Testimony of Micah Lansford, PharmD
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Before the Senate Armed Services Committee
Subcommittee on Personnel
July 15, 2026

Regarding the TRICARE Pharmacy Program Managed by Express Scripts Inc.

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

Thank you for the opportunity to testify regarding the TRICARE Pharmacy Program managed by Express Scripts, Inc. (ESI). My name is Dr. Micah Lansford. I am a pharmacist and the owner of Roden-Smith Pharmacy in Clovis, New Mexico, a community closely tied to Cannon Air Force Base.

The issue before this Committee is whether the TRICARE pharmacy benefit is being managed for military families and taxpayers, or whether ESI is exploiting its contract structure to benefit itself at the expense of local access, patient choice, and community-based pharmacy care.

ESI is not simply a neutral processor. It manages the network, offers the contract terms, processes the claims, controls many access rules, operates mail-order and specialty pharmacy channels, and benefits when prescriptions move away from unaffiliated community and retail pharmacies. In fact, the more unsustainable ESI makes participation for local pharmacies, the more ESI stands to benefit when patients are pushed into channels it owns or controls.

One of the clearest examples I can offer involves Jelayne and her husband, Len, who have permitted me to share their story.

Len is a retired Air Force veteran and TRICARE beneficiary who made Clovis his home after years of military service. He has complex medical conditions, including kidney disease. He sees multiple doctors, is disabled, and relies on Jelayne as his primary caregiver.

Before ESI pushed Roden-Smith Pharmacy out of participation in the TRICARE network, we provided his care. Each month, I spoke with Jelayne before preparing his regular prescriptions. Len's medications were organized for a consolidated pickup, and this check-in provided a consistent touch point of care before medications ever left the pharmacy. When acute needs came up for them, we were a short phone call away or a quick stop in. That routine and availability gave Jelayne something every caregiver needs: confidence that someone else was helping watch over her husband's care.

When I told Jelayne we were forced out of the TRICARE network because the ESI reimbursement was unsustainable, she was in tears.

In my career, patients have rarely cried over an insurance network change. They cry when they feel they are losing someone they trust. Jelayne was not grieving the loss of a pharmacy; she was grieving the loss of a critical part of her care network.

Len and Jelayne are not an exception. They are only one example of the type of patient TRICARE is supposed to serve well: the retired service member with complex conditions and the caregiver trying to keep their medications straight.

Len and Jelayne are patients; they are not simply transactions. They are not best served by a system that assumes every beneficiary can log in, manage refills online, receive medications by mail, organize them correctly, and resolve problems without in-person support.

Many of our other TRICARE patients were disappointed, confused, and sometimes angry. Some believed we had chosen not to support military families. That was deeply painful because nothing could have been further from the truth.

The reality was the opposite. Roden-Smith had served the military families in our community for over 30 years. But accepting a contract that reimbursed below the cost of providing care would not have served military families. It would have endangered the pharmacy and the care of all of the other patients that we serve. ESI's unsustainable contract terms would have required us to dispense medications at a reimbursement less than the cost of the dispensed medication and absorb losses we could not sustain. No community pharmacy serving military families should have to make that choice.

Since losing access to Roden-Smith Pharmacy, Jelayne's experience has become harder, not easier. We still communicate regularly, and just recently, she told me of an experience where she tried to refill one of Len's medications. After multiple calls, long hold times, confusion over whether they had received the prescription, and even confusion between the generic name and the brand name of the drug, they finally located the refill. For Jelayne, that was not a minor inconvenience. It was one more burden placed on a caregiver already challenged by managing the care of her disabled husband. At Roden-Smith Pharmacy, we had never been a source of confusion; we had always been a source of support and reliability. Len's medications were synchronized, prepared predictably, and supported by a pharmacist who knew them and their situation.

This is what happens when reimbursement is squeezed so tightly that local pharmacy care disappears: the prescription may still exist somewhere in the system, but the caregiver is left alone to make that system work. The only one benefiting from this scenario appears to be ESI.

This is not a partisan issue. It is a military family issue. A taxpayer accountability issue. A contractor oversight issue. A competition issue. A military readiness issue. Above all, it is a patient care issue.

Under ESI's current TRICARE contract, ESI sits at nearly every pressure point in the pharmacy benefit:

- **ESI controls network access.** By making participation unsustainable for unaffiliated community pharmacies, ESI produces a smaller network while still calling it adequate.
- **ESI controls reimbursement.** ESI can pay community pharmacies below the cost of providing care, capture savings or margin through the claims process, and weaken the very pharmacies that compete with its own channels.
- **ESI controls the substitute.** When local pharmacies are pushed out, ESI points patients toward mail-order and specialty channels it owns or benefits from, then treats those channels as equivalent to local pharmacy care. They are not equivalent.

