

# MISSISSIPPI HB 1665

## *Pharmacy Benefit Prompt Pay Act — Amended*

### **Cost Impact Analysis: NADAC + \$11.29 Dispensing Fee Floor**

Prepared for Mississippi State Legislature | March 2026

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## **Executive Summary**

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Mississippi House Bill 1665 proposes a reimbursement floor of NADAC (National Average Drug Acquisition Cost) plus \$11.29 as a professional dispensing fee for all prescriptions filled in the state. While the bill's intent is to support independent pharmacies facing below-cost reimbursements, the mechanism it employs—a universal dispensing fee floor—creates a measurable, unavoidable cost increase that falls directly on employees and plan members at the pharmacy counter.

This analysis finds:

- The proposed dispensing fee represents a significant increase over current rates of \$1–\$2, raising the total allowed amount per prescription substantially.
- Rebates cannot offset dispensing fee increases—they are structurally separate mechanisms applied at different times and to different components of the drug cost.
- With 86% of prescriptions in the Mississippi State Employees Health Plan filled as generics, and most generics carrying minimal or zero rebates, the vast majority of prescriptions have no rebate cushion to absorb the fee increase.
- West Virginia—the primary state cited by proponents—published data showing that even with 100% rebate pass-through, premiums still increased. The state's own actuaries called the result an “actuarial wash.”
- The bill applies universally to all pharmacies, including large chain retailers, meaning the cost floor benefits the entire market rather than targeting the independent pharmacies it was designed to protect.
- ERISA preemption creates serious legal vulnerability for self-funded employer plans, which represent the majority of large-employer coverage in Mississippi.

**The conclusion is straightforward: HB 1665, as currently structured, increases prescription drug costs for Mississippi employees and plan members without delivering the savings its proponents project.**

## **How NADAC + \$11.29 Increases Costs**

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### **The Current Cost Structure**

Under the current system, when a patient fills a prescription, the total allowed amount is the sum of the drug ingredient cost and the dispensing fee. The patient pays the lesser of their copay or the allowed amount. Dispensing fees today typically range from \$1 to \$2 per prescription.

HB 1665 would set the dispensing fee floor at \$11.29—an increase of \$9 to \$10 per prescription over current rates. This is not a new fee. It is a dramatic increase to an existing fee with no mechanism for the increase to be absorbed anywhere in the system.

### The Impact at the Point of Sale

The following table illustrates the direct patient impact:

Cost Component	Today	Under HB 1665
Drug Cost (Generic)	\$3.00	\$3.00
Dispensing Fee	\$1.00 – \$2.00	\$11.29
Total Allowed Amount	\$4.00 – \$5.00	\$14.29
Patient Pays	<b>\$4.00 – \$5.00</b>	<b>\$10.00 – \$14.29</b>

Key Point: There is nowhere for this increase to go except to the employee at the pharmacy counter. The allowed amount is a hard mathematical calculation. When one component of that calculation increases by \$9 to \$10, the total increases by the same amount.

### Why Rebates Cannot Offset the Dispensing Fee

#### Structural Mismatch: Timing and Component

Proponents of HB 1665 argue that increased rebate pass-throughs will offset the higher dispensing fee. This argument fails on two structural grounds:

**The Two Fundamental Flaws in the Rebate Offset Argument**

- **Timing:** Dispensing fees are paid at the point of sale—the moment the patient picks up their prescription. Manufacturer rebates are received by the plan weeks or months later. A patient paying \$10–\$14 at the counter today receives no benefit from a rebate the plan receives in Q2.
- **Component:** Rebates apply exclusively to the drug ingredient cost. They do not touch, reduce, or interact with the dispensing fee in any way. Total cost = ingredient cost + dispensing fee. Reducing ingredient cost through rebates while simultaneously raising the dispensing fee floor is a net cost increase, not a wash.

### Generics Dominate—And Generics Don’t Have Meaningful Rebates

The rebate offset argument is weakest precisely where it matters most—generic prescriptions, which dominate the formulary.

