published average wholesale cost figure which does not take into account various and non-trivial discounts. Such a rule appears appropriate. We presume that the accuracy of the reimbursements will be checked by sample audit. We feel that actual acquisition cost could be defined as that which appears on the most recent invoice for that drug prior to the date that the prescription was dispensed. That is, that the cost of the drug be established according to the Last-In-First-Out inventory method, so as to preserve simplicity.

This might involve some windfall gains to pharmacists at first, since they may still have in inventory drugs bought earlier at a lower price. It is possible, but seems less probable, that the opposite might happen. In cases where specific drug prices fall, as might happen when a patent expires, the LIFO system would mean that the pharmacist is reimbursed for less than his actual acquisition cost unless a grace period (e.g. 90 days) is allowed. This problem is especially apparent with respect to MAC prices set for multi-source drugs, as is discussed below. Another resolution of the issue might be to reimburse on LIFO costs unless a pharmacist demonstrates, with copies of invoices, that he is disadvantaged in view of his actual, historical acquisition cost. This, of course, would impose additional administrative costs which might be too great.

B. Maximum Allowable Cost for Multiple-Source Drugs

The portion of the proposed rule which has most merit is that which leads to the use of low-cost generic equivalents. Staff understands that a specially created Board would identify those multiple-source drugs for which significant amounts of Federal funds may be expended under the relevant medical programs, and for which there are or may be significantly different prices charged by various product formulators and labelers. By liaison with FDA, the Board would also determine which of those identified drugs are believed to be therapeutically equivalent—*i.e.*, which chemically equivalent drugs offer the same therapeutic results in most individuals. The Board would then determine the lowest price at which each such drug is widely and consistently available to providers. This would be the proposed "MAC," the maximum allowable cost beyond which no pharmacy may be reimbursed despite its actual acquisition cost. (Reimbursement will be given for a higher-priced drug only if a physician certifies in writing that the selected brand (or source) is the only source which the patient can tolerate.) As an incentive to purchase below the MAC and prevent the MAC from becoming a floor as well as a ceiling, pharmacists would be permitted to retain 25 percent of the difference between actual cost, if lower than the MAC, and the MAC.

It is clear that the MAC regulation will promote competition in such a way that *all* consumers will be benefited. Manufacturers who charge a price above the MAC price will have to lower the price if they are to retain a share of the Medicaid volume, which is currently about one-sixth of all out-of-hospital prescription sales. Manufacturers will have to charge pharmacists the same prices, on a single drug, regardless of whether the final buyer is a Medicaid or non-insured consumer. Thus, the wholesale cost of drugs dispensed to non-Medicaid consumers will also go down.

It also seems reasonably clear that if a pharmacist chooses to stock a MAC-level drug for Medicaid patients, he is more likely to use this low-cost drug in filling generically written prescriptions; this is in contrast to the current situation where pharmacists, perhaps unsure of sufficient demand for non-branded drugs, stock primarily brand-name drugs and often fill generic scripts with these same high-cost products. The benefits involved in the lower acquisition cost of drugs will accrue to non-Medicaid consumers only if a price advantage is passed along to them, and this will depend on the level of competition among retail pharmacists. The savings on acquisition cost will be greater the more intense is the level of competition.

Moreover, producers will be under pressure to lower their prices even below the MAC level to maintain or increase sales. This pressure will be strengthened in that pharmacists are given an incentive to seek out low-cost sources; as mentioned, the proposal permits pharmacists to keep 25 percent of the difference between actual acquisition cost and the specified MAC level. