

PREPARED STATEMENT
OF
DR. DAVID SMITH
DEPUTY DIRECTOR, DEFENSE HEALTH AGENCY
REGARDING
THE TRICARE PHARMACY BENEFITS PROGRAM
BEFORE THE
UNITED STATES SENATE ARMED SERVICES SUBCOMMITTEE ON PERSONNEL

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INTRODUCTION

Chairman Tuberville, Ranking Member Warren, and distinguished Members of the Committee: Thank you for the opportunity to testify before you today, alongside my distinguished colleagues from the private sector. I am here to discuss the TRICARE Pharmacy Benefits Program, and how the Department is effectively managing this important health benefit that helps support force readiness, recruitment, retention, and the health of our service members and their families. A resilient pharmacy program supports both beneficiary health and military readiness by ensuring reliable access to essential medications wherever the force operations. The Department also recognizes that sustaining this benefit requires balancing beneficiary access with fiscal stewardship, medical readiness, and the long-term affordability of the Military Health Enterprise. Accordingly, the Department continuously evaluates both program performance and emerging pharmaceutical cost trends to ensure resources remain available to support operational medical capabilities and patient care.

The Department is proud to deliver one of the most comprehensive health benefits of any employer in the country. We provide timely access to quality care in the United States and

overseas to service members families, both past and present, regardless of their geographic location. This benefit includes both health services delivered in military hospitals and clinics, as well as care delivered in the private sector.

THE TRICARE PHARMACY BENEFITS PROGRAM CONTRACT

The TRICARE pharmacy benefit includes access to prescription medicines offered to Department of War (DoW) beneficiaries through three points of service: (1) the direct care system which consists of our military medical treatment facilities (MTFs), (2) the TRICARE Mail Order Pharmacy (TMOP) which provides home delivery of prescriptions, and (3) the TRICARE Retail Pharmacy Network, which features a national network of more than 46,000 civilian retail pharmacies. For Medicare-eligible beneficiaries enrolled in TRICARE For Life (TFL), TRICARE works with Medicare as wraparound coverage—Medicare pays first for covered medical services and TRICARE generally pays second, often covering remaining cost shares; for pharmacy, Medicare Part D is usually not needed because the TRICARE pharmacy benefit provides “creditable coverage,” meaning it is at least as good as, and often more comprehensive than, standard Medicare drug coverage. Over 70% of all prescription medications are provided through the latter two programs – TRICARE mail order and retail network pharmacies. DoW beneficiaries can also elect to use any pharmacy of their choice, even if it is not part of the TRICARE Retail Pharmacy network. Beneficiaries who choose to use a non-network pharmacy are required to pay 100% of the cost of the prescription and file a claim for reimbursement after applicable deductibles and copays are applied. These three points of service are designed to provide beneficiaries with clinically appropriate access while allowing the Department to manage costs through a combination of direct federal purchasing, negotiated manufacturer discounts, statutory refunds, and formulary management.

The Defense Health Agency (DHA) manages the mail order and retail pharmacy benefit through a contract, known as TPharm, with private sector contractors experienced in and capable of managing comprehensive, nationwide prescription medicine operations and networks. DHA is currently in the 5th generation TPharm contracts, the first of which was awarded in 2001. With each successive contract, DHA has added new features and strengthened the terms of the contracts in support of beneficiaries and taxpayers. The current TPharm contract (TPharm5) is administered by Evernorth Federal Services (EFS), formerly known as Express Scripts, Inc. This contract was awarded in August 2021, and the last option year ends on December 31, 2029.

DHA administers TPharm5 through a Pharmacy Benefit Administrator (PBA) model, rather than a traditional Pharmacy Benefit Manager (PBM) model commonly used by many employers and health insurance firms. The defining feature of the PBA model is that DHA pays the contractor a fixed administrative fee per prescription filled at retail or TMOP. The TPharm5 contractor cannot generate revenue from the price of the drugs themselves at either retail or mail order outlet. PBMs also use control over formulary placement as another mechanism to drive revenue streams, which cannot happen under the TPharm5 contract due to the Government's Uniform Formulary process (which I will cover more later).

The PBA model eliminates common commercial industry profit mechanisms used by commercial PBMs such as spread pricing, retained rebates, and other manufacturer incentives. Through this model, the government ensures contractor incentives are aligned with DHA pharmacy program goals rather than revenue generated from drug pricing. Unlike traditional commercial PBMs, the Department retains responsibility for formulary decisions, pharmaceutical purchasing strategies, manufacturer negotiations, and rebate recovery. The

contractor is compensated through fixed administrative fees rather than drug prices, aligning contractor incentives with the program performance rather than pharmaceutical expenditures.

