Greg Reybold, Esq.
Vice President of Public Policy
American Pharmacy Cooperative, Inc.
5601 Shirley Park Drive
Bessemer, Alabama 35022

July 13, 2026
The Honorable Tommy Tuberville, Chairman
The Honorable Elizabeth Warren, Ranking Member
Subcommittee on Personnel
Committee on Armed Services
United States Senate
Washington, DC 20510

cc: The Honorable Roger Wicker, Chairman, Full Committee
cc: The Honorable Jack Reed, Ranking Member, Full Committee

**RE: TRICARE Pharmacy Program**

Dear Chairman Tuberville, Ranking Member Warren, and Members of the Subcommittee:

Thank you for the opportunity to submit this written statement in advance of my upcoming oral testimony, and thank you for your attention to Pharmacy Benefit Manager (PBM) practices within the TRICARE pharmacy program and how those practices may negatively impact their beneficiaries, taxpayers, and retail pharmacies across the country.

The practices of large PBMs, including TRICARE's contracted manager, Express Scripts ("ESI"), have been the subject of significant scrutiny over the past several years by Congress, state legislatures, and the FTC, alongside numerous audits of PBM practices at both the federal and state levels.

Some of these troubling practices include steering patients into PBM-owned pharmacies, paying PBM-owned pharmacies higher reimbursement rates than non-affiliated pharmacies, marking up generic "specialty" medications required to be filled at PBM-owned specialty pharmacies, adjusting and offsetting retail pharmacy reimbursements after adjudication, engaging in spread pricing, and leveraging their aggregate books of business to generate revenue that is not passed back to clients, even when contractual or legal pass-through requirements explicitly exist. With regard to ESI, and as more fully elaborated below, their practices within Federal Employee Health Benefits Program ("FEHBP") plans are particularly relevant and instructive.

Additionally, while PBM reimbursement practices regarding independent pharmacies have drawn widespread attention, including from the FTC, this problem has been particularly acute within the TRICARE pharmacy program. It has resulted in the exodus of approximately 15,000 independent pharmacies across the country.

As more fully elaborated below, evidence suggests this contraction was by design, with ESI leveraging its control over reimbursements as a mechanism to achieve its end of reducing the number of pharmacies in the TRICARE retail pharmacy network.

In response to questions and concerns raised by members of this Committee and other members of Congress, the Defense Health Agency (DHA) has taken the broad position that the TRICARE pharmacy program is fundamentally different: that ESI does not negotiate rebates or set the formulary, and that the TRICARE Fifth Generation (T5) Agreement prohibits spread pricing, pharmacy transaction fees, and drug markups at ESI's mail-order and specialty pharmacies. To paraphrase, the response has been "nothing to see here." DHA appears to harbor no outward concerns over ESI's behavior or the execution of its duties under the TRICARE contract.

At the outset, it is vital to acknowledge that there are indeed unique components of the TRICARE pharmacy program, some of which are mandated by federal law. However, these structural differences do not negate the need for rigorous oversight or accountability regarding ESI's administration of the program. Rather, they require closer scrutiny and increased vigilance.

Providing benefits to approximately 9.5 million active-duty service members, retirees, and their families, TRICARE is one of the largest standalone healthcare programs in the nation and one of ESI's largest accounts. We must ensure that ESI is leveraging the immense size and scale of this program to the sole benefit of its beneficiaries, the DoD, and American taxpayers, not using it to negotiate, collect, and retain aggregate discounts for themselves.

However, a review of ESI's practices within the FEHBP, alongside their own legal representations in litigation, reveals grave cause for concern. Taken together, these precedents should compel immediate, continued scrutiny and should instruct the specific steps required to ensure that PBMs administering TRICARE benefits cannot leverage vertical integration or TRICARE volume to extract corporate profit at the expense of the TRICARE pharmacy program. Any such extraction of profit directly hurts TRICARE beneficiaries, American taxpayers, and the community pharmacies that have proudly cared for our service members and their families.

To achieve true accountability, the path forward requires a three-pronged approach: a comprehensive audit leveraging the unique expertise of the Office of Personnel Management Office of Inspector General (OIG) via an inter-agency agreement with the DoD, structural improvements to the T5 pharmacy contracting standards, and decisive legislative action.

## THE TRICARE PHARMACY PROGRAM STATUTORY FRAMEWORK

The federal legislative framework for the TRICARE pharmacy program is unique in several ways. As a preliminary matter, the federal code structurally advantages the program's mail-order pharmacy over retail network pharmacies.

