STATEMENT FOR THE RECORD

of the

MILITARY OFFICERS ASSOCIATION OF AMERICA (MOAA)

for a

LEGISLATIVE HEARING

before the

Senate Committee on Armed Services
Personnel Subcommittee

To Receive Testimony on the TRICARE Pharmacy Program

July 15, 2026

Executive Summary

The Military Officers Association of America (MOAA) appreciates the Senate Armed Services Personnel Subcommittee's oversight of the TRICARE Pharmacy Program. MOAA recommends the following focus areas to preserve the high standard of pharmacy access, coverage, and affordability that servicemembers, retirees, and their families have earned.

- **Ensure Access to Medically Necessary Medications:** Beneficiaries have no process to request a medical necessity review for drugs placed on TRICARE's Tier 4/Non-Covered category, even after formulary alternatives have failed. MOAA urges congressional oversight of prior Senate direction requiring the Defense Health Agency (DHA) to establish a medical necessity and prior authorization process for Tier 4 medications.
- **Reinstate GLP-1 Coverage for TRICARE For Life (TFL):** The DHA's decision to revoke GLP-1 coverage for Medicare-eligible retirees created an inequity among beneficiary groups and appears inconsistent with congressional intent that TFL beneficiaries receive the same pharmacy benefit available to other TRICARE beneficiaries. MOAA urges Congress to ensure DHA has the authority and resources necessary to restore GLP-1 coverage for eligible TFL patients.
- **Restore the TRICARE Retail Pharmacy Network:** Reduced contract requirements under the fifth-generation pharmacy contract (TPharm5) led to retail pharmacy network cuts that reduced beneficiary access to prescription medications. The narrowed network pushed an additional 98,000 beneficiaries outside of drive-time access standards and disproportionately impacted elderly beneficiaries, rural residents, and those with complex medical conditions. To fully evaluate the retail pharmacy network cuts, MOAA urges Congress to require transparency regarding savings attributable to network reductions versus other TPharm5 reforms.
- **Preserve Affordable Pharmacy Copays After 2027:** Current law allows DHA to adjust pharmacy copays beginning in 2028 without any beneficiary protections or consideration of commercial health plan benchmarks. MOAA recommends establishing a statutory guardrail to prevent disproportionate copay increases and ensure TRICARE Pharmacy copays remain aligned with benchmark plans.

Broad pharmacy access, comprehensive medication coverage, and affordable copays have long been hallmarks of the TRICARE Pharmacy Program, but these core benefits have suffered steady erosion in recent years. Even modest reductions in pharmacy benefits can have significant consequences for patients who rely on daily maintenance medications. While MOAA acknowledges the need for cost containment, any pharmacy reforms must preserve the high standard of access, coverage, and affordability that honors our nation's commitment to those who serve and have served, their families, and their survivors.

CHAIRMAN TUBERVILLE, RANKING MEMBER WARREN, and members of the committee, on behalf of the Military Officers Association of America (MOAA), our more than 350,000 members, and the 9.4 million TRICARE beneficiaries we advocate for, we thank you for the opportunity to share our views on the TRICARE Pharmacy Program.

Neither MOAA nor its subsidiary charities hold any federal grants, subgrants, contracts, or subcontracts related to the subject matter of the hearing.

The Military Officers Association of America (MOAA) is committed to preserving and protecting the earned benefits of our uniformed services community. We appreciate the committee's rigorous oversight of all aspects of military health care, including the TRICARE Pharmacy Program. Your efforts are instrumental to ensuring robust and affordable prescription drug coverage and access is maintained for servicemembers, retirees, their families, and survivors.

Less than 1% of Americans serve in uniform, yet they bear full responsibility for the defense of our nation. In return, our country has made a commitment to provide them – and the families who serve alongside them – with a health care benefit they can rely on through their years of service and into retirement.

Beneficiary expectations have been shaped by decades of consistently broad pharmacy access and comprehensive medication coverage. Those expectations are not incidental – they are part of the value of the earned benefit. Recent reductions in the retail pharmacy network and medication coverage policy have eroded that value.

