



TRICARE PHARMACY
PROGRAM:
*PASS-THROUGH IN NAME ONLY?
WHAT FEDERAL AUDITS OF EXPRESS
SCRIPTS MEAN FOR TRICARE
DRUG PRICING POLICY*

Executive Summary

The TRICARE pharmacy program provides prescription benefits to roughly 9.5 million active-duty service members, retirees, and dependents, representing one of the largest standalone healthcare programs in the country.

Despite assertions by the Defense Health Agency (“DHA”) and Express Scripts (“ESI”) that the TRICARE Fifth Generation (“T5”) contract prohibits spread pricing and captures all savings and fees from retail pharmacies, drug manufacturers, and wholesalers through a pass-through framework, recent revelations warrant further scrutiny and action.

Audits from the Office of Personnel Management Office of Inspector General (“OIG”) regarding ESI’s handling of Federal Employee Health Benefits Program (“FEHBP”) plans reveal that transparent, pass-through contract terms have failed to prevent ESI from extracting off-ledger revenue to the tune of more than \$56 million in discounts, rebates, and fees not passed through. ESI failed to pass on these negotiated discounts by, amongst other things, implementing complex contractual mechanisms that delink discounts from drug-specific and plan-specific transactions via aggregate cross-plan price concessions and fees extracted from retail pharmacies, drug manufacturers, and drug wholesalers.

The OIG’s findings in the FEHBP are particularly relevant to TRICARE since ESI administers its retail pharmacy network services across TRICARE and FEHBP plans on an undivided and indivisible basis.

Additionally, ESI’s decision to purge nearly 15,000 retail pharmacies from the TRICARE network has been the subject of significant scrutiny. Information and analysis provided by APCI in written and oral testimony to the Senate Armed Services Subcommittee on Personnel revealed ESI’s actions in culling TRICARE’s retail pharmacy network may have been driven by self-interest. As more fully elaborated below, the purge of retail pharmacies followed several years of reduced utilization of ESI’s mail-order pharmacy. Additionally, despite claims that reducing the network was motivated by savings, DHA’s own data suggests that generic medications are cheaper for DHA and TRICARE beneficiaries at retail pharmacies.

The foregoing information should compel congressional action, including without limitation a comprehensive audit into ESI’s aggregate, non-claim-specific and non-plan-specific discounts with pharmacies, drug manufacturers, or wholesale distributors relying on TRICARE program volume. The audit should also inspect ESI’s decision to cull the retail pharmacy network, its copay practices and accounting practices across retail and mail-order channels, as well as an assessment of all costs associated with the dispensing of medications through ESI’s mail-order pharmacy.

Beyond an immediate audit, Congress should enact statutory reforms to protect beneficiary access and program integrity.

ESI Practices in TRICARE Pharmacy Program Go Unexamined

DHA maintains that TRICARE is insulated from spread pricing and other Pharmacy Benefits Manager (“PBM”) revenue extraction tactics based on a combination of programmatic structure and contractual protections:

[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.¹

A review by the Government Accountability Office (“GAO”) revealed that DHA relies heavily on unverified self-reporting by ESI.² Put another way, DoD is operating off of untested assumptions that its contract with ESI is doing what it intended it to do.

¹ 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>.

² 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].

However, within another federal program, the FEHBP, pass-through contract requirements have failed to rein in spread pricing and other tactics used by ESI to extract revenue for itself instead of passing it along to its FEHBP clients.³ More specifically, within the FEHBP, ESI received non-client-specific and non-claim-specific discounts and fees from pharmacies, drug manufacturers, and wholesalers that it retained for itself.⁴

ESI's practices in FEHBP are particularly relevant because court filings and public disclosures show that ESI's operations are blended across commercial and federal books of business. Specifically, in litigation, ESI represented that it performs retail network services across federal and non-federal plans on an "undivided" and "indivisible basis," confirming it "does not negotiate separate TRICARE or FEHB-specific agreements with retail pharmacies" but instead "negotiates a single network agreement with each pharmacy."⁵

ESI Aggregate Discount Practices and FEHBP Precedents

With regard to ESI's FEHBP retail pharmacy benefits administration, the OIG discovered that 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. The OIG identified the following discrepancies:⁶

Discrepancy	ESI APWU Audit	ESI Compass Rose Audit
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

In responding to the OIG's findings and attempting to justify the margins, ESI peeled back the curtain revealing it engages in non-client-specific aggregate guarantees within its retail networks:⁷

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.