First, federal law provides that:

> [T]he pharmacy benefits program shall require eligible covered beneficiaries generally to refill non-generic prescription maintenance medications through military treatment facility pharmacies or the national mail-order pharmacy program.[1]

In layman's terms, federal law prohibits retail network pharmacies from filling brand-name maintenance medications on an ongoing basis in most cases. Importantly, ESI's mail-order pharmacy is the designated mail-order pharmacy under the TRICARE pharmacy program.[2] Additionally, federal law provides that prescription drugs not included on the uniform formulary be available "through the national mail-order pharmacy program."[3]

Federal law also codified copay tiers that make the use of retail pharmacies significantly more expensive for non-active-duty beneficiaries than the mail-order pharmacy.[4] Under the 2026 cost-sharing structure, a beneficiary is heavily penalized for using a local retail pharmacy of their choice:[5]

| **Pharmacy Type** | **Generic Drug Days' Supply** | **Beneficiary Copay** |
|---|---|---|
| Mail-Order | 90-Day Supply | $14 |
| Retail Pharmacy | 90-Day Supply (3 x 30-day) | $48 |

This structure forces beneficiaries to pay **242% more** to fill generic drugs at retail pharmacies. While these tiers are promoted as a way to pass mail-order "savings" to beneficiaries[6], in actual implementation, and as more fully elaborated below, beneficiaries often pay less than the statutory copay at retail pharmacies for generic drugs.[7]

For context, several of these codified requirements, if implemented via contract between a PBM and a commercial or local governmental client, would run afoul of certain state anti-steering laws.[8] It is also worth noting that these federal provisions restrict patient choice and are contrary

---

[1] 10 U.S.C. § 1074g(a)(9)(A).
[2] See DoD, DHA, TRICARE Pharmacy Program: Home Delivery, available at https://tricare.mil/homedelivery/.
[3] 10 U.S.C. § 1074g(a)(5).
[4] 10 U.S.C. § 1074g(a)(6)(A).
[5] *Id.*
[6] *See* DoD, DHA, TRICARE Pharmacy Program: Home Delivery, available at https://tricare.mil/homedelivery/; see also DoD, DHA, TRICARE Pharmacy Program: Pharmacy Costs, available at https://tricare.mil/Costs/PharmacyCosts.
[7] DoD, DHA, Evaluation of the TRICARE Program: Fiscal Year 2023 Report to Congress, p. 50 (Feb. 28, 2023) [hereinafter *TRICARE 2023 Report*], available at https://health.mil/Reference-Center/Reports/2023/09/07/Annual-Evaluation-of-TRICARE.
[8] *See* O.C.G.A. § 33-64-11(a)(7) (prohibiting patient steering); *see also* O.C.G.A. § 33-64-1(15) (defining "steering" to include offering or implementing plan designs that require an insured to use a PBM-affiliated pharmacy, or increasing an insured's cost when choosing not to use an affiliate pharmacy).

to free-market principles, effectively affording a statutorily entrenched competitive advantage to the TRICARE pharmacy program's mail-order pharmacy, ESI.[9]

Additionally, the federal code itself explicitly contemplates formularies as well as the ability for the program to avail itself of federal pricing and rebates, whether the drug is dispensed through the program's mail-order pharmacy or a pharmacy within its retail network.[10]

**DHA'S PASSIVE OVERSIGHT AND THE UNTESTED ASSUMPTIONS OF THE T5 AGREEMENT**

In a May subcommittee hearing, in response to a question regarding whether he was concerned about certain ESI practices within the TRICARE network, Assistant Secretary Bass answered:

> [T]his PBM, this TRICARE PBM, is different than a normal PBM. It provides administrative services only and is a contract management mechanism for the departments. It does claims, mail order pharmacy, and is paid a fixed fee for each of the prescriptions. The Department of War controls the pricing and retains the cost savings.[11]

In a September 2025 Report to the Armed Services Committee, the DOD provided assurance that the T5 contract between it and ESI was "structured to ensure DoD has full transparency of cost and oversight of the TRICARE pharmacy benefit program."[12] It noted that, amongst other things, that the DoD does not utilize its PBM for formulary management, that the PBM does not negotiate drug prices, that a replenishment model is used to maintain inventory for the mail-order program with the DHA purchasing drugs for the mail-order and military medical treatment facilities through the National Prime Vendor Contract, and that the PBM is paid a mail-order administrative fee per prescription dispensed.[13]

Regarding ESI's TRICARE retail network specifically, the DoD stated:

> [t]here are no spread pricing, price concessions, rebates, or other remunerations to the PBM for pharmaceutical agents dispensed to beneficiaries under the TRICARE retail pharmacy network point of service. The PBM is solely paid an administrative fee for processing retail prescription claims. The PBM acts as a fiscal intermediary for DoD per the TPharm contract, and all negotiated savings (i.e., lower reimbursement rates) are passed directly to the DOD.[14]

To be clear, the DoD's intentions under the T5 contract deserve praise, they sought to prohibit spread pricing, secure pass-through terms, and capture all negotiated savings.

However, a recent GAO review of TRICARE pharmacy program oversight highlighted that the DHA relies heavily on unverified, contractor-reported data to monitor key aspects of program

---

[9] *See* FTC, "Pharmacy Benefit Managers: The Powerful Middlemen Inflating Drug Costs and Squeezing Main Street Pharmacies, Interim Staff Report, July 2024, available at https://www.ftc.gov/system/files/ftc_gov/pdf/pharmacy-benefit-managers-staff-report.pdf?os=fdF&ref=app ("FTC Interim Report").

[10] *See* 10 U.S.C. § 1074g(a)(2) & (f) (regarding the application of federal ceiling prices and manufacturer rebates to the retail network).