- The Mississippi State Employees Health Plan reports an 86% generic fill rate (GFR) for plan year 2025. That means 86 out of every 100 prescriptions filled are generic drugs.
- Generic drugs carry minimal rebates or no rebates at all. Manufacturer rebates are primarily structured around brand-name drugs, where manufacturers have pricing leverage and market exclusivity to negotiate against.
- With 86% of prescriptions in the generic category and limited rebate applicability to generics, the rebate offset argument covers a small minority of total prescriptions.
- Approximately 90% of prescriptions nationally are generics—consistent with Mississippi’s own data—meaning the gap between rebate-eligible prescriptions and total prescriptions is substantial.

The math is straightforward: if 86% of prescriptions are generics with minimal rebates, and rebates only apply to ingredient cost anyway, then the dispensing fee increase lands on the vast majority of prescriptions without any offsetting mechanism.

## The West Virginia Evidence

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### West Virginia as the Primary Proponent Case Study

Proponents of NADAC-plus legislation frequently cite West Virginia as proof that this approach works. West Virginia was the first state to require NADAC-plus reimbursement in the commercial market, implementing the policy via legislation in 2022. A three-year analysis of results is now available from the West Virginia Office of Insurance Commissioner.

That evidence does not support the claims being made.

#### What West Virginia’s Own Data Shows

- The West Virginia OIC’s own multi-year analysis described the combined effect of NADAC-plus reimbursement and 100% rebate pass-through as an “actuarial wash.”
- Premiums still increased. The policy “blunted” the increase—it did not prevent it or reverse it.
- West Virginia’s public employee plan (PEIA) fiscal notes acknowledged a \$5.9 million cost increase directly attributable to the NADAC-plus dispensing fee requirement.
- West Virginia’s public employees have continued to face premium increases, with state employees seeing a 14% hike and local government employees a 16% hike in recent years.
- West Virginia already has the highest average unsubsidized premiums in the nation, with further increases projected.

*The proponent argument is not that West Virginia saved money. The argument is that it saved less money than it would have without the policy. That is a fundamentally different claim—and it still resulted in higher costs for employees.*

## Comparing Mississippi and West Virginia

Several important differences make the West Virginia experience a poor predictor of success in Mississippi:

- West Virginia’s dispensing fee was set at \$10.49—Mississippi’s proposed floor of \$11.29 is higher, meaning Mississippi’s cost exposure is greater.
- West Virginia’s pharmacy market and formulary mix differ from Mississippi’s. Mississippi’s 86% GFR on the state employee plan means even greater exposure to the generic rebate gap.
- West Virginia’s ERISA preemption analysis is contested. Their OIC issued guidance stating the law applies to self-funded ERISA plans, but this interpretation has not been uniformly accepted and creates legal risk for employers.

## ERISA Preemption: A Critical Legal Risk

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### The Preemption Landscape

The Employee Retirement Income Security Act (ERISA) preempts state laws that “relate to” employee benefit plans. This creates a fundamental legal problem for several key provisions of HB 1665.

Most large employers in Mississippi—and the majority of employees with employer-sponsored coverage—are covered through self-funded ERISA plans. If key provisions of HB 1665 are preempted as applied to self-funded plans, the practical effect is that the law would apply primarily to fully-insured markets (individual and small group), while large employer plans operate outside it.

### Specific Provisions at Risk

- Reimbursement Floor (Section 73-21-155): Directly dictating how claims under employer-sponsored plans are paid is squarely within ERISA’s preemption zone. Courts have consistently found this type of mandate preempted when applied to self-funded plans.
- Rebate Pass-Through Mandate (Section 73-21-158): Regulating the financial relationship between a PBM and a plan sponsor implicates the structure of the employee benefit plan itself.
- Reporting Requirements (Section 73-21-165): Requiring PBMs to report plan-specific financial data to the Mississippi Board of Pharmacy creates a parallel state reporting regime that conflicts with ERISA’s exclusive federal oversight framework for self-funded plans.

*West Virginia’s OIC issued guidance arguing its PBM reimbursement laws are “cost regulation” and not preempted by ERISA. However, this interpretation is contested and has not been*

*uniformly accepted by courts. Mississippi legislators should not assume West Virginia's approach will survive legal challenge here.*

## The Universal Floor Problem

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HB 1665 applies the NADAC + \$11.29 reimbursement floor to all pharmacies—chain, independent, mail order, and specialty alike. This is a critical structural problem that undermines the stated purpose of the legislation.