ESI leverages its control to push patients toward an inferior version of pharmacy care, calls it adequate, and profits from the transition. **Patients lose access, community pharmacies lose the ability to participate, and ESI strengthens its own position.** That is not a neutral administration. That is structural self-dealing. No contractor should be allowed to referee the game while competing in it.

The issue before this Committee is whether the current TRICARE pharmacy benefits provide military families with the access, choice, and pharmacy care Congress intended—and whether the structure of that contract creates incentives that deserve closer independent scrutiny.

The question is not if ESI is following the contract. The question is if ESI is opportunistically exploiting it to the detriment of our military patients and taxpayers.

Who I Am and the Community I Serve

I am from Clovis, New Mexico, and I have spent the majority of my life there. My pharmacy, Roden-Smith Pharmacy, has served this region's nearly 50,000 residents and 12,000 active duty and dependents for more than 75 years.

Cannon Air Force Base (AFB) is part of the identity of Clovis. Clovis is deeply proud of the mission and the people who serve this country through Cannon AFB. The service members stationed there live in our community. Their families go to our schools. Their spouses work in our local businesses. They are our patients, employees, neighbors, and friends.

This issue is deeply personal to me. I have employed military spouses, and some of my closest friends are active-duty and retired personnel. I have been the pharmacist these families called after hours when a spouse was deployed and a child needed an antibiotic. **In a military town, a community pharmacy is not just a dispensary: it is a place where families go for practical help, real-time answers, immunizations, acute medications, counseling, caregiver support, and a familiar face who understands the community they live in.**

I also bring this perspective from years of pharmacy policy and advocacy work. I currently serve as President of the New Mexico Pharmacists Association, serve on the board of the New Mexico Pharmacy Business Council, and was recently elected to the American Pharmacies Board of Directors. I have a history of serving on the New Mexico Medicaid Pharmacy and Therapeutics Committee and currently serve in national advisory roles focused on retail and long-term care pharmacy. Across these roles, my work has focused on sustaining patient access, improving pharmacy practice, and addressing the reimbursement challenges that affect pharmacies serving real patients in real communities.

ESI's Unacceptable TPharm5 Pharmacy Contract

Roden-Smith Pharmacy proudly served TRICARE beneficiaries for many years. Even before the new contract with ESI was presented, reimbursement under many PBM contracts had become increasingly difficult. The ESI TRICARE contract took an already challenging environment and made participation financially unsustainable, effectively asking us to fill nearly every TRICARE prescription at a loss.

I faced an appalling choice: continue filling TRICARE prescriptions under ESI's terms and risk losing my pharmacy or preserve the pharmacy so we could continue serving our community. I chose the latter because no pharmacy can lose money indefinitely and still be there for its patients.

At the time, the ESI TRICARE contract was on track to become one of the lowest-paying contracts in our pharmacy, even worse than New Mexico Managed Medicaid. That comparison matters because New Mexico eventually recognized its reimbursement model was unsustainable and adopted a more transparent, acquisition-cost-based approach for community pharmacies. ESI refused to do so.

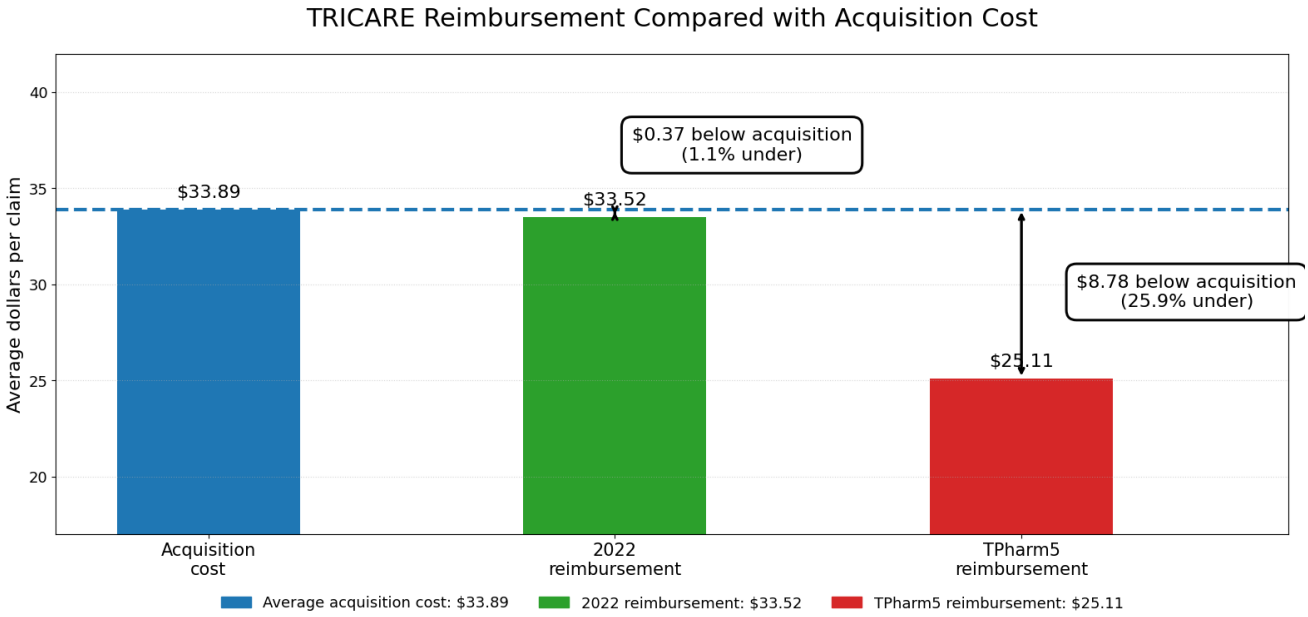
Community pharmacies want to serve TRICARE beneficiaries. I want to serve them again. But access cannot depend on contracts that make participation financially impossible in practice.