[11] Hearing on Department of Defense Personnel Policies and Programs in Review of the Defense Authorization Request for Fiscal Year 2027 Before the S. Comm. on Armed Services, Subcomm. on Personnel, 119th Cong. (May 20, 2026) (oral testimony of the Honorable Keith Bass, Assistant Secretary of Defense for Health Affairs).

[12] DoD, DHA, TRICARE Payments for Drugs on the Federal Supply Schedule, Report to the Senate Armed Services Committee (Sept. 2025) [hereinafter *DoD FSS Report*], available at https://health.mil/Reference-Center/Reports/2025/09/11/TRICARE-Payments-for-Drugs-on-the-Federal-Supply-Schedule.

[13] *Id.*

[14] *Id.*

operations, underscoring the urgent need for a comprehensive, independent look at the financial books.[15]

In sum, DHA maintains that the unique nature of the TRICARE pharmacy program, combined with the structural language of the T5 contract, ensures ESI acts strictly as a fiscal intermediary and that all savings are passed through. However, a review of OIG audit findings, ESI's defenses of the practices uncovered in those audits, and ESI's representations made in various litigations demonstrate an urgent need to investigate ESI's conduct in administering the TRICARE pharmacy program.

## OIG AUDIT FINDINGS AND ESI'S PRACTICES IN THE FEHBP

### The Spread is There: Despite Existence of a Pass-Through Contract, OIG Audits Uncover ESI Negotiating and Keeping Aggregate Retail Pharmacy Discounts and Fees for Itself in FEHBP

In March of 2024, the OIG released its Final Audit Report for its Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2016 through 2021 (ESI APWU Audit).[16] The purpose of the ESI APWU Audit was "to determine whether the costs charged to the FEHBP, and the services provided to its members, were in accordance with the terms of the Contract, the Agreement, and applicable federal regulations."[17]

Similar to the T5 Agreement, ESI's contract with the Postal Workers Union Health Plan was a pass-through-transparent contract:

> The PBM agrees to provide pass-through transparent pricing based on the PBM's cost for drugs . . . in which the Carrier receives the value of the PBM's negotiated discounts, rebates, credits, and other financial benefits.[18]

In its audit, the OIG found that ESI "did not provide pass-through transparent pricing to the Carrier and the FEHBP at the value of the PBM's negotiated discounts found in retail pharmacy agreements."[19]

In its review, the OIG discovered that ESI provided the OIG with "internal reimbursement schedules," i.e. the retail pharmacy reimbursement rates "were created by the PBM for its clients and not negotiated with the retail pharmacies."[20] As such, the OIG "re-requested that the PBM provide [the OIG] with its actual pharmacy agreements.[21]

---

[15] U.S. Gov't Accountability Office, GAO-25-107187, Defense Health Care: DoD Should Improve Monitoring of TRICARE Beneficiaries' Access to Prescription Drugs (Feb. 2025) [hereinafter *GAO Access Report*].
[16] U.S. Office of Personnel Management, Office of the Inspector General, Final Audit Report: Audit of the American Postal Workers Union Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2016 through 2021, Report No. 2022-SAG-029 (Mar. 29, 2024) [hereinafter *ESI APWU Audit*].
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*

When the OIG obtained the actual retail pharmacy agreements, the OIG found that ESI's FEHBP pricing was higher than the discounts negotiated in its retail pharmacy agreements resulting in a **$12.4 million overcharge**.[22]

Put another way, the reimbursement schedules ESI provided to its client and the OIG **did not match** the reimbursement schedules in ESI's agreements with the retail pharmacies and it resulted in spread pricing.

ESI defended the margin by stating:

> ESI. . . may maintain non-client specific aggregate guarantees with pharmacies and may realize positive margin. ESI may charge pharmacies standard transaction fees to access ESI's pharmacy claims systems and for other related administrative purposes. ESI may also maintain certain preferred value or quality networks; pharmacies participating in those networks may pay or receive aggregated payments related to these networks.[23]

The OIG cut through the corporate jargon, explicitly concluding that ESI uses fluctuating retail pharmacy claim pricing to generate backend margins via standard spread-pricing mechanics:

> *"Pharmacies allow PBMs to fluctuate the pricing of retail pharmacy claims as long as total business (all clients) equals the negotiated discount in the pharmacy agreements. The PBM's discounts given to the Carrier are not the negotiated discount, but instead are the discounts that align closest to the guarantee found in the Carrier's PBM agreement.* ***This industry standard is used by PBMs under traditional spread pricing arrangements, not transparent pricing arrangements****."* [emphasis added].[24]

Additionally, the ESI APWU Audit revealed $2.2 million in pharmacy transaction fees which were not passed through to the Carrier. ESI maintained the transaction fees were "not tied to the cost of prescription drugs," but the OIG noted "the transaction fees would not have been paid to the PBM without the FEHBP prescription being filled."[25]

In November of 2024, the OIG released its Final Audit Report for its Audit of Compass Rose Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2017 through 2022 (ESI Compass Rose Audit).[26] Similar to the T5 Agreement, and ESI's agreement with the Postal Workers Union Health Plan, ESI's agreement with Compass Rose Health Plan required "pass-through transparent pricing."[27]