Unlike many health care benefits that are used only occasionally, millions of beneficiaries depend on the pharmacy benefit regularly; those with chronic conditions may rely on it every day. Even seemingly modest reductions in the benefit can have an outsize impact on access, financial burden, health outcomes, and confidence in the TRICARE benefit.

We appreciate that both Chairman Tuberville and Ranking Member Warren acknowledged the potential negative impact of pharmacy benefit erosion during the July 15 hearing. MOAA agrees with Ranking Member Warren's assessment that "*the consequences of losing access to your local pharmacy can be immeasurable*." We also concur with Chairman Tuberville that "*we must strike the right balance between controlling costs and maintaining access. Savings achieved on paper are not real savings if they result in delayed treatment, reduced readiness, or additional health care costs down the road.*"

MOAA recognizes the need for responsible cost containment, but the military health care benefit must preserve the high standard of access, coverage, and financial protections servicemembers have earned. Maintaining trust is essential not only to honoring the sacrifices of today's servicemembers and retirees, but also to demonstrating to future generations that our nation keeps its commitments to those who serve.

Ensure Access to Medically Necessary Medications

The TRICARE Pharmacy Program established a three-tier formulary that, until 2019, covered nearly all FDA-approved medications.[1] The FY2018 National Defense Authorization Act (NDAA) authorized TRICARE to establish a Tier 4/Non-Covered category within the pharmacy formulary.[2] TRICARE has since added dozens of medications to Tier 4,[3] yet beneficiaries have no option to request a medical necessity review of a Tier 4 drug when treatment has failed with other formulary options.

Medical necessity exception processes are standard practice in benchmark commercial health plans and provide an important safeguard to ensure patients can access appropriate treatments when preferred alternatives are ineffective.[4] The Senate report accompanying the FY2022 NDAA directed the Defense Health Agency (DHA) to establish a medical necessity and prior authorization process that would allow beneficiaries to request coverage of a Tier 4 medication at the same copay or cost share as a Tier 3 nonformulary drug.[5] This process has not yet been implemented.

> *My wife has had severe asthma since childhood. Many years ago, she was also diagnosed with severe gastroesophageal reflux disease (GERD), a condition that often coexists with asthma. Her gastroenterologist prescribed several medications, none of which worked. Finally, when Dexilant was prescribed, my wife found relief from the searing pain and her asthma symptoms improved. She took Dexilant for about 15 years until TRICARE refused to refill it.[6] Both her gastro and pulmonary doctors wrote justifications, but TRICARE would not approve it. The substitute meds do not work as well as Dexilant to curb the acid, repair the damage, and prevent further reflux.*
>
> *– Clyde T., USA (Ret)*

MOAA supports efforts to reduce the use of medications that provide no meaningful therapeutic advantage relative to lower cost alternatives. However, cost containment must be balanced with ensuring beneficiaries access to medically necessary care. Military families must have the option to request a medical necessity review for Tier 4. Establishing such a process would align TRICARE with benchmark health plan practices and provide an essential safeguard for beneficiaries with unique medical needs.

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[1] Except those in conflict with TRICARE coverage policy – i.e., used to treat a non-covered condition; prescribed for cosmetic purposes; unproven or experimental

[2] FY2018 NDAA, Section 702

[3] TRICARE does not publish a list of Tier4/Non-Covered drugs. However, the Johns Hopkins Health Plan, a U.S. Family Health Plan TRICARE Prime option, maintains a list on its website.

[4] Example: The FEP Blue Formulary Exception process allows members to apply for coverage of a non-covered drug if they have tried the covered drug(s) and treatment has been unsuccessful.

[5] Senate Report 117-39 – Medical necessity and prior authorization process for noncovered drugs in the TRICARE program, page 195

[6] Dexilant was moved to Tier 4 in November 2019, a decision that impacted 19,000 TRICARE beneficiaries with valid prescriptions. Dexilant is covered by 80% of commercial health plans and 70% of Medicare Part D and Medicaid plans. Benchmark plan FEP Blue covers Dexilant.

MOAA urges Congress to provide oversight on FY2022 NDAA Senate report language directing a medical necessity and prior authorization process for noncovered drugs in the TRICARE Pharmacy Program.