I want the Committee to understand one point clearly: Roden-Smith Pharmacy did not walk away from TRICARE beneficiaries. We tried to find a way to continue serving them.

In 2022, ESI presented Roden-Smith Pharmacy with new Federal/DoD/TRICARE contract terms set to begin in 2023. Those terms were not simply difficult; they were structurally unsustainable.

Because PBM contracts commonly include confidentiality restrictions, I am unsure if I can even publicly disclose the specific reimbursement terms without express authorization from ESI or appropriate direction from Congress. That fact alone should concern this Committee. Pharmacy reimbursement in a taxpayer-funded military health benefit should not be so opaque that pharmacies are restricted from publicly explaining why they cannot afford to serve military families.

What I can say is this: ESI's contract terms used benchmark-based reimbursement formulas involving figures such as average wholesale price (AWP), wholesale acquisition cost (WAC), and maximum allowable cost (MAC) in ways that were deeply disconnected from the actual cost of operating a pharmacy.

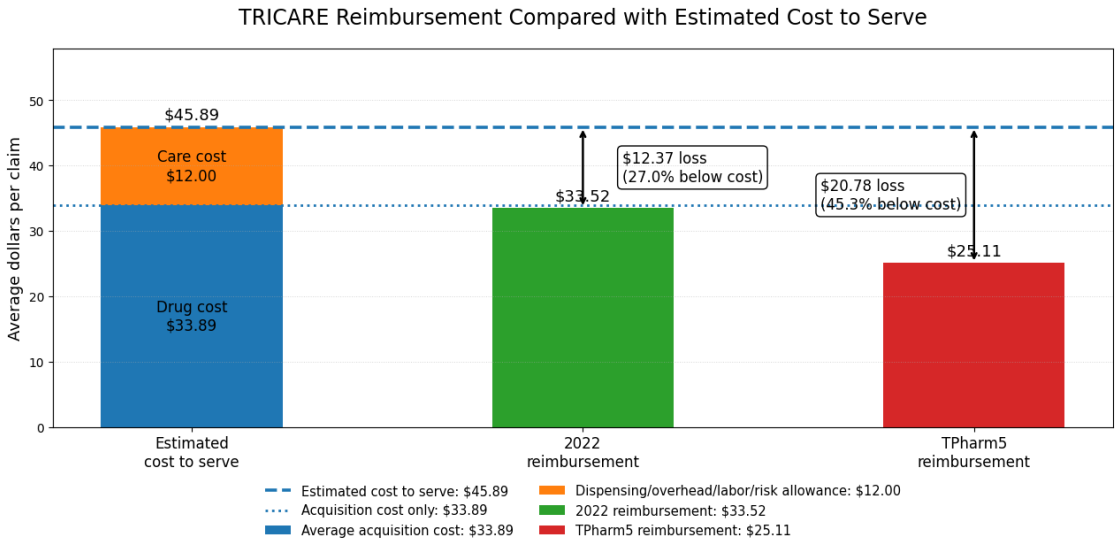


Based on 6,750 TRICARE claims from 2022. Dollar figures are average dollars per claim.

I reviewed my pharmacy's data for my TRICARE patients in 2022 (TPharm4) and was able to project my reimbursement under the contract ESI wanted me to sign moving forward (TPharm5) and compare these numbers to my actual cost to purchase these medications. The chart above illustrates that our average acquisition cost per prescription in 2022 was **$33.89**. The reimbursement per prescription in 2022 averaged **$33.52**. This isn't outlier data. This is the average of all 6,750 prescriptions we filled for beneficiaries that year under the old contract, resulting in an average **loss of $0.37 per prescription**. As bad as the old ESI contract was, the terms of the new contract with ESI set to begin in 2023 (TPharm5) were materially worse. Under the terms offered, ESI would have required our pharmacy to **lose nearly $9 on average for every prescription filled**.

