

**STATEMENT OF CARLO P. MICHELOTTI, ASSISTANT CHIEF,
MEDI-CAL BENEFITS SECTION, CALIFORNIA DEPARTMENT OF
HEALTH**

Mr. MICHELOTTI. Thank you, Mr. Chairman.

I will dispense with the opening remarks and try to go through the testimony quickly in the interest of time.

I am here today to present to you a profile of the ceiling price program for drugs available through the medicaid program in California. The purpose of this testimony is to share this experience and in doing so extend the support of the California Department of Health to the proposed Federal MAC program subject to the suggested technical changes noted in our letter of January 8, 1975, providing comments on the proposed regulations. A copy of that letter is an attachment to this testimony.¹ The best way to proceed, I feel, is to present a chronology of California's drug program as I have known it over the past several years. I place particular emphasis on the price ceilings that we may have had in effect, at one time or another, particularly our current program known as the maximum allowable ingredient cost (MAIC) program. I feel MAIC is the inspiration for the Federal Maximum Allowable Cost (MAC) program which we are discussing here today.

More than a decade ago, California was involved in what was known as the public assistance medical care (PAMC) program. The payment for services was administered by counties handling Federal and county resources and was not a direct State-administered program as we know it today. PAMC provided outpatient drugs through community pharmacies.

Even in those days, I am referring now to the early sixties, California had a limited number of ceiling prices known as "maximum allowable wholesale cost" (MAWC) for several drugs which were available generally. These included items such as prednisone, penicillin-G, thyroid, phenobarbital, and a limited number of others. These ceiling prices were an attempt to contain very high drug costs. Although the drugs were available generically, many products maintained a very high price profile. For example, Schering Corporation's Meticorten was selling in the range of \$17 per 100 tablets for the 5 miligram size as opposed to other generically available brands of the same generic drug selling for less than \$1. The range of prices was the rationale for adopting price ceilings.

The MAWC ceiling prices were not intended to limit availability of generic drugs to the lowest cost item within a generic type. They were, however, intended to bring about reasonable controls over a broad band of drug product prices that were as prevalent then as they are today.

This brings us then to 1966 and the advent of the current medicaid program pursuant to Public Law 88-97, wherein a State could assume centralized control of administration of a health program for the poor and near poor under title 19 of the Social Security Act. For the first 4 years of California's medicaid program, which we have labeled the "medi-cal program", MAWC were continued just as before affecting a very limited number of drug products in a small number of generic types.

¹ See prepared statement and letter, pages 12014 to 12045.