The OIG cut to the chase, concluding that ESI was employing tactics to generate backend margins that created spread for ESI:⁸

"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].

Additionally, in a July 15, 2026, Senate Armed Services Subcommittee on Personnel hearing on the TRICARE pharmacy program, new light was shed on how ESI leverages its TRICARE retail contracts to move money around post-adjudication across the plans it administers.⁹ Specifically, Senator Warren highlighted Section 3.5 of an ESI retail pharmacy contract, which reserves the right to use an aggregate reimbursement reconciliation and offset methodology.¹⁰

⁴ Id.

⁵ 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).

⁶ ESI APWU Audit; ESI Compass Rose Audit. Note, between the two audits, over \$56 million in discrepancies were identified including related to drug manufacturer rebates, discounts, and fees paid to ESI or its affiliated rebate aggregator or pharmacies but this chart focuses on discounts retained from non-affiliated retail pharmacies.

⁷ ESI APWU Audit.

⁸ Id.

⁹ TRICARE Pharmacy Program: Hearing Before the Subcomm. on Personnel of the S. Comm. on Armed Services, 119th Cong. (July 15, 2026).

¹⁰ Id.

This revelation, combined with the OIG audit findings, ESI's response, and ESI's admission it administers federal and non-federal client retail networks on an undivided and indivisible basis, underscores the urgent need to determine whether ESI is deriving margin for itself by leveraging TRICARE volume via aggregate non-client-specific and non-claim-specific discounts.

With regard to discounts ESI or its affiliates receive from drug manufacturers or wholesalers, the T5 contract language cited in recent federal litigation bars ESI specifically from collecting fees, rebates, discounts, or premiums specific to processing TRICARE prescriptions.¹¹

However, in FEHBP, ESI itself has disclosed it negotiates non-prescription-specific discounts. For example, in response to the OIG identifying \$5.9 million in drug-inventory purchasing discounts, ESI responded by stating “non-specific drug discounts are received based on the total purchases made from drug manufacturers and wholesalers for the PBM's inventory.”¹²

Once again, the OIG was unpersuaded:

The PBM would not have received these non-specific drug discounts without the FEHBP drug utilization, therefore even if these discounts may not be attributed to a certain drug, they are attributable to an entire client group.¹³

By leveraging TRICARE's massive volume across its broader book of business, ESI may be able to capture non-plan-specific, and non-claim-specific discounts, fees, and other concessions from drug manufacturers and wholesalers that never attach to a specific TRICARE claim yet exist because of TRICARE's market scale.

Given the OIG's findings and ESI's own admissions regarding non-client-specific and non-claim-specific aggregate pricing practices across pharmacies, manufacturers, and wholesalers, DHA's reliance on unverified self-reporting is fundamentally misguided, demanding a comprehensive audit alongside robust legislative reform.

Copay Implementation Dynamics and ESI Administration of TRICARE's Retail Network

ESI's vertically integrated mail-order pharmacy enjoys several advantages written into federal law over retail pharmacies. These advantages include (1) requiring the use of mail-order pharmacy for most brand name maintenance medications; and (2) codified copay tiers that financially penalize TRICARE beneficiaries for using a local retail pharmacy of their choice. For example, under federal law, the copay for 90-days' worth of generic medications at a retail pharmacy is 242% more than the copay to use ESI's mail-order pharmacy.¹⁴

Despite these tiers being promoted as a means to pass mail-order “savings” to beneficiaries, with ESI managing the retail pharmacy network and owning the mail-order pharmacy contracted with DHA, the reality could not be more different.¹⁵