DHA oversees TPharm5 contract performance through layered, independent, and continuous oversight mechanisms to monitor contractor performance, enforce accountability, and support contract compliance. Comprehensive performance measures address items to include claims accuracy and timeliness, network adequacy, network savings, prescription and Prior Authorization (PA) processing, beneficiary access, customer services, and contractual required reporting compliance. Routine audits and reviews include reviews of 94 Contract Data Reporting Lists (CDRL), clinical criteria implementation audits, and independent claims compliance and accuracy reviews.

Performance metrics tied to award fee and incentives help align contractor performance with program goals, quality standards, and service expectations. TPharm5 contract oversight also includes regular governance and performance briefings to DHA leadership, covering contractor performance, contract compliance, emerging issues, and clinical performance measures.

In line with our commitment to oversight and continuous monitoring, we are committed to addressing findings from the 2025 GAO-25-107187 report on TPharm oversight. GAO reviewed the TRICARE pharmacy benefit and issued two findings: (1) The Director of the DHA should monitor the contractor's timeliness in dispensing mail order specialty drugs (2) The Director DHA should periodically audit TRICARE pharmacy program contractor-reported data for accuracy, as required by DHA's Quality Assurance Surveillance Plan. DHA plans to meet with GAO in mid-August 2026 to discuss a plan to close out these two recommendations.

I want to highlight that the DHA recovers costs on drug prices directly from pharmaceutical manufacturers (not the TPharm contractor) through the TRICARE Retail Refund Program (TRRP) for drugs dispensed at retail. This program leverages authority provided in Section 703 of the National Defense Authorization Act (NDAA) for Fiscal Year 2008, to bill pharmaceutical manufacturers for refunds of payments over federal ceiling prices on each manufacturer's covered drugs dispensed at retail pursuant to 38 U.S.C. 8126. Recovered refunds are returned to the government and are independent of the TPharm5 contract. Since the program was first introduced, the Department has recognized over \$22B in savings; FY26 savings alone are projected to reach \$2B. Collectively, these pricing authorities negotiated discounts, statutory refunds, and federal procurement mechanisms substantially reduce the Department's net pharmacy costs compared with commercial market pricing while preserving beneficiary access.

ACCESS TO PHARMACY SERVICES

TPharm5 established access to pharmacy service requirements as part of the contract. The contractor must offer at least one network pharmacy within a 15-minute drive for 90% of all beneficiaries (i.e., urban, suburban, and rural) and maintain a minimum network size of 35,000 pharmacies. Currently, 98.17% of beneficiaries are within a 15-minute drive time and over 99% are within a 30-minute drive. The retail network also consists of over 46,000 pharmacies, over 11,000 higher than the contractual floor. The contractor has met or exceeded access standards throughout the contract period to date. The Department continually evaluates network design to ensure beneficiary access is maintained while avoiding unnecessary costs associated with maintaining underutilized pharmacy locations. Network optimization remains an important tool for balancing access with responsible stewardship for taxpayer resources.

The limited access gaps are primarily concentrated in highly rural areas. Only 1.83% of beneficiaries are not within a 15-minute drive of at least one network pharmacy; these beneficiaries are concentrated in largely rural areas of Iowa, Idaho, Maine, Missouri, Montana, North Dakota, South Dakota, and Wyoming. Although well over 99% of beneficiaries are within a 30-min drive they always have the option of a non-network pharmacy (especially for urgent/emergent) medications or TMOP.

TPharm5 reduced the minimum network size from 50,000 to 35,000 pharmacies based on a Johns Hopkins analysis per request by the Government showing that pharmacy use is highly concentrated: 50% of pharmacies accounted for 93% of utilization, and 10% accounted for 50%. Reducing low-volume pharmacies improved negotiating leverage, lowered reimbursement costs, and preserved beneficiary access. Additionally, if DHA returned to this earlier standard, it would only reach another 0.6% of beneficiaries at substantially higher costs.

