I think they misunderstand what we are trying to do. We are not going to assemble a large staff to carry out this program. The Social Security Administration for several years has maintained a small but effective staff working in the drug price field as part of their medicare responsibility. While implementation of the MAC program would probably require a modest expansion of this staff, that surely would not begin to offset the potential savings. The principal administrative machinery is already in place and functioning at the State level.

As to the cost of monitoring to assure compliance with the regulations, the vast majority of those affected by the program we believe will be in voluntary compliance. What additional auditing we might have to undertake would merely represent an extension of our present auditing activities under medicare and medicaid.

We estimate that the administrative costs would not exceed 5 to 7 percent of the projected savings, or around $4 to $6 million. I would very much hope that it could be done for less, and I believe it can, but we want to use the more liberal estimate at this point so that if we are able to do it for less than that, why we at least will not be accused of promising things we cannot achieve.

The suggestion that administrative costs would consume all of the money saved, or even a significant portion of it, is grossly and improperly exaggerated.

There are a great many other issues. We have had about 200 mentioned in the course of the comment period, and these need to be addressed before any further action can be taken implement it.

We will fully analyze and address these issues, and for that reason, we cannot predict the actual substance of the final regulation, but I think it is clear that the policy will not restrict or encumber the ability of doctors to prescribe as they see fit in the interests of all of their patients. It will not discourage or prevent pharmacists from processing medicaid prescriptions, nor deny them equitable reimbursement for their essential professional services.

It will not create a second or lower class of care for any beneficiary in a federally funded program, and it will certainly not discourage new efforts at drug development by the pharmaceutical industry.

We think establishing a working national policy on drug cost reimbursement could pave the way for a drug benefit under national health insurance, and that is included in the comprehensive health insurance plan that we submitted last year. This would, in turn, almost certainly lead to increased resources for drug development and increased market and increased volume.

The program is workable, as proven in the States I have mentioned, and we think it is long overdue as a national policy. We have had constructive comment, and we are paying the closest attention to it. We are certainly going to do our part to make the program equitable and workable, and obviously to make sure that it is workable we need the understanding, the acceptance, and the support of the entire health and pharmaceutical community.

I think I should make one other point in closing. There have been some complaints about this as a totally unjustifiable Federal intervention into medicine and into matters that are in effect, it has been said, none of the Government's business. Well, in the absence of