The audit found there was in excess of **$5.8 million** in PBM negotiated pharmacy discounts that ESI retained for itself.[28] Importantly, the OIG found that ESI "used its own internal pricing with a higher reimbursement rate for FEHBP than the discounts negotiated in its retail pharmacy/network agreements."[29]

---

[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] U.S. Office of Personnel Management, Office of the Inspector General, Final Audit Report: Audit of Compass Rose Health Plan's Pharmacy Operations as Administered by Express Scripts, Inc. for Contract Years 2017 through 2022 [hereinafter ESI Compass Rose Audit].
[27] *Id.*
[28] *Id.*
[29] *Id.*

The audit also identified $925,000 in retail pharmacy transaction fees which were not passed through to the Carrier.[30]

Taken together, these audits uncovered that ESI is creating spread by leveraging tactics including non-claim specific aggregate discounts and transaction fees that are not tied to the price of a drugs.

| **Discrepancy** | **Postal Workers Union Report # 2022-SAG-029 [ESI] [2016-2021] Mar. 2024** | **Compass Rose Report # 2023-SAG-019 [ESI] Nov. 2024** |
|---|---|---|
| Pass through of retail pharmacy discounts | $12,484,472 | $5,819,737 |
| Pass through of credits for retail pharmacy transaction fees | $2,279,264 | $925,895 |

*See* ESI APWU Audit*, supra* note 16*;* ESI Compass Rose Audit*,* note 26*.*

**OIG Audits Uncover ESI Keeping Manufacturer Rebates and Discounts**

The ESI APWU Audit identified, $4.9 million in drug manufacturer rebates paid to ESI that were not passed back to the plan; $14.4 million in drug manufacturer rebates that were paid to Ascent Health Services, an ESI affiliate housed overseas that serves as a rebate aggregator; and $5.9 million in drug-inventory purchasing discounts.[31]

With regard to the drug-inventory purchasing discounts, ESI maintained "non-specific drug discounts are received based on the total purchases made from drug manufacturers and wholesalers for the PBM's inventory."[32] However, the OIG noted:

> The PBM would not have received these non-specific drug discounts without the FEHBP drug 14 Report No. 2022-SAG-029 utilization, therefore even if these discounts may not be attributed to a certain drug, they are attributable to an entire client group.[33]

Similarly, in the ESI Compass Rose Audit, the OIG identified $9.5 million in drug manufacturer rebates that were paid to Ascent Health Services, an ESI affiliate housed overseas that serves as a rebate aggregator; and $190,000 in drug-inventory purchasing discounts.[34]

[30] *Id.*
[31] *ESI APWU Audit supra* note [16].
[32] *Id.*
[33] *Id.*
[34] *ESI Compass Rose Audit supra* note [26].

## ESI'S SPREAD PRICING AND REBATE PRACTICES IN THE FEHBP DEMAND SCRUTINY IN THE TRICARE PHARMACY PROGRAM

### ESI Performs Retail Pharmacy Network Services on an Indivisible Basis across TRICARE and non-TRICARE Plans

As a preliminary matter, despite being different plans, there are significant parallels between TRICARE and the FEHBP plans audited by the OIG. First, ESI administers the retail pharmacy networks for the TRICARE pharmacy program and the APWU and Compass Rose plans.[35] Second, ESI is required to pass-through retail pharmacy pricing in all three plans, meaning spread pricing is prohibited in all three plans.[36] Given these reasons, the OIG findings in FEHBP should compel immediate DHA scrutiny of ESI's retail pharmacy pricing practices in TRICARE including, without limitation an audit.

However, the reasons become even more stark in light of ESI's own legal representations regarding how it administers its retail pharmacy networks. Specifically, in legal filings in connection with a 2023 lawsuit brought by the Ohio Attorney General, alleging that ESI, its offshore vertically integrated rebate aggregator, and other related companies conspired to drive up prescription drug prices, ESI maintained that:[37]

- "Express Scripts performed pharmacy network services for federal and non-federal clients on an indivisible basis."
- "Express Scripts' pharmacy network services are performed simultaneously and on an undivided basis for TRICARE and non-TRICARE plans."
- "Express Scripts does not negotiate separate TRICARE or FEHB-specific agreements with retail pharmacies; it negotiates a single network agreement with each pharmacy."

In seeking to use TRICARE as a shield in litigation to argue federal preemption, ESI has inadvertently made a damning confession: the retail network pharmacy services it provides to the TRICARE pharmacy program and its FEHBP clients are effectively indivisible and indistinguishable.

Recall also how ESI defended its practices in the FEHBP regarding aggregate pharmacy discounts and non-drug specific transaction fees:

> *"ESI . . . may maintain non-client specific aggregate guarantees with pharmacies and may realize positive margin. ESI may charge pharmacies standard transaction fees to access ESI's pharmacy claims systems and for other related administrative purposes."*[38]

Taken together, ESI's judicial representations regarding how it performs and manages its retail network services, its staunch defense and admission of its aggregate guarantees and non-drug specific transaction fees, and the OIG's actual findings in the FEHBP audits seamlessly intersect.