ADDED FEATURES OF THE TPHARM5 CONTRACT

In TPharm5, DHA emphasizes dispensing specialty medications at TMOP and providing attendant clinical pharmacy services to address the increased cost and complexity of care involved in the distribution and use of specialty drugs. Specialty medications are the leading driver of TRICARE pharmacy costs, accounting for **53%** (\$5371 Million in FY 2025) of total spend while representing less than 1% of prescription volume. Examples of specialty cost drivers include biologic medications such as Skyrizi and Dupixent, as well as non-biologic oncology medications such as Revlimid. The Department expects specialty pharmaceuticals, including biologics, oncology therapies, rare disease treatments, and emerging gene and cell therapies, to remain among the fastest-growing drivers of pharmacy expenditures. Accordingly, the DoW

continues to evaluate clinical management strategies, formulary tools, and purchasing approaches to preserve beneficiary access while managing long-term affordability.

The government retains full visibility and control over the cost of pharmaceuticals, dispensed from TMOP, including specialty medications. The Defense Logistics Agency procures and replenishes through its Prime Vender Program all dispensed medications "in kind" using established pricing off Federal Supply Schedules (FSS), Federal Ceiling Price/Big 4 pricing (Veterans Healthcare Act of 1992), mandatory National Contracts, and negotiated prices as part of the Uniform Formulary Blanket Purchase Agreement program, with EFS receiving no reimbursement for the cost of the drugs themselves dispensed under TMOP.

Under the mail order pharmacy point of service, Accredo, an affiliated but operationally independent entity from Evernorth (both companies are owned by Cigna), dispenses specialty medications and provides specialty pharmacy services that include enhanced customer service, and provides personalized, 24/7 care and support from a team of pharmacists and nurses trained are delivered at no additional cost beyond the existing TRICARE mail-order cost-shares established by law. Accredo dispenses approximately 64% of the specialty prescription volume for the TRICARE pharmacy benefit. Of the 64% (174,344 prescriptions for OP4, Q1), 92% of the specialty prescription claims are dispensed through TMOP where drugs are procured through the Defense Logistics Agency's contracted National Prime Vendor for Government contracted drugs.

The requirement to use mail order for select non-generic covered maintenance medications is established in law. Section 702(c) of the NDAA for Fiscal Year 2015 requires that TRICARE beneficiaries who were receiving select non-generic covered maintenance medications at a retail network pharmacy move those refills to either the mail order option or

from an MTF as part of the Enhanced MOP or MTF (EMM) program. If the specialty medication is not included in EMM, TRICARE beneficiaries retain a choice in where they fill the medication. Similar to other financial requirements in the TPharm5 contract, the contractor is reimbursed a fixed administrative fee for specialty medication dispensed, and revenue is not connected to the price of the medication.

TRICARE FORMULARY MANAGEMENT

The TRICARE Pharmacy Uniform Formulary (the covered drug list) is determined by the government through the physician-led DoW Pharmacy and Therapeutics (P&T) Committee process, rather than the TPharm5 contractor. The DoW P&T Committee develops and recommends drugs for formulary tiers; sets prior authorization (PA) criteria; and ensures the pharmacy benefit is standardized across all points of service. Additionally, the committee establishes conditions for negotiating discounts with pharmaceutical manufacturers and selects preferred agents, prioritizing clinical appropriateness first, while maintaining fiscal responsibility through comparative cost-effectiveness. In accordance with the law, and in support of public transparency behind our prescription drug coverage decisions, the Uniform Formulary Beneficiary Advisory Panel (BAP), composed of representatives from nongovernmental organizations and associations that represent the interests of eligible beneficiaries, meets to review proposed changes in formulary coverage, prior authorization criteria and other matters. Clinical effectiveness remains the primary determinant of formulary decisions; however, comparative cost-effectiveness and lifecycle affordability are also evaluated to ensure that finite military health resources are used efficiently while maintaining high-quality care. Where appropriate, the Department also considers supply chain continuity, and the ability to reliably support military requirements when evaluating long-term pharmaceutical management strategies.

The DHA Director reviews P&T and BAP minutes before making final formulary decisions and memorializes his determination by signing the DoW P&T Committee minutes. As a result of a combination of overall P&T efforts, in Fiscal Year 2025, cost avoidance for the program and the taxpayer was achieved through negotiated discounts for prescriptions dispensed through the mail-order and military medical treatment facility (MTF) pharmacies, as well as through refunds associated with retail pharmacy prescriptions totaling more than \$6.5 Billion dollars relative to Federal Supply Schedule and statutory refunds. These savings help offset increasing pharmaceutical expenditures and preserve funding capability across the broader military health system enterprise.