Reinstate GLP-1 Coverage for TRICARE For Life

Restoring coverage of GLP-1 medications for Medicare-eligible retirees and their dependents using TRICARE For Life (TFL) is one of MOAA's top legislative priorities.

MOAA has heard from more than 800 TFL beneficiaries who lost coverage for their GLP-1 medications. These retirees report significant concerns about the impact on their health and describe feeling unfairly singled out by a policy that applies only to Medicare-eligible beneficiaries. Many note the inequity of losing a benefit earned through decades of military service while younger retirees and family members who meet the same clinical criteria continue to receive coverage.

> *"I have not felt this good since Airborne School. The dosage for my hypertension medications has been revised downward and my obstructive sleep apnea has greatly improved. As a veteran with 23 years of service, I ask myself, 'Why are retirees being targeted?' I also wonder if this is only the first of additional TRICARE policies yet to come that will continue to erode our health care benefit." –MAJ, USA (Ret)*

Background

Beginning in 2021, the TRICARE Pharmacy program covered GLP-1 medications – including Wegovy, Zepbound, and Saxenda – for beneficiaries who met strict clinical criteria for obesity-related medical conditions. TRICARE has never covered these medications solely for weight-loss or cosmetic purposes for any beneficiary category.

On Aug. 31, 2025, TRICARE ended coverage of GLP-1 medications for TFL beneficiaries citing "regulatory controls." Coverage remains available for beneficiaries enrolled in TRICARE Prime and TRICARE Select who meet the clinical criteria, as well as for all beneficiaries prescribed GLP-1 medications to treat Type 2 diabetes. Unlike the Tier 4/Non-Covered drug issue discussed previously, this policy does not restrict access based on the medication itself – it restricts access based solely on beneficiary status.

Congressional Intent

Although statute governing obesity treatment under TRICARE has evolved over time, eliminating GLP-1 coverage for TFL beneficiaries is inconsistent with congressional intent:

- Legislation that extended TRICARE pharmacy benefits to Medicare-eligible retirees requires TFL beneficiaries to receive the same pharmacy coverage and cost-sharing protections as other TRICARE beneficiaries.[7]

[7] FY 2001 NDAA, Section 711(b)

– While decades-old federal statute[8] limits coverage of obesity treatments under the TRICARE basic benefit, the 2017 law that authorized TRICARE to cover obesity treatments[9] applies to *all* TRICARE-covered beneficiaries and *all* TRICARE plans, including TFL.

TFL Out of Step with Medicare

While TRICARE has revoked GLP-1 coverage for Medicare-eligible beneficiaries, other federal health programs are moving in the opposite direction. The Centers for Medicare & Medicaid Services (CMS) is testing the Medicare GLP-1 Bridge and Medicare/Medicaid BALANCE Model to expand access to GLP-1 medications and improve health outcomes for older adults, leaving TFL policy increasingly out of step with broader federal efforts.

MOAA urges Congress to ensure DHA has the statutory authority and appropriations necessary to reinstate TRICARE Pharmacy Program coverage of GLP-1 medications for eligible TFL beneficiaries.

Restore the TRICARE Retail Pharmacy Network

MOAA continues efforts to restore the TRICARE retail pharmacy network after the reduction in minimum network size – from 50,000 to 35,000 pharmacies – resulted in fewer participating pharmacies and reduced beneficiary access.

Background

The DHA reduced network requirements in TRICARE's 5th Generation Pharmacy Contract (TPharm5)[10] as a cost-saving measure. As a result, the TRICARE retail network shrank by nearly 25% in 2022, falling from approximately 55,000 to 42,000 locations and disproportionately impacting independent pharmacies.

At the July 15 hearing, both DHA Deputy Director Dr. David Smith and Express Scripts and Evernorth Care Management President Dr. Adam Kautzner noted the network has grown to about 46,000 pharmacies since the initial cuts. While MOAA welcomes this progress, the network remains well below its pre-TPharm5 size even though Express Scripts is exceeding the contract's minimum requirements by 11,000 pharmacy locations. Under TPharm5, the contractor could remain in compliance with as few as 35,000 network pharmacies.