---

[35] *See DoD FSS Report supra* note [12]; *see also ESI APWU Audit supra* note [16]; *ESI Compass Rose Audit supra* note [26].
[36] *Id.*
[37] See Complaint, State of Ohio ex rel. Dave Yost v. Ascent Health Services, LLC, Express Scripts, Inc., et al., No. 23-CV-H-03-0179 (Ohio C.P. Del. Cnty. filed Mar. 27, 2023) [hereinafter Ohio v. Express Scripts]; Brief for Defendants-Appellants, *State of Ohio ex rel. Yost v. Ascent Health Servs., LLC*, No. 24-3033 (6th Cir. Apr. 30, 2025).
[38] *ESI APWU Audit supra* note [16].

They foreshadow exactly what an independent OIG audit of the TRICARE pharmacy program is likely to find.

**Programmatic Differences Aside, Scrutiny of ESI Contracts With Drug Manufacturers and Wholesalers Is Warranted.**

As pointed out by the DoD, there are legitimate programmatic differences in how pharmacy benefits are administered in TRICARE, including, without limitation, ESI not being responsible for setting and managing the TRICARE pharmacy program formulary, rebate collection, and the unique mail-order program which reflects drugs dispensed via ESI's mail-order pharmacy being replenished by the Defense Logistics Agency with drugs obtained through the national prime vendor contract.[39]

Nonetheless, scrutiny of ESI drug manufacturer contracts is necessary based upon ESI's representations in response to the OIG's ESI APWU Audit that:

> "[N]on-specific drug discounts are received based on the total purchases made from drug manufacturers and wholesalers for the PBM's inventory."[40]

Additionally, in Ohio ex rel. Yost v. Ascent Health Services, the Court cited a relevant T5 contract provision, stating the DoD bars ESI from collecting "fees, rebates, discounts, or premiums ***specific to processing TRICARE prescriptions***."[41] [emphasis added].

While the foregoing is but one provision, and there may be other applicable provisions that change the analysis, the reality is that while the DoD may believe ESI is not receiving any rebates or discounts in connection with medications, barring ESI from collecting rebates "specific to processing TRICARE prescriptions," seems to leave a door open for ESI to receive "non-specific drug discounts."

Additionally, in a lawsuit by ESI, once again attempting to leverage the TRICARE pharmacy program in an attempt to argue preemption, ESI conceded that it pulls from its commercial inventory to fill TRICARE mail-order prescriptions:

> The TPharm5 contract further requires ESI to use a "replenishment model" for pharmaceutical supplies and drugs (both specialty and non-specialty). TPharm5 §§C.6.1, C.6.8. Under that model, the government does not pay ESI the cost of each pharmaceutical dispensed, or send ESI's pharmacies the pharmaceutical directly from the government's wholesale pharmaceutical distributor (referred to as the "National Prime Vendor" or "NPV"). Instead, ESI's pharmacies must dispense a prescription from their own, commercially acquired inventory, and then request "replenishment" of the same drug from the NPV.[42]

Finally, in a contract between ESI and a state governmental client, ESI reveals some of the different ways in which ESI and its affiliates may derive revenue from drug manufacturers, including:[43]

---

[39] *See DoD FSS Report supra* note [12].
[40] *ESI APWU Audit supra* note [16].
[41] Ohio ex rel. Yost v. Ascent Health Servs., LLC, No. 24-3033, slip op. at 6 (6th Cir. Jan. 27, 2026).
[42] *Express Scripts, Inc., et al. v. Marlin Blane, et al.*, No. 3:26-cv-00806 (M.D. Tenn. filed June 12, 2026) [hereinafter *Express Scripts v. Blane*], Complaint at ¶ 69.
[43] Prescription Benefit Management Services Agreement between New York City Office of Labor Relations and Express Scripts, Inc., Ex. M (Financial Disclosures) (Nov. 9, 2021) (produced via public records request).

> ESI provide[s] administrative services to contracted manufacturers, which include, for example, maintenance and operation of systems and other infrastructure necessary for invoicing and processing rebates, pharmacy discount programs, access to drug utilization data, as allowed by law, for purposes of verifying and evaluating applicable payments, and for other purposes related to the manufacturer's products. ESI receives administrative fees directly from participating manufacturers and indirectly from GPOs. In its capacity as a PBM company, ESI may receive other compensation from manufacturers for the performance of various programs or services, including, for example, formulary compliance initiatives, clinical services, therapy management services, education services, inflation protection programs, medical benefit management services, cost containment programs, discount programs, and the sale of non-patient identifiable claim information. This compensation is not part of the formulary rebates or associated administrative fees, and ESI may realize positive margin between amounts paid to clients and amounts received. ESI retains the financial benefit of the use of any funds held until payment is made to the client

> ESI subsidiary pharmacies purchase prescription drug inventories, either from manufacturers or wholesalers, for dispensing to patients. Often, purchase discounts off the acquisition cost of these products are made available by manufacturers and wholesalers in the form of either up-front discounts or retrospective discounts. These purchase discounts, obtained through separate purchase contracts, are not formulary rebates paid in connection with our PBM formulary rebate programs. Drug purchase discounts are based on a pharmacy's inventory needs and, at times, the performance of related patient care services and other performance requirements. When a subsidiary pharmacy dispenses a product from its inventory, the purchase price paid for the dispensed product, including applicable dispensing fees, may be greater or less than that pharmacy's acquisition cost for the product net of purchase discounts. In general, our pharmacies realize an overall positive margin between the net acquisition cost and the amounts paid for the dispensed drugs.
>
> ESI also maintains other lines of business that may involve discount and service fee relationships with pharmaceutical manufacturers and wholesale distributors. Examples of these businesses include a wholesale distribution business, group purchasing organizations (and related group purchasing organization fees), and a medical benefit management company. Compensation derived through these business arrangements is not considered for PBM formulary placement, and is in addition to other amounts described herein. These service fees are not part of the formulary rebates or associated administrative fees.

Based upon the foregoing, even though ESI does not negotiate drug-specific rebates with pharmaceutical manufacturers in the TRICARE pharmacy program, a review of agreements between ESI and drug manufacturers and wholesalers is necessary to determine whether ESI derives any revenue (directly, through its off-shore sister rebate-aggregator company, or through its mail-order pharmacies) from drug manufacturers or wholesalers that in any way is based upon or leveraged by non-claim specific TRICARE pharmacy program volume and if so, whether that revenue is being accurately reported and passed through to the TRICARE pharmacy program.

## VERTICAL INTEGRATION AND THE EXPOSURE OF THE TRICARE MAIL-ORDER SAVINGS MYTH

### The Structural Advantage and the Shift in Beneficiary Preference

As a preliminary matter, in addition to the structural advantages mail-order pharmacy enjoys over retail pharmacies as a result of federal law, these advantages have been compounded by the fact that DHA has allowed the mail-order program to be administered by ESI via its vertically integrated mail-order pharmacy:

> ESI informed DoD of its intent to use Express Scripts Pharmacy as TRICARE's mail-order pharmacy when ESI applied for the TRICARE contract. And when DoD awarded ESI the contract, it accepted Express Scripts Pharmacy as the "Contractor's Mail Order Pharmacy." DoD thus contemplated and understood Express Scripts Pharmacy's involvement when it granted the TRICARE contract to ESI in 2002. [44]

Additionally, both ESI and DHA communicate to TRICARE beneficiaries that mail-order is their cheaper option, pointing to the statutory framework of differential copay structures addressed above. Indeed, ESI even made this representation in its pleadings:

> TRICARE members save money and pay lower copays for 90-day supplies of medications dispensed via mail-order. For example, the cost-sharing amount for a 30-day supply of a retail generic will be $16 in 2027. The cost-sharing amount for a 30-day supply of a retail brand will be $48. In 2027, the cost-sharing amount for a 90-day supply of a mail-order generic will be $14 and the cost-sharing amount for a 90-day supply of a mail-order brand will be $44.[45]

However, despite the statutory copay framework, and the marketing of the framework as a reason for beneficiaries to choose mail-order, something interesting happened, in the TRICARE pharmacy program, retail pharmacy utilization increased while mail-order pharmacy utilization decreased from 65 percent in FY 2018 to 56 percent in FY 2022.[46]

### DoD Data Indicates Higher Average Costs for Mail-Order Generic Prescriptions

Per the DoD's own data, generic medications at retail pharmacies are on average cheaper than ESI's mail-order pharmacy and can be cheaper than the copay set forth in federal law.

Specifically, according to DoD reports, the average cost to the DoD for a 30-day supply for a generic drug was more at mail-order than at retail, some years as much as 85% more expensive at mail-order.

---

[44] *Express Scripts v. Blane, supra* note [42], Complaint at ¶ 65.
[45] *Id.* at ¶ 71.
[46] *TRICARE 2023 Report, supra* note [7], at p. 50.

| Fiscal Year | AVG Cost to DOD at Retail for 30-day supply of generic | AVG Cost to DOD at mail-order for 30-day supply of generic | The difference |
|---|---|---|---|
| 2022 | $8 | $9 | $1 (12.5% more expensive at mail order) |
| 2020 | $9 | $12 | $3 (33.3% more expensive at mail order) |
| 2019 | $12 | $15 | $3 (25% more expensive at mail order) |
| 2018 | $14 | $26 | $12 (85% more expensive at mail order) |
| 2017 | $15 | $21 | $6 (40% more expensive at mail order) |

*See* Footnote. [47]

With regard to beneficiary costs, the DHA, has conceded:

> [B]ecause the copayment for retail generic drugs is the lower of the statute copayment and the actual government cost (after rebates), **the average retail generic drug copayment is less than that for home delivery drugs** (albeit for a lower average days' supply).[48][emphasis added].