COVERAGE OF GLP-1 MEDICATIONS

Exacerbating the significant growth in specialty medications in general are the growing number of GLP-1 drugs used for diabetes and weight loss, which are a leading cost driver for the Department. Currently, GLP-1 medications account for approximately 15% of overall pharmacy spend. And although DHA benefits from manufacturer discounts on GLP-1s, utilization is increasing faster than discounts. The Department is actively evaluating utilization trends, prescribing patterns, clinical appropriateness, and long-term budget impacts associated with GLP-1 therapies. As utilization evolves, the Department will continue assessing evidence-based management strategies that maintain access to eligible beneficiaries while ensuring long-term affordability.

Pharmaceutical spending represents one of the fastest-growing components of the Department's health expenditures. Continued growth in specialty pharmaceuticals, biologics, and chronic disease therapies will require ongoing efforts to preserve affordability while maintaining high-quality beneficiary care. The Department remains committed to

pursuing evidence-based formulary management, federal purchasing authorities, negotiations, biosimilar adoption, and other cost-management strategies that strengthen both fiscal stewardship and patient outcomes.

By statute, TRICARE is generally excluded from covering treatments for obesity if obesity is the sole or major condition treated, including appetite suppressants and other medications that are primarily intended to control weight or for the purpose of weight reduction, regardless of the existence of comorbid conditions, to include, for example, cardiovascular conditions. Before 2018, the Department did not pay for weight loss drugs for any TRICARE beneficiaries. When Congress created TRICARE Select in Section 701 of the NDAA for Fiscal Year 2017, the Department leveraged the authorities under that NDAA, as well as 10 U.S.C. § 1097, to authorize extra benefits for TRICARE Select and Prime specifically, and to cover medically necessary weight loss drugs when provided by a network provider.

In 2025, the Department discovered that this coverage for weight loss drugs was incorrectly extended to TRICARE For Life (TFL) beneficiaries and corrected that oversight. However, TFL beneficiaries with a diagnosis of diabetes continue to have access to GLP-1s that are indicated for the treatment of diabetes.

PHARMACEUTICAL SUPPLY CHAIN RESILIENCE

Unlike most commercial health plans, the Department's pharmacy program must support routine beneficiary care and the unique medical requirements of a globally deployed military force. This requires acquisition and supply chain strategies that prioritize assured access and operational resilience in addition to cost and efficiency. The Department continues to strengthen pharmaceutical supply chain resilience as a component of military readiness while ensuring reliable access to critical medicines. This is essential not only for beneficiary care but also for

sustaining deployed forces, supporting contingency operations, and ensuring the Military Health System can respond during crisis. The Department continues to identify risks associated with concentrated foreign sourcing of active pharmaceutical ingredients, finished pharmaceuticals, and other critical medical products. Within existing authorities, DoW is mitigating risks through aligning interagency investments in proactive risk identification, supplier diversification, procurement reform, and advanced domestic manufacturing technologies to build a resilient and secure pharmaceutical supply chain for the warfighter. We are engaging with industry partners to explore innovative technologies such as continuous manufacturing and 3D printing to onshore production capabilities. Consistent with broader Department efforts to strengthen the defense industrial base, DHA is working with interagency partners and industry to improve supply assurance, encourage domestic manufacturing capacity where appropriate, and increase the resilience of pharmaceutical production supporting military requirements. These efforts are intended to reduce strategic vulnerabilities while ensuring timely access to critical medications during both peacetime and contingency operations.

CONCLUSION

The DHA is proud of the comprehensive, worldwide pharmacy benefit it offers to our 9.5 million beneficiaries and satisfied with the performance of its contractor in assisting with the execution of its contract responsibilities. Similar to the overall US health system, pharmaceutical cost growth remains an area of focus and concern. The Department continues to explore approaches that ensure continued, timely access to their hard-earned benefits in a fiscally responsible manner. Looking ahead, the Department's priorities include sustaining beneficiary access, strengthening pharmaceutical supply chain resilience, and improving affordability

through evidence-based management to help support the Department's broader readiness and health care missions.

I am grateful for the ongoing support that this Committee has provided to the Department and to the MHS in support of our service members, their families and all who have served. I look forward to remaining focused on maintaining a pharmacy benefit that supports beneficiaries while strengthening pharmaceutical supply chain resilience, preserving fiscal stewardship, and ensuring reliable access to critical medication in support of military readiness. Thank you again for the opportunity to address you today and briefly highlight our approach to managing this important program. I appreciate your vital support to the MHS and look forward to answering your questions.