Before TPharm5, TRICARE's retail pharmacy network was comparable to FEP Blue, a key benchmark. Today, it falls short of the Blue Cross Blue Shield plan that serves roughly two-thirds of Federal Employee Health Benefits Program enrollees and includes more than 55,000 network pharmacies.

[8] 10 U.S.C. § 1079(a)(10)
[9] FY 2017 NDAA, Section 729
[10] TRICARE's 5th Generation Pharmacy Contract: TPharm5 - Congressional Research Service, November 2022

This is not just the typical reshuffling of network participants that accompanies a new pharmacy contract — it is a cut to the benefit that weakens protections servicemembers have earned and the TRICARE Pharmacy Program should provide.

Beneficiary Impact

For healthy families in metro areas, switching to another pharmacy for occasional medication needs is an inconvenience – more so for mobile military families who regularly experience unavoidable disruptions in health care. But for many elderly beneficiaries, rural families, and those with complex medical needs, the narrowed network has created barriers to accessing medications.

Dr. Smith and Dr. Kautzner noted that more than 98% of beneficiaries still live within a 15-minute drive of a network pharmacy. However, drive time alone is an inadequate measure of access. It does not account for medical complexity, unique needs of the elderly, and the critical role local pharmacies play in rural communities. The witnesses also failed to mention that tens of thousands of beneficiaries are no longer within distance-based access standards due to the network cuts.

Elderly patients often depend on independent pharmacies for specialized services, medication counseling, and convenient locations (i.e., within or near hospital campuses or long-term care facilities). In many rural communities, beneficiaries who once relied on nearby Walmart or community pharmacies now must bypass those locations and travel farther to reach a network pharmacy.

> *"My 98-year-old mom is an Army officer's widow living in an assisted living retirement home in Washington state. To reduce medication errors, the retirement home only deals with one local pharmacy. That pharmacy is no longer a network pharmacy, and mom's prescription drug costs have gone up over 300% as a result of DoD's decision to save a few bucks out of their multibillion-dollar budget on the backs of retirees and their widows." –CDR, USN (Ret)*

> *"I live in a very rural area in Michigan's Upper Peninsula. I am also a physician and I have numerous TriCare beneficiaries who use community pharmacies. Although I do have a chain pharmacy in my immediate area, they are very difficult to work with both as a patient and prescriber. The chain pharmacy has had significant supply chain/stock issues on common medications. Our community pharmacy has been able to avoid those supply chain problems and is able to promptly fill medications when the chain pharmacy cannot. There are numerous smaller outlying communities near my practice that do not have any chain pharmacy options at all, and I have TriCare beneficiaries who live in those areas and who will have to drive an hour or more to get medications once this change takes effect." –Veteran, USA*

The narrowed network has substantially increased the likelihood of prescription drug access challenges for military families. Before the cuts, there was a 17% chance that a military family's

preferred/needed pharmacy would be out of network. That more than doubled to 36% following the network cuts in 2022.[11]

Using a non-network pharmacy is not an acceptable solution. Non-network pharmacies require beneficiaries to pay upfront for their medications and then file a claim for partial reimbursement – this is impractical for many beneficiaries, particularly the elderly and those with medically complex conditions who may be on multiple medications, have fixed incomes, and face challenges with administrative tasks.

GAO Report – Beneficiary Impact

We appreciate Congress directing a Government Accountability Office (GAO) review[12] of the TRICARE pharmacy network. That report found network reductions had measurable consequences for beneficiaries:

- The number of beneficiaries without a network pharmacy within distance-based access standards grew by 55%, from 177,000 to 275,000. These 98,000 additional beneficiaries face new barriers to obtaining medications – not because they live in pharmacy deserts, but because nearby pharmacies were removed from the network.
- During the initial network cut in 2022, approximately 380,000 beneficiaries lost access to a pharmacy they had recently used, with 300,000 impacted as additional pharmacies left the network through January 2023.

The GAO analysis focused primarily on geographic access and did not quantify other important impacts, such as long-term care residents who lost the pharmacy that supplies their facility, reduced options during drug shortages, or the loss of specialized services and convenient niche locations. MOAA continues to hear from military families facing barriers to access stemming from these factors, underscoring that pharmacy access is about more than drive time alone.