To put that into perspective, under the prior ESI contract, Roden-Smith Pharmacy **lost nearly $2,500** in 2022. Based on the same prescription volume and utilizing the reimbursement methodology ESI proposed in its new contract, **it would have resulted in a loss of nearly $60,000** in 2023.

It's important to note that these figures reflect **only** the difference between drug acquisition costs and reimbursement. They **do not** include the many additional expenses required to operate a pharmacy, such as payroll, rent, insurance, utilities, technology, and other overhead. Items such as these are often covered with the inclusion of a professional dispensing fee. The ESI Tricare Contract simply did not have one. The chart below accounts for those operating costs.



Based on 6,750 TRICARE claims from 2022. Dollar figures are average dollars per claim. Estimated cost to serve equals average acquisition cost plus a $12 dispensing/overhead/labor/risk allowance.

Retail community pharmacies must purchase inventory, employ licensed professionals, maintain regulatory systems, counsel patients, and assume responsibility for dispensing medications safely. The problem was that the ESI contract treated pharmacy care as if it were merely a commodity transaction, with little or no recognition of the professional work required to safely serve patients.

Even in the face of these overwhelming losses, I was unwilling to walk away from the TRICARE community at Cannon AFB. Instead of simply rejecting the contract, I proposed several compromises in a last effort to preserve access to care for TRICARE beneficiaries.

First, I asked to remain in-network for urgent and local needs, including acute medications, antibiotics, and immunizations — services mail order cannot provide.

ESI refused.

Second, I reviewed what ESI described as a rural contract opportunity. Although the structure differed, the reimbursement remained unsustainable. I proposed a transparent model based on National Average Drug Acquisition Cost (NADAC) plus a professional dispensing fee, similar to the reimbursement approach New Mexico later adopted for Community Pharmacies under managed Medicaid. This is also the model that is currently included in S.4106, the Rx ACCESS Act, introduced by Senators Tom Cotton and Tim Kaine, members of this committee.

ESI refused again and stated that the offered rates were best and final.

As a result, Roden-Smith Pharmacy had to leave the TRICARE network.

Those requests were about access, not convenience. Despite these projections, I knew the consequences would extend far beyond my pharmacy's balance sheet. In emails to ESI, I explained that these reimbursement terms would inevitably reduce access to care for TRICARE beneficiaries at Cannon AFB. Routine services that patients relied on—vaccinations, same-day antibiotics for acute illnesses, and the personalized care that community pharmacies provide—would become more difficult or impossible to access. I proposed several compromises in an effort to prevent that outcome, but ESI made it clear that its original, unsustainable offer was its best and final contract terms.

That was not the outcome I wanted, and it was not what our patients wanted. But no pharmacy can continue serving patients under a contract that requires it to lose money on the care it provides.

The question is not if ESI rates are defensible on a spreadsheet. The question is if those rates were sustainable for the pharmacies patients actually depend on.

Pharmacy Is Not a Free Market

Beyond my role as a pharmacy owner, I also own Blackwater Coffee Co., a coffee shop, in Clovis. Owning both has given me a clear contrast between a normal consumer market and the pharmacy marketplace. It is sometimes hard to believe.

In the coffee business, the rules are straightforward. If customers like the product and service, they return. If costs increase, we can adjust prices. If a product is unprofitable, we stop selling it. We can respond to changing business conditions.

Community pharmacy does not work that way.

In pharmacy, the patient is rarely the true economic decision-maker. The payer, PBM, or plan sponsor determines which medications are covered, which pharmacies patients may use, and how much the pharmacy will be paid.

That is not a normal free market.

When a PBM reimburses less than the cost of acquiring and safely dispensing a medication, I cannot simply raise my prices or negotiate with the patient. The terms have already been set.

The options available to a community pharmacy are limited: reduce staff, cut services, decline contracts, or attempt to offset prescription losses through unrelated retail sales. None address the underlying problem—the pharmacy's primary healthcare service is being underpaid by the entity controlling the benefit.

Community pharmacies carry responsibilities that extend far beyond handing over a prescription. We're responsible for dispensing medications accurately, counseling patients so they understand how to take them safely, monitoring for interactions, securing controlled substances, and documenting every step of the process. We answer to boards of pharmacy, the DEA, the FDA, federal and state regulators, accreditors, and insurance networks that credential us. And increasingly, we're also expected to serve as insurance experts explaining benefit designs, prior authorizations, network restrictions, and coverage denials. Too often pharmacists spend more time explaining the patient’s benefits than information regarding their medication. And that irony is hard to ignore.

Yet PBMs often treat the prescription as a commodity and pharmacy reimbursement as optional.

Prescription care should not be a loss leader.

If a taxpayer-funded pharmacy benefit routinely requires pharmacies to dispense medications below cost, the problem is not that pharmacies failed to compete. The problem is that the market has been distorted by the entities controlling reimbursement.

That distortion benefits vertically integrated PBMs. When community pharmacies are underpaid or pushed out of practical participation, PBMs can more easily redirect patients into PBM-owned pharmacy channels.