The foregoing statement is striking for several reasons. First, federal law does not contemplate a lesser of logic for the copayment of retail prescriptions.[49] Moreover, while the DoD regulations do seem to allow for a lesser of logic, they do not draw a distinction between retail or mail-order for those purposes.[50] Nonetheless, implicit in that DoD's statement is that copayments to mail-order pharmacies do not contemplate a lesser of logic.[51] Indeed, in connection with preparing these statements, an EOB for a TRICARE beneficiary was reviewed, and the beneficiary paid a $14 copay to the TRICARE mail-order pharmacy in 2026 in the months set forth in the chart below.[52]

Importantly, the chart below also underscores that even with the uniqueness of the TRICARE program, ESI is reimbursing retail pharmacies in the commercial market less for some generic

[47] Data compiled from the respective annual DoD DHA Evaluation of the TRICARE Program Reports to Congress (FY 2019–2023). Data for FY 2021 is omitted as the relevant metrics were unavailable in that year's public reporting.
[48] *TRICARE 2023 Report, supra* note [7], at p. 50.
[49] 10 U.S.C. § 1074g(a)(6)(A).
[50] 32 C.F.R. § 199.21(j)(5) ("The beneficiary copayment amount for any generic drug prescription may not exceed the total charge for that prescription.").

[51] *See TRICARE 2023 Report, supra note [7], at p. 50.*
[52] TRICARE Explanation of Benefits (reviewed by author). Identifying details have been omitted to protect beneficiary privacy. Drug dosage strength was omitted in EOB reviewed.

drug claims than the copays beneficiaries are paying to ESI's mail-order pharmacy in the TRICARE mail-order program in 2026.

For context, the below commercial reimbursements are examples taken from Georgia statutory required reporting prepared by ESI.[53]

| **Drug** | **TRICARE ESI Mail-Order Reimbursement 2026 Paid By Beneficiary** | **ESI Reimbursement to GA Pharmacy In Commercial Mkt 2026** | **% Markup to Tricare Beneficiary Copayment Compared to GA Pharmacy Reimb. In Commercial Mkt** |
|---|---|---|---|
| Simvastatin tab 90<br><br>Dispensed Jan 2026 | $14 | $1.20 | 1,066% more expensive at ESI mail-order |
| DONEPEZIL HCL TABLET 90<br><br>Dispensed JAN 2026 | $14 | $1.65 | 743% more expensive at ESI mail-order |
| ESCITALOPRAM TAB 90<br><br>Dispensed March 2026 | $14 | $1.53 | 815% more expensive at ESI mail-order |
| LISINOPRIL TAB 90<br><br>DISPENSED MARCH 2026 | $14 | $0.91 | 1,438% more expensive at ESI mail-order |

**Purge of Community Pharmacies from the TRICARE Pharmacy Network**

With utilization of ESI's mail order pharmacy declining by 9 percent between 2018 and 2022, ESI requested that the DHA downsize the retail pharmacy network.[54] In the fourth quarter of 2022, DHA waived retail network size requirements representing that a smaller network could result in government savings.[55] This justification is curious since, as noted above, in the

[53] Express Scripts, *National Average Drug Acquisition Cost (NADAC) Report*, 2026 Period 1 [hereinafter *2026 NADAC Period 1 Report*] (reflecting drug reimbursement unit costs for Simvastatin 20 MG [.01344/unit], Donepezil HCL 10 MG [.01844/unit], Escitalopram 10 MG [.01700/unit], and Lisinopril 10 MG [.01022/unit]).; see O.C.G.A. § 33-64-9.1 (Under this law, PBMs are only mandated to report claims reimbursed at 10% above or 10% below NADAC).

[54] TRICARE 2023 Report, supra note [7], at p. 50; Karen Jowers, About 2,000 Independent Pharmacies Coming Back to TRICARE, Mil. Times (Dec. 8, 2022), available at https://www.militarytimes.com/pay-benefits/2022/12/08/about-2000-independent-pharmacies-coming-back-to-tricare/#:~:text=Ruedisueli%20noted%20that%20a%20Nov.%2029%20Congressional,start%20of%20the%20new%20contract%2C%E2%80%9D%20CRS%20reported.

[55] *GAO Access Report*, *supra* note [15].

TRICARE pharmacy program retail pharmacies are on average less expensive than mail-order for generic medications, retail copays can be lower for beneficiaries, and 88% of all medications dispensed at retail pharmacies are generic.[56]

Unfortunately, the DHA's authorization to drastically reduce the retail network resulted in nearly 15,000 community pharmacies being purged from the network.[57] This contraction heavily impacted independent pharmacies and forced approximately 380,000 military beneficiaries to find a new pharmacy after their trusted local provider was dropped.[58]

To understand the localized devastation of this policy, one needs only look to Arkansas:

- According to data provided by the Arkansas Pharmacy Association, as of July 2026, 401 Arkansas retail pharmacy locations are out of the TRICARE network. This includes 249 independent pharmacies. [59]
- While 401 Arkansas retail pharmacies are out of the Tricare retail pharmacy network, 55 % of ESI's mail-order pharmacy volume in the state comes from the TRICARE pharmacy program.[60]

Furthermore, the data demonstrates a higher rate of utilization within the TRICARE program compared to the commercial market. In 2024, the average number of mail-order prescriptions per TRICARE beneficiary in Arkansas was 19.3 per year, compared to 12.6 prescriptions per year for non-TRICARE commercial beneficiaries within the state.[61] This represents a 53.2% higher average mail-order prescription volume per capita within the TRICARE program than within ESI's commercial client base in the same state.