The bill is framed as protecting independent pharmacies from below-cost reimbursements. But by setting a universal floor, it guarantees higher reimbursements to large chain pharmacies (Walgreens, CVS, Walmart) as well, regardless of whether those chains need the support. Given that large chains fill the majority of prescriptions in Mississippi, the cost impact of raising their reimbursement floor is substantial.

### The Universal Floor Creates Three Problems

- **Cost Without Targeting:** Higher reimbursements flow to all pharmacies, including chains that are not financially distressed, meaning plan sponsors and employees bear increased costs without achieving the narrower goal of supporting independent pharmacies.
- **No Market Mechanism:** By removing the ability of plans to negotiate lower rates with high-volume chains, the bill eliminates a key cost-management lever for employer plans.
- **Competitive Distortion:** Independent pharmacies and large chains are not similarly situated. A universal floor does not address the structural competitive disadvantage independents face—it simply raises the floor for everyone.

## Recommendations for the Legislature

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The Mississippi Legislature's goal of ensuring viable independent pharmacy access for patients—particularly in rural and underserved areas—is legitimate and important. The mechanism in HB 1665, however, is blunt and costly. The following targeted alternatives could achieve the policy goal with substantially less cost exposure:

- **Targeted Independent Pharmacy Protection:** Rather than a universal floor, establish a below-cost reimbursement prohibition specifically for independent pharmacies and small pharmacy operators, allowing market-rate negotiation with large chain pharmacies to continue.
- **Require Transparency Before Mandating Costs:** Require PBMs to report actual reimbursement rates, rebate flows, and spread pricing data to the Board of Pharmacy and Legislature before any reimbursement floor is established, so that the floor can be calibrated to actual market conditions rather than a national average.
- **Commission an Independent Actuarial Study:** Before enacting a reimbursement floor, require an independent actuarial analysis of the cost impact on Mississippi State

Employees Health Plan, public school teacher plans, and private employer-sponsored plans using actual Mississippi claims data.

- Separate Dispensing Fee Reform from Ingredient Cost Reform: If dispensing fee floors are warranted, tie them explicitly to documented acquisition cost shortfalls rather than applying a flat dollar floor statewide.
- Clarify ERISA Application: Work with legal counsel to understand which provisions of HB 1665 can be enforced against self-funded ERISA plans before enactment, to avoid passing a law that applies only to the insured market while leaving the majority of employees unprotected.

## Conclusion

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HB 1665's NADAC + \$11.29 dispensing fee floor is not a cost-neutral reform. It is a cost increase—one that falls directly and immediately on employees and plan members at the point of sale, with no reliable offsetting mechanism.

The rebate offset argument fails because rebates and dispensing fees are structurally separate: one affects ingredient cost after the fact, the other affects what patients pay right now. With 86% of Mississippi's state employee prescriptions filled as generics—a category with minimal rebate applicability—the offset is largely theoretical.

West Virginia, the state most cited by proponents, describes its own results as an “actuarial wash”—premiums still increased, just somewhat less than they might have. That is not a compelling endorsement for Mississippi employees who would face higher out-of-pocket costs under this bill.

**The Legislature should pursue the legitimate goal of protecting independent pharmacies through targeted, empirically grounded mechanisms—not a universal cost floor that increases prescription costs for every Mississippi employee and their family.**

## Appendix: Key Data Sources and References

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- Mississippi HB 1665, Senate Amendments (2026 Session)
- West Virginia OIC Insurance Bulletin No. 22-03: PBM Pharmacy Reimbursement
- West Virginia OIC Actuarial Analysis: NADAC+ Three-Year Review (published February 2026, NCPA)
- West Virginia PEIA Fiscal Note, SB 453 (2024): \$5.9 million cost increase acknowledgment
- West Virginia Code of State Rules, Series 114-99, Section 5.8: NADAC + \$10.49 dispensing fee requirement
- West Virginia PEIA Premium Rate History (2022–2026), [peia.wv.gov](http://peia.wv.gov)

- Mississippi State Employees Health Plan: 86% Generic Fill Rate, Plan Year 2025
- NCPA 2024 State PBM Regulation Recap: Kentucky, Tennessee, West Virginia commercial market floors
- CMS NADAC: National Average Drug Acquisition Cost Methodology, Centers for Medicare and Medicaid Services