That is not free-market competition. It is self-dealing through benefit design.

When a community pharmacy declines an unsustainable contract, it should not be viewed as unwilling to compete. It is responding to a market where the rules are set by a contractor that also benefits when community pharmacies cannot participate. This only hurts TRICARE beneficiaries in the end.

The question is not whether community pharmacies are competitive. The question is whether meaningful competition is even possible.

Medication Delivery Is Not Pharmacy Care

The evidence presented thus far demonstrates two critical failures.

First, the reimbursement terms in ESI's offered contract through TPharm5 were economically untenable. Second, the vertically integrated PBM model gives independent pharmacies little practical ability to negotiate or seek competitive alternatives.

More fundamentally, ESI's underlying premise is flawed.

The TRICARE pharmacy benefit managed by ESI should recognize a basic truth: filling a prescription is not the same as providing pharmacy care.

Mail-order pharmacies may have a role to play for patients who knowingly choose it because it best fits their needs. But that is very different from a system that financially incentivizes, pressures, or effectively forces patients away from local pharmacies and into a mail-order model controlled by the same pharmacy benefit manager administering the benefit.

ESI may measure success by whether a prescription was filled and shipped on time. But a filled prescription is not the same as adherence, and a shipment is not the same as a patient taking medication correctly.

If the value of mail order is that it lowers costs while maintaining quality, Congress should examine whether that assumption remains true.

The concerns I raise are not unique to Roden-Smith Pharmacy or the TRICARE program. In a June 2024 investigation, *The Wall Street Journal* reported that mail-order pharmacy, long promoted as a way to reduce prescription costs, was, in many cases, increasing employer spending. The article explained that when a PBM owns the mail-order pharmacy, "the PBM effectively sells a drug to itself," creating opportunities to generate additional spread revenue while employers often lack visibility into the underlying economics. It also described one employer where approximately 10% of prescriptions accounted for more than 80% of total prescription spending through mail order. These reports do not prove the TRICARE program operates the same way. They do demonstrate why Congress should independently examine whether similar financial incentives exist within ESI's TRICARE contract rather than relying solely on ESI's own self-evaluation.

Medication fulfillment is still not the same as pharmacy care. As a community pharmacist, I have had patients bring in bags of unused medications for destruction because mail order simply kept sending them. On paper, those prescriptions appeared compliant. In reality, they represented waste, confusion, duplicate therapy, side effects, or medications the patient had stopped taking months earlier.

My experience is consistent with concerns documented beyond TRICARE. In 2025, *The Wall Street Journal* analyzed Medicare Part D data and found that excessive early refills cost Medicare and patients approximately **$3 billion** over a three-year period. Although mail-order pharmacies accounted for only about **9% of prescriptions**, they generated roughly **37% of those excess refills**, leaving many patients with

months of unnecessary medications. The investigation illustrates an important distinction: a prescription can be filled, shipped, and counted as successful while the patient accumulates medications they no longer need or no longer understand. Those findings demonstrate why Congress should examine whether measuring prescription fulfillment in TRICARE is being mistaken for measuring quality patient care.

Community pharmacy catches those problems because community pharmacy is built on relationships.

Medication synchronization illustrates the difference. For my pharmacy, every refill becomes a clinical checkpoint. We ask whether medications are working, whether doses have changed, whether side effects have developed, whether the patient is taking the medication correctly, and whether they have too much or too little medication remaining.

Patients should generally run out of their chronic medications on schedule. When they do not, that tells us something. Too much medication may mean a patient stopped taking it, another provider changed the dose, or confusion has developed. Running out early raises different questions. Those conversations happen because a pharmacist knows the patient—not because a prescription was successfully delivered.

That is not just dispensing. That is accessible healthcare. These problems are not theoretical. They occur every day, and they are precisely the kinds of issues that claims data and automatic refill reports often fail to detect.

Imagine this common scenario as one of Roden Smith Pharmacy's patients.

Perhaps you grew up in Clovis. Maybe we graduated high school together, or you were my teacher years ago. Life has taken you to Dallas, but your parents, both retired service members now in their 80s, still live in Clovis, determined to remain independent.

You've flown home for Labor Day weekend to check on them.

As you open the kitchen cabinet, you find bottles of medications everywhere. Some came from mail order. Some are old. Many are duplicates. Some have different strengths. A few were changed or discontinued by specialists months ago. Your parents cannot explain which medications they are still taking and which ones they should have stopped. They only know the bottles keep arriving and they're pretty sure the correct pill is the white one.

Last year, Roden-Smith Pharmacy was packaging every medication by date and time. It was beyond simple. One phone call or text to the pharmacist answered questions, coordinated changes, and gave the family confidence that someone you trust was watching over the entire medication regimen.

Now Roden-Smith Pharmacy is no longer in the network.