In actual implementation retail pharmacies are cheaper for generic medications for both beneficiaries and the DoD.¹⁶ Under 32 C.F.R. Section 199.21(j)(5), generic drug copayments cannot exceed the total charge for the prescription. In practice, ESI applies a lesser-of rule at retail pharmacies, charging beneficiaries less than the statutory copay when the actual drug cost is low.¹⁷ Conversely, DHA's own data implies ESI charges the full statutory copay (such as \$14 for a 90-day generic fill) at its mail-order pharmacy, even if acquisition and dispensing costs fall below that amount despite the fact that regulation draws no distinction between retail and mail-order pharmacies for copay purposes.¹⁸

With regard to beneficiary costs, the DHA has conceded:

[B]ecause the copayment for retail generic drugs is the lower of the statutory 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).¹⁹

¹¹ Ohio ex rel. Yost v. Ascent Health Servs., LLC, No. 24-3033, slip op. at 6 (6th Cir. Jan. 27, 2026).

¹² ESI APWU Audit.

¹³ Id.

¹⁴ 10 U.S.C. § 1074g(a).

¹⁵ 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>.

¹⁶ 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>.

¹⁷ Id.

¹⁸ See TRICARE 2023 Report, supra note 16.

¹⁹ Id.

The DoD's own annual reports show the average cost to DoD of a 30-day generic supply was higher at mail order than at retail in every reported year from FY2017 to FY2022, by as much as 85%.²⁰

Facing a 9 percentage point decline in mail-order utilization between 2018 and 2022, ESI requested that DHA waive its retail network requirements and DHA granted the request on the premise of government savings, a premise contradicted by DHA's own data, resulting in nearly 15,000 community pharmacies being purged and displacing 380,000 beneficiaries.²¹ This justification is paradoxical given that retail generics carry lower average costs for both DHA and beneficiaries, and 88% of retail fills are generics.

Conclusion

To address these systemic vulnerabilities, Congress should mandate a comprehensive audit of ESI's practices within TRICARE broadly. Rather than relying solely on unverified contract assurances, an evaluation should examine how ESI leverages TRICARE volume across its broader books of business to negotiate non-claim-specific aggregate discounts, rebates, and service fees with retail pharmacies, drug manufacturers, and wholesale distributors. Additionally, an audit should inspect ESI's decision to cull the retail network, as well as its post-adjudication offsets, transaction fee collections, accounting mechanics of beneficiary copays, and the true underlying costs of dispensing through ESI's mail-order pharmacy relative to retail channels.

Beyond administrative oversight, statutory reforms are needed to realign program incentives. At a minimum, Congress should amend the federal code to eliminate built-in statutory advantages for PBM-owned mail-order pharmacies, addressing mandatory mail-order usage requirements for brand-name maintenance medications alongside artificial copay disparities that affect beneficiaries who choose local retail locations. Lawmakers should also pursue the core policy framework advanced in H.R. 6609 and H.R. 6610 for the TRICARE program including transparent National Average Drug Acquisition Cost ("NADAC") based reimbursement standards, full rebate pass-through, prohibition on patient steering, and limits on post-adjudication clawbacks. These reforms would help ensure federal program volume effectively serves military families, supports community retail access, and safeguards taxpayer resources.

Finally, Congress should address the underlying conflict of interest by directing that future TRICARE pharmacy contracts prohibit the contracted PBM from owning or being affiliated with mail-order or specialty pharmacies, and by codifying that prohibition in statute, whether specific to TRICARE or more broadly, as proposed in S. 4509 and H.R. 8779.

²⁰ Data compiled from the respective annual DoD DHA Evaluation of the TRICARE Program Reports to Congress (FY 2019–2023). Relevant metrics for FY 2021 were unavailable in that year's public reporting.

²¹ See GAO Access Report, *supra* note 2; see also Karen Jowers, *About 2,000 Independent Pharmacies Coming Back to TRICARE*, Mil. Times (Dec. 8, 2022).