2026 prescription benefits

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In this month's article I would like to focus on the changes to the NALC Health Benefit Plan's 2026 prescription benefits. The Plan fully understands that the change from copay to coinsurance in our 2026 prescription benefit package is significant for some members. It's important to understand the reason for the change, what's on the horizon, and how each member can help control their individual costs that may have increases under the new prescription coverage.

Benefit changes are not made lightly. Health care coverage is a complex issue, and we must ensure long-term sustainability while considering future and overall health costs, evolving trends, which include higher usage of brand-name medications, and lastly, equitability for *all* health plan members.

Approximately 87.5 percent of the plan's dispensed prescriptions are generic medications; however, despite the high percentage of generic medications still being prescribed, the cost associated with pharmaceutical benefits has drastically increased. This increase is related to the introduction of high-cost brand name drugs and GLP-1 medications for diabetes and weight loss.

Although we recognize our members may need to use these medications, the high costs have resulted in the health care industry nationwide trending toward percentage-based coverage, with many of the other Postal Service Health Benefits (PSHB) plans already moved into the coinsurance structure. Despite our attempts to resist this change and mitigate the impact for a few years, it was no longer sustainable. NALC had to make a difficult decision—change the prescription benefits or add additional premium increase to all members to cover those rising costs.

Why did we choose to change the benefit rather than include an additional increase to premiums?

First, additional premium increases affect all members. In addition, premiums are absolute. There is no avenue for an individual member to obtain savings on their premiums. With an 87.5 percent generic dispensing rate, the majority of our members would be adversely affected.

Also, with the evolving market in the pharmaceutical industry, drug pricing can fluctuate dramatically. The Plan's Pharmacy Benefit design was no longer providing the best value to our members using generic medications—a tenet of the Plan's copay model. For example, under the copay structure, a prescription that costs $3,000 had a $50 copayment, or 2 percent member cost share. But in comparison, a generic medication that costs $50 had a $10 copayment, or 20 percent-member cost share.

Making a benefit change to coinsurance versus additional premium increases provides reasonable coverage for all members, regardless of the type of medication prescribed, and mitigates the cost-share disparity without adding a significant increase to all premiums.

Another way to consider the prescription benefit coverage change is to look at it from a broader perspective. Compare the Plan's prescription coverage to the Plan's medical coverage. Currently, all members pay an equal coinsurance percentage for medical procedures. Although every procedure may have a different cost and different out-of-pocket expense, each member is equally financially protected by the Plan's catastrophic maximum out-of-pocket limit.

Although we have consistently encouraged our members to discuss generic options with their providers to obtain the best value, I do understand that many health conditions may benefit from a prescription that does not offer a generic alternative. Rest assured that we are committed in our efforts to work toward lowering prescription costs for our members and are working closely with CVS, our pharmacy benefit manger, on innovative solutions for brand-name drug coverage and to help lower costs for our members who may need GLP-1 medications for diabetes and weight loss.

While we continue our efforts to help lower costs, we encourage members to use options available to help lower their individual out-of-pocket cost.

Non-Medicare members can use manufacturer discounts or coupon cards. Members should speak to their physician or pharmacist about assistance programs that may be available, visit the manufacturers' website to learn more about coupons that are available, or visit prescription discount platforms and cost comparison tools.

Medicare members, although not permitted to use coupons or discounts, have a significantly lower out-of-pocket cost when enrolled with SilverScript or our Aetna Medicare Advantage option ($2,100). Plus, this amount is calculated using Medicare's assigned value for medications, not the actual cost paid. To learn more about the Medicare Part D out-of-pocket maximum, please refer to your monthly statement, which indicates the amount met toward the $2,100 out-of-pocket expenses. (Beneficiaries may reach this amount earlier than anticipated, as many Part D drugs will have an applied out-of-pocket credit significantly higher than what was actually paid.)