It is a holiday weekend. The base pharmacy is closed. All ESI clinical support can tell is that the prescriptions have been auto-refilled and should have arrived on time. Your flight leaves tomorrow morning. You spend the weekend doing what you can and wondering if you can really leave them like this.

A claims report may show perfect adherence.

Standing in that kitchen tells a different story.

Too many pharmacy benefit designs appear built around the healthiest patients—those taking one or two stable medications with few barriers to care. But many TRICARE beneficiaries don't fit into that box.

A pharmacy benefit designed for the easiest patients fails the patients who need pharmacy care the most.

Medication is not simply a commodity. Patients are not claims. Pharmacists are not distribution centers. The relationship between a patient and a pharmacist often determines whether medication is understood, tolerated, taken correctly, and continued appropriately.

The current ESI-managed TRICARE structure separates reimbursement from patient care. ESI may capture the reimbursed prescription, but local pharmacies continue answering medication questions and helping patients navigate issues that mail-order support cannot resolve. ESI receives the reimbursed claim while community pharmacies are often left providing uncompensated care.

That should concern Congress.

Military families deserve more than medication distribution. They deserve pharmacy care that respects patient choice, values local relationships, and helps patients use medications safely and correctly.

Mail order may deliver medication. Community pharmacy delivers care.

Congress Should Not Rely on Express Scripts to Evaluate Itself

My experience is one example, but the larger issue extends well beyond Roden-Smith Pharmacy, Clovis, or even TRICARE. It is the degree of control large pharmacy benefit managers (PBMs), including ESI, and their vertically integrated counterparts, exercise over the industry.

Congress should be cautious about relying solely on analyses built primarily with PBM-supplied data.

ESI manages the TRICARE pharmacy network, sets reimbursement, processes claims, controls much of the underlying data, defines savings, reports network adequacy, operates affiliated pharmacy channels, and benefits financially when prescriptions move into those channels.

That is not a neutral structure. It is a conflict structure.

That should concern Congress, particularly in a taxpayer-funded program.

The most direct way to eliminate that conflict is to separate the administration of the pharmacy benefit from the ownership of the pharmacies dispensing the prescriptions. A contractor should not be put in the position of setting reimbursement for competing pharmacies, controlling beneficiary access, and then profiting when prescriptions are redirected to pharmacies owned by that contractor or its affiliates.

Last year the Government Accountability Office (GAO) released a report calling for the increased monitoring of ESI's role as the PBM in the TRICARE program.[1] They found that DHA did not monitor ESI's timeliness in dispensing mail-order specialty drugs, nor in verifying the accuracy of data that ESI relies on to ensure beneficiary access to pharmacy services, as required via audits in its Quality Assurance Surveillance Plan which outlines the contract oversight. GAO found that the ESI reports contained errors in both beneficiaries' specialty use and beneficiaries affected by pharmacies leaving the network. This was compounded by two months of missing data from April 2024 to June 2024 when 200 pharmacies left the network.

Furthermore, the Office of Personnel Management's (OPM) Office of the Inspector General (OIG) has released several audit reports of PBMs' operations over the last few years - and what did they find? In December 2025, a report found that in the National Association of Letter Carriers Health Benefit program operated by CVS

[1] https://www.gao.gov/products/gao-25-107187

Caremark, the PBM, overcharged the government $8.2 million over five years.[2] And $6.9 million came directly from the PBM charging the government more than they paid the retail pharmacies, a practice known as spread pricing. However, what should be of particular interest to this committee is the 2024 OPM OIG audit, which found ESI, the PBM operating the American Postal Workers Union Health Plan, overcharged the government $44.8 million from 2018 to 2021.[3] This included actions such as overstating pharmacy costs, not giving the plan pass-through pricing on pharmacy claims, and not passing along purchasing discounts and rebates.

If these are the audit numbers on plans that serve between 200,000 and 300,000 beneficiaries each, what will an audit show of a program like TRICARE that represents over 9 million patients worldwide?

The question is not whether ESI is large, sophisticated, or capable of administering a contract. The question is whether ESI has been allowed to administer the TRICARE pharmacy benefit in a way that favors its own economics over military families, taxpayers, and community-based retail pharmacy access.

That question should not be answered by ESI alone and is why TRICARE should have oversight, requiring an annual independent audit.

If ESI reports that the network is adequate, Congress should ask whether that conclusion has been independently verified. If it reports improved adherence, Congress should ask whether that reflects actual medication use or simply prescriptions that were automatically filled and shipped. If it reports savings, Congress should ask compared to what benchmark, using whose data, and after accounting for payments within its affiliated pharmacy channels. The current Fiscal Year 2027 National Defense Authorization Act (NDAA) that was passed by this committee includes an amendment offered by Senator Elizabeth Warren including audit language that would examine these exact questions. I would urge the inclusion of this language in the final passage of the NDAA this year.