These figures present a notable paradox: while TRICARE network changes reduced local, independent retail access under the assumption of government savings, the mail-order structure in Arkansas is characterized by significantly higher per capita prescription volumes, even as the DoD has indicated that mail-order actually carries higher average costs to the government for generic medications.

## CONCLUSION, RECOMMENDED ACTIONS AND LEGISLATIVE REMEDIES

Based upon the foregoing, serious concerns exist regarding whether ESI is engaging in spread pricing in the TRICARE retail pharmacy network, leveraging the volume of the TRICARE network in a manner to retain volume-based and non-drug-specific discounts from retail pharmacies, drug manufacturers, and wholesalers. In addition, the vertical integration between ESI and its mail-order pharmacies raises serious questions with regard to generic drug prices, communications regarding mail-order savings, and the decision to reduce the size of the TRICARE retail network when data suggests retail pharmacy is the cheaper channel for generic medications and retail pharmacy utilization was increasing prior to ESI's request to reduce the network. Finally, structural statutory advantages exist for mail-order pharmacy over retail

[56] TRICARE 2023 Report, supra note [7], at p. 50.
[57] GAO Access Report, supra note [15].
[58] *Id.*
[59] Arkansas Pharmacy Association, TRICARE Network Access Analysis (unpublished).
[60] Express Scripts, Inc. v. Richmond, No. 4:25-cv-00520-BSM (E.D. Ark. May 29, 2025) (hereinafter "Richmond Complaint"), Complaint at ¶ 1.
[61] *Id.*

pharmacies within the TRICARE pharmacy program. As such, the following recommendations are made to ensure accountability, transparency, retail pharmacy access, and free market principles.

**1) Inter-Agency Audit**

The DoD OIG should enter into an interagency agreement with the OPM OIG to conduct an audit of ESI's practices within the TRICARE pharmacy program. Such an audit should include but not be limited to a review of ESI's retail pharmacy contracts to identify whether they match ESI's reimbursement schedules provided to DHA, whether ESI is engaging in aggregate pricing and post-adjudication offsets within the retail network, whether there are non-drug specific transaction fees being assessed to retail pharmacies within the TRICARE network, and whether there are non-specific drug discounts or fees (including for administrative services) being paid by retail pharmacies, drug manufacturers, or wholesalers to ESI or ESI-affiliated entities and if so, whether those discounts and fees are being retained by ESI. This will necessarily require a review of agreements between ESI (and any applicable affiliates) and retail pharmacies, agreements between ESI and drug manufacturers, and agreements between ESI and drug wholesalers. Additionally, the audit should include verification of the accuracy of required ESI reporting as well as ESI's mail-order practices, including prescriptions refilled too soon, waste in its auto-refill program, and treatment and accounting of inventory reporting in connection with replenishment.

**2) Structural Improvements to the T5 Bid Process and Contracting Standards**

Future contracts should prohibit vertical integration between the contracted PBM and any upstream or downstream entity involved in the procurement or dispensing of prescription medications, including mail-order and specialty pharmacies. In addition, the use of aggregate pricing, effective rate pricing, post-adjudication offsets, and all non-claim-specific discounts and fees from pharmacies, drug manufacturers, and wholesalers should be prohibited. There should also be robust network access for retail pharmacies with fair and transparent reimbursement and any-willing provider standards, as well as comprehensive and required periodic audits.

**3) Legislative Remedies**

As a preliminary matter, the above-mentioned audit can be required via the 2027 National Defense Authorization Act. Furthermore, 10 U.S.C. § 1074g should be amended to strip out all statutory mandates regarding the required use of mail-order pharmacy and the artificial copay tiers that penalize beneficiaries for utilizing community retail pharmacies and be replaced with a prohibition on the program's contracted PBM having ownership in mail-order or specialty pharmacies similar to the prohibitions found in S. 4509 and H.R. 8779.

In addition, legislative consideration should be given to ensure beneficiary choice of provider and robust retail pharmacy access to the TRICARE pharmacy network via federal "Any-Willing-Provider" requirements, and statutory prohibitions on PBM patient steering (short of vertical integration prohibitions). Additionally, statutory prohibitions on aggregate and effective rate pricing practices, and post-adjudication clawbacks, adjustments, and offsets should also be enacted. Finally, the TRICARE pharmacy program's contracted PBM should no longer be permitted to arbitrarily establish drug prices for retail pharmacy reimbursement purposes. Instead, a transparent, market-based index methodology, closely mirroring the NADAC-based

reimbursement models set forth in H.R. 6609 and H.R. 6610, should be adopted to ensure true price transparency, market-driven predictability, and sustainable reimbursement rates for community providers.

In implementing these targeted statutory changes, the U.S. Congress would simultaneously increase drug pricing transparency and expand access to care for TRICARE beneficiaries while permanently ensuring sustainable, market-based reimbursement for the retail pharmacies providing essential care to our nation's military families.

Respectfully submitted,

**S/ Greg Reybold**

Greg Reybold
Vice President of Healthcare Policy