to Q2 2026

Fresno
Primary driver of
Q2 increase

Plan cost comparison

Comparison	Prior	Current	$ Change	% Change
Q2 2025 → Q2 2026	$9.78M	$10.88M	+$1.10M	+11.2%
Q1 2026 → Q2 2026	$9.56M	$10.88M	+$1.33M	+13.9%

County view

County	Q2 2025	Q2 2026	YoY $	YoY %
Fresno	$5.73M	$6.76M	+$1.02M	+17.9%
Tulare	$4.05M	$4.13M	+$0.08M	+1.9%
Total	$9.78M	$10.88M	+$1.10M	+11.2%

USI interpretation

Q2 2026 increased versus both Q2 2025 and Q1 2026. The increase is driven primarily by Fresno County. Claim count declined from Q1 to Q2 while plan cost increased, pointing to drug mix, GLP-1/specialty exposure, and high-cost claim timing rather than utilization volume.

Appendix C: Why CarelonRx Q1 2026 Reported Savings Look Higher

APPENDIX

Important distinction: reported program savings are not the same thing as lower total plan cost

$1.05M
EmpiRx Q1 2025 clinical savings

$1.87M
CarelonRx Q1 2026 reported program savings

+$0.81M
Difference in reported savings

+77%
Reported savings increase

CarelonRx Q1 2026 savings component	Q1 2026
Cost management savings	$1.617M
Manufacturer coupon savings program	$0.157M
Medical specialty utilization management	$0.091M
Ensure Rx savings	$0.0001M
Total reported product/program savings	$1.866M

Do not overstate this as “Carelon saved more.”

CarelonRx Q1 2026 is a broader reported program-savings number. EmpiRx Q1 2025 is reported as clinical savings tied to the annual clinical guarantee. These metrics may not be measured the same way.

Reality check

Q1 2025 plan cost was $8.19M under EmpiRx; Q1 2026 was approximately $9.54M under CarelonRx. Higher reported savings did not mean lower gross plan cost.

Sources: Keenan Q1 2025 and Q1 2026 savings reporting; SJVIA claims analysis. Reported program savings and clinical savings may not be directly comparable.

Appendix D: Member Alternatives if AOM Coverage Is Excluded

APPENDIX

HRA is not an option; member support should be defined before any benefit change

FDA-approved cash / self-pay pathways

Members who still want AOM therapy may pursue manufacturer/direct pharmacy, telehealth, or other cash-pay pathways outside the plan. USI should validate current options and communications before rollout.

Bariatric surgery evaluation

For clinically eligible members, bariatric surgery remains a medical-benefit pathway and should be evaluated separately from pharmacy AOM coverage.

Physician-led weight management

Create a medical or vendor pathway for obesity evaluation, nutrition support, behavioral coaching, labs, contraindication review, and escalation criteria.

Transition / exception process

If coverage is excluded, define advance notice, grandfathering, exception criteria, and appeal handling before implementation.

Non-GLP-1 FDA-approved obesity medications

Where clinically appropriate, members may discuss other FDA-approved weight management medications with their providers. These are not equivalent to GLP-1 AOMs and require medical judgment.

Compounded GLP-1 cash-pay pathways

Position as a member-directed option through telehealth/cash-pay vendors such as Hims & Hers, Noom, and similar models where legally available and clinically appropriate. Members may also use available FSA or HSA can be utilized to help cover eligible prescription costs.

Sources: USI pharmacy strategy framework; FDA/NIDDK guidance on approved obesity medications and compounded GLP-1 risks.

Appendix E: AOMs vs. Bariatric Surgery

APPENDIX

Cost-benefit view: recurring pharmacy spend vs. front-loaded medical intervention

AOM / GLP-1 pharmacy path

- SJVIA AOM run-rate is approx. $9.3M gross and $5.6M after modeled rebate value.
- Recurring budget exposure as long as therapy continues and coverage remains available.
- Broader access and no procedure risk, but utilization can grow quickly.
- Cost levers: eligibility, continuation rules, weight-management support, tiering, and cash/direct purchasing strategy.

Cost-benefit lens

- Medication: lower upfront friction, but sustained Rx costs can accumulate quickly.
- Surgery: higher upfront medical episode, but may be more cost-effective over time for clinically eligible severe obesity.
- Published 2-year study: GLP-1 RA total costs $63.5K vs. bariatric surgery $51.8K; weight loss 10.3% vs. 28.3%.
- Actual value depends on eligibility, adherence, discontinuation, complications, comorbidities, and plan-paid amounts.

