

nized pharmacists at the community practicing level in California, has been in consistent support of our ceiling price program. They do not necessarily support all of our medicaid controls. For example, we have a basic benefit limitation of two prescription drugs per month. They disagree with that. Any drugs beyond two prescriptions per month have to be prior authorized by a local Medical consultant, and they feel this is really a timeconsuming imposition on their professional prerogative.

They disagree with our updating on the drug pricing master file. They feel we should do it more frequently to reflect those prices available in the marketplace on a more current basis.

They disagree with some of the fiscal intermediary controls about lost prescription claims and so forth.

But specifically, our ceiling price program has general and overwhelming support of the pharmaceutical profession. I must say the California Medical Association does not support our ceiling price program. In fact, as a medical association, and I think they reflect the position of medical—organized medicine generally in the Nation—that they do not like a formulary. They feel a drug formulary is contrary to the prescribers prerogative, so the putting on of any constraint cannot be in the patient's best interest. Thus, you either have support or opposition depending on viewpoint.

But again, getting back to the original question, the specific program has not had a significant amount of opposition.

Mr. GORDON. Can you tell us what effect the antisubstitution laws have on the administration and efficiency of the MAIC program?

Mr. MICHELOTTI. OK. In California right now, there are two proposed pieces of legislation, one in the assembly and one in the State senate to repeal the antisubstitution measures in California.

There were also two bills presented in the last legislative session. They were defeated the last legislative session. This particular legislative session the bill in the assembly has passed through the assembly health committee and it seems to have gathered some momentum.

For our departmental position, the repeal of the antisubstitution measure would be most helpful and simplify any type of price ceiling program. It would simply streamline the change if a prescriber prescribed a high cost item, and he did not indicate on his prescription that he did not want it substituted, it would be a simple matter for the pharmacist then to select that item that he was comfortable with therapeutically and that would fit within our price ceiling program.

Right now the situation is that if a prescriber prescribes by a brand name or indicates a drug which is more expensive than our ceiling price program, the pharmacist is obligated to call the physician and get a change in order, *if* the physician elected to change the order.

Mr. GORDON. Does he generally do that?

Mr. MICHELOTTI. By and large they do. There are times I would expect a physician is convinced that a particular product that he has prescribed is necessary for the patient. If that is his position, fine, there are prior authorization mechanisms that it would make it available.

I will retract from that. This is not totally correct.

With our ceiling price program the price that is entered into our drug pricing master with the fiscal intermediary, the payment mech-