Visibility on TPharm5 Savings

In addition to reducing the pharmacy network size, TPharm5 added the specialty pharmacy Accredo, allowing specialty prescription fulfillment with medications procured at Federal Supply Schedule pricing. Although specialty medications account for less than 1% of TRICARE prescription drug volume, they account for 53% of TRICARE Pharmacy Program spending.[13] This suggests that specialty pharmacy changes may account for a substantial share of TPharm5's projected savings.

To evaluate whether the retail pharmacy network reduction is justified, Congress and military and veteran service organizations need transparency into the savings generated by each major TPharm5 change. Without that information, it is impossible to determine whether the narrowed network is producing meaningful savings or if most of the savings are being generated by specialty pharmacy reforms.

[11] Calculation – number of TRICARE network pharmacies as a share of total U.S. pharmacy locations (estimated to be 66,000 in 2022)

[12] Defense Health Care: DOD Should Improve Monitoring of TRICARE Beneficiaries' Access to Prescription Drugs – GAO, February 2025

[13] DHA Written Testimony, July 15, 2026 – page 6

The GAO reported that DHA officials expected to complete an assessment of the financial impact of the TPharm5 contract in January 2025.

MOAA urges Congress to require transparency on savings generated by the TPharm5 contract, including a breakdown of savings attributable to network cuts versus changes to specialty medication fulfillment.

Preserve Affordable TRICARE Pharmacy Copays After 2027

For more than two decades, Congress has intervened to ensure TRICARE beneficiaries have access to affordable prescription medications while maintaining alignment with commercial health plan benchmarks. Most recently, the FY2018 NDAA established copays through 2027 for prescriptions filled through retail pharmacies and mail order. MOAA appreciates that medications dispensed through military treatment facility pharmacies have remained available at no cost to beneficiaries, preserving a long-standing cornerstone of the TRICARE pharmacy benefit.

Beginning in 2028, however, DHA will be authorized to adjust TRICARE pharmacy cost sharing annually based on changes in the cost of pharmaceutical agents and prescription dispensing. The statute does not require DHA to consider prevailing commercial health plan cost sharing practices or the impact of higher copayments on military beneficiaries, creating the potential for beneficiary costs to outpace those in benchmark health plans.

Congress has consistently demonstrated its intent to align TRICARE pharmacy cost sharing with commercial plan benchmarks. The legislation establishing the TRICARE Pharmacy Program referenced "common industry practice,"[14] and subsequent congressional action to establish pharmacy copays has maintained alignment with benchmark health plans.

MOAA is concerned that unrestricted copay increases could undermine beneficiary access to prescription medications. Excessive pharmacy copays can discourage medication adherence, leading to poor management of chronic conditions, avoidable hospitalizations, and ultimately higher overall health care expenditures.

To protect beneficiary access to affordable prescriptions, MOAA recommends amending section 1074g(a)(6)(B) of Title 10, U.S. Code to provide that annual pharmacy cost-sharing adjustments after 2027 be limited to the lesser of common industry practice or the previous year's cost-sharing amount adjusted to reflect changes in the cost of pharmaceutical agents and prescription dispensing.

This targeted amendment would preserve DHA's authority to adjust pharmacy copays when appropriate while ensuring TRICARE beneficiaries remain protected from disproportionate cost increases that exceed commercial health plan benchmarks.

[14] FY2000 NDAA, Section 701

MOAA urges Congress to establish a guardrail on DHA's authority to modify TRICARE Pharmacy Program copays:

Amend section 1074g(a)(6)(B) of Title 10, U.S. Code to provide that annual pharmacy cost-sharing adjustments after 2027 be limited to the lesser of common industry practice or the previous year's cost-sharing amount adjusted to reflect changes in the cost of pharmaceutical agents and prescription dispensing.

MOAA appreciates the committee's long-standing support and oversight of the military health care benefit and thanks you for the opportunity to provide this statement in response to the July 15 hearing. Delivering on the commitment of accessible, high quality, affordable health care is a fundamental obligation to those who have served and sacrificed on behalf of our nation. We look forward to working with the committee to strengthen TRICARE and the pharmacy program – key components of the compensation and benefits package that sustains the all-volunteer force.