Bariatric surgery path

- Medical-benefit pathway; not a one-for-one replacement for pharmacy AOM coverage.
- Front-loaded cost with pre-op, procedure, post-op, and long-term monitoring requirements.
- Potential long-term medical offset through durable weight loss and comorbidity improvement.
- Candidate subset only; requires medical necessity, member readiness, provider network, and quality oversight.

External benchmark	GLP-1 therapy often has lower initial cost but recurring annual spend	Bariatric surgery generally has higher upfront cost but may be more cost-effective over time for eligible severe obesity

Sources: SJVIA claims analysis; JAMA Surgery 2025 comparative cost/outcomes study; American College of Surgeons 2024 cost-effectiveness summary. Values shown are directional and require SJVIA-specific medical claims modeling.

Appendix F: Generic Price-Per-Pill Program

APPENDIX

Terry Killilea / USI model applies to generics; savings come from fixed unit-cost procurement

$1.62M	$1.73M	$1.554M	$11.14+
Minimum projected annual savings	High-performance projected savings	Generic pricing opportunity modeled in report	Minimum savings per Rx

What changes

- Generic claims are priced using a fixed dollar-per-unit schedule by GCN rather than subjective AWP discount or MAC economics.
- The model targets high-cost generics and specialty generics where traditional PBM generic pricing can materially overcharge.
- The model is auditable at claim level: quantity × unit price = expected claim cost.

What does not change for members

- No pharmacy network narrowing is required to achieve the modeled savings.
- No reduction in the pharmacy benefit is required.
- No member disruption is expected solely from moving generic pricing to a fixed unit-cost methodology.

Source: SJVIA Assessment of Prescription Pricing/Potential for Cost Reduction, June 2026.

Appendix G: Why Few PBMs Participate / How the RFP Changes

APPENDIX

Price-per-pill reduces PBM discretion and requires objective, auditable generic pricing

Traditional AWP / MAC RFP

- PBMs bid AWP discounts, MAC guarantees, rebates, admin fees, and aggregate performance terms.
- Savings are often modeled using PBM assumptions and aggregate guarantees.
- Claim-level outliers can be obscured by averages, exclusions, and offsetting.
- More PBMs are willing to bid because the model preserves PBM pricing flexibility.

Best use

Brand, specialty, rebate, admin fee, clinical program, and network comparison.

Generic price-per-pill RFP

- Vendors must price generics using fixed dollar-per-unit values by GCN.
- Savings are calculated from objective line-item math, not PBM repricing assumptions.
- The plan can validate pricing directly at claim level.
- Fewer PBMs participate because it limits margin, MAC discretion, repricing flexibility, and opaque generic economics.

Best use

Generic pricing procurement and high-cost generic oversight; still pair with brand/specialty/rebate analysis.

Board takeaway

A price-per-pill RFP is not simply a different discount. It is a different procurement philosophy: objective generic unit pricing, claim-level auditability, and less PBM pricing discretion.

Source: SJVIA pricing assessment and USI pharmacy consulting framework.

Appendix H: Recommended 2026–2027 Pharmacy Direction

APPENDIX

Use data, governance, and market leverage before final renewal decisions

Now

Validate controls

Confirm GLP-1 policy, PA controls, benefit configuration accuracy, rebates, and exclusions.

Q3 2026

Build dashboard

Track GLP-1/AOM, specialty, PMPM, top drugs, high-cost claimants, pharmacy channel, and net-cost drivers.

Q4 2026

Model options

Evaluate AOM exclusion/member alternatives, bariatric strategy, generic unit pricing, DTC pathways, and rebate impact.

1/1/2027

Keep options open

Be prepared for renewal action, market check, or competitive PBM evaluation based on validated economics.

What USI will bring back

- Validated AOM / GLP-1 forecast and PMPM
- Benefit-design options with member-impact analysis
- Carelon rebate / guarantee / configuration validation
- Specialty and biosimilar strategy

Additional deliverables

- Generic price-per-pill RFP readiness
- AOM exclusion alternatives without HRA
- Bariatric surgery strategy comparison
- Clear renewal recommendation before decisions are required

Board takeaway

The objective is not more detail; it is better decision support: stronger oversight, validated net cost, and multiple options before SJVIA commits to the 2027 pharmacy strategy.

Source: USI pharmacy consulting strategy framework based on SJVIA claims, trend reporting, pricing assessment, and CarelonRx diligence needs.