None of this should be controversial. If any contractor administering a taxpayer-funded program also controlled the data used to evaluate that program while competing against outside providers, Congress would demand independent oversight.

TRICARE should be no different.

These concerns should not be addressed solely by ESI. Congress must require an independent audit.

Military Readiness Begins at Home

The consequences of the ESI-managed TRICARE pharmacy network are not limited to pharmacy balance sheets. They are felt by the beneficiaries it is intended to serve. In communities like Clovis and Cannon AFB, local pharmacy access is not a convenience. It is part of the healthcare infrastructure military families rely on. When that access is weakened, the burden shifts to patients and caregivers. Mail-order may work well for a healthy patient taking one stable medication. But, as I've stated many times, TRICARE beneficiaries are not always that patient, and they all deserve the best care.

For most families, pharmacy access is not simply about whether medication eventually arrives. It is about getting answers today—before a dose is missed, before a mistake is made, or before an illness becomes more serious.

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[2] https://www.oversight.gov/sites/default/files/documents/reports/2025-12/2024-SAG-022.pdf

[3] https://www.oversight.gov/sites/default/files/documents/reports/2024-10/2022-SAG-029.pdf

I have seen military families rely on local pharmacists during deployments, illnesses, medication changes, and emergencies. I have also seen the confusion that occurs when medications come from multiple sources with no one seeing the complete picture.

That fragmentation creates risk. Community pharmacies mitigate risk.

Military readiness depends on more than aircraft, training, and equipment. It also depends on the families waiting at home.

I have experienced this firsthand: an Air Force member deployed halfway around the world, focused on the mission and carrying responsibilities most of us will never fully understand. The few minutes he gets to talk with his family each week are precious. Instead, he spends those calls listening to his wife struggle to navigate a sick child, a delayed prescription, and a problem no one seems able to solve. He hangs up carrying the weight of knowing his family is overwhelmed while he is thousands of miles away and powerless to help.

That is not a theoretical scenario. These are the families I have served, the people behind the prescriptions and claims data. That is not what military families deserve. In military communities, pharmacy care has never been just about filling prescriptions. It is about neighbors caring for neighbors.

One of my closest friends was deployed when his young son suffered a serious allergic reaction. I was there to help. Another military spouse, a neighbor, home alone with two young children, called because her child's fever had climbed above 103 degrees and she didn't know what to do next. Those are the calls I receive. Those are the families we serve.

Around Clovis, when someone deploys, we don't just fill prescriptions—we mow lawns, bring meals, check on spouses, and look after one another. That is what military communities do: they show up for each other.

We will continue doing those things whether ESI reimburses the prescription claim or not.

Readiness is not created only on the flight line, in the field, or during deployment. It is also built at home, through the support systems that allow service members to focus on their mission knowing their families are cared for. When those systems become harder to navigate, the burden does not disappear—it shifts to spouses, parents, and service members themselves. Every unnecessary barrier to accessing medications, resolving problems, or receiving timely care creates another distraction for the very people our military expects to remain ready.

The question before Congress is why a taxpayer-funded military health benefit would make that local support system harder to access. Why should military families lose trusted relationships, immediate access, and community support in exchange for supposed efficiencies that remain unproved and may primarily benefit the contractor administering the program?

Pharmacy policy is readiness policy.

This does not mean every prescription belongs at a community pharmacy. It means beneficiaries should not be pushed away from community pharmacies by a benefit structure that makes local participation financially unsustainable while favoring ESI-controlled channels. Network adequacy cannot be measured by counting pharmacies on a map. It must measure whether patients can actually obtain timely medications, receive appropriate care, and whether pharmacies can realistically remain in the network.

Congress should evaluate the ESI TRICARE contract through that lens. Military families deserve access to care through local options, meaningful patient choice, and access to pharmacists who know them and can help them use medications safely. A pharmacy benefit that works only for the easiest patients is not good enough for TRICARE.

The question is not what military families can get by with. The question is: What do they deserve?

What Congress Should Do

Federal regulators, auditors, and investigators have already documented serious concerns involving ESI and the largest pharmacy benefit managers.

In July 2024, the Federal Trade Commission reported that the six largest PBMs managed nearly 95% of U.S. prescriptions and warned that vertically integrated PBMs have both the ability and incentive to steer patients toward affiliated pharmacies, disadvantage community pharmacies, and impose unfair contract terms.[4]

In September 2024, the FTC filed an administrative complaint against the three largest PBMs, including ESI, alleging rebate practices that inflated insulin prices and favored higher-cost products.[5]

In January 2025, the FTC reported that affiliated PBM pharmacies generated more than $7.3 billion above estimated acquisition cost on specialty generic drugs and were reimbursed more favorably than unaffiliated pharmacies, suggesting steering toward affiliated channels.[6]

In February 2026, Reuters reported that ESI entered into a settlement with the FTC that included independent oversight, greater transparency, and restrictions on certain rebate practices.[7]

These findings demonstrate that Congress has ample reason to examine ESI's TRICARE contract independently.

In fact, outside of TRICARE, Congress has begun to look into this limiting issue of vertical integration in the pharmacy space. In December 2024, Senators Elizabeth Warren and Josh Hawley and Representatives Diana Harshbarger and Jake Auchincloss introduced the Patients Before Monopolies Act, which would prohibit PBMs from owning pharmacies; they reintroduced this bill earlier this year as S.4509/H.R.8879.[8,9] Additionally, Representatives Raja Krishnamoorthi and Diana Harshbarger introduced H.R. 4409, the Fair Pharmacies for Federal Employees Act, which would prohibit the OPM from contracting in the federal employee health benefits program with PBMs that also own or manage their own pharmacies to prevent this vertical integration.[10]

States have already begun addressing this conflict directly. Arkansas enacted legislation in 2025 prohibiting PBMs from owning or operating pharmacies, and Tennessee enacted similar legislation in 2026.[11] Both laws face legal challenges, so they do not yet provide completed outcome data. However, they demonstrate a growing recognition that the conflict created when the benefit administrator also owns the dispensing pharmacy is structural—not merely a matter of contract transparency or improved reporting.[12]

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[4] https://www.ftc.gov/reports/pharmacy-benefit-managers-report

[5] https://www.ftc.gov/news-events/news/press-releases/2024/09/ftc-sues-prescription-drug-middlemen-artificially-inflating-insulin-drug-prices

[6] https://www.ftc.gov/reports/specialty-generic-drugs-growing-profit-center-vertically-integrated-pharmacy-benefit-managers

[7] https://www.reuters.com/world/cigna-settles-ftc-insulin-case-commits-overhauling-drug-pricing-2026-02-04/
https://apnews.com/article/arkansas-pharmacies-pbms-sarah-huckabee-sanders-alabama-9e2449a2ac7f7aa206cd49f9211447b3

[8] https://www.congress.gov/bill/118th-congress/senate-bill/5503/cosponsors

[9] http://auchincloss.house.gov/media/press-releases/release-auchincloss-warren-harshbarger-hawley-reintroduce-bipartisan-legislation-to-rein-in-pharmacy-benefit-managers-pbms-cut-drug-costs

[10] https://krishnamoorthi.house.gov/media/press-releases/congressman-krishnamoorthi-introduces-legislation-rein-pharmacy-benefit

[11] https://apnews.com/article/arkansas-pharmacies-pbms-sarah-huckabee-sanders-alabama-9e2449a2ac7f7aa206cd49f9211447b3

[12] https://www.reuters.com/world/cigna-settles-ftc-insulin-case-commits-overhauling-drug-pricing-2026-02-04/

The question is not why Congress should audit the ESI TRICARE contract. The question is why it would not.

I respectfully recommend six actions.

1. Require an independent audit.

Examine reimbursement, mail-order and specialty pharmacy economics, network adequacy, patient steering, reimbursement methodology, and whether ESI-affiliated pharmacies are treated more favorably than non-affiliated community pharmacies.

2. Measure real access—not theoretical access.

Network adequacy should reflect whether beneficiaries can obtain timely medications and pharmacy care—not simply whether a pharmacy appears on a map. Rural, military-connected, and medically underserved communities deserve particular attention.

3. Require transparent, sustainable reimbursement.

Direct TRICARE to evaluate acquisition-cost-based reimbursement models, such as NADAC plus a professional dispensing fee, or another transparent approach that ensures pharmacies are not routinely reimbursed below the cost of safely providing care.

4. Protect patient choice.

TRICARE beneficiaries should not be financially pressured into ESI-controlled pharmacy channels when a community pharmacy is the better clinical or practical choice.

5. Establish meaningful conflict-of-interest safeguards.

ESI should not be permitted to manage the network, set reimbursement, control the data, report the results, compete through affiliated pharmacy channels, and then rely on its own information to demonstrate success. Independent oversight and transparency are essential.

6. Require a non-vertically integrated pharmacy benefit administrator.

The TRICARE pharmacy benefit contract should not be awarded to an entity that owns or operates pharmacies, or that is under common ownership or control with any retail, mail-order, specialty, or other dispensing pharmacy. The contractor administering the benefit should not be permitted to set reimbursement for competing pharmacies, control network access, direct beneficiary utilization, and then profit when prescriptions move to pharmacies it owns.

Pharmacy access is part of military readiness. Military families, like Jelayne and Len, deserve a pharmacy benefit that supports real care—not simply medication distribution. The solution is straightforward: Audit the contract. Measure real access. Require transparent reimbursement. Protect patient choice. Separate benefit administration from pharmacy ownership. Ensure independent oversight.

That is what TRICARE beneficiaries deserve. That is what community pharmacy longs to provide.

Thank you for the opportunity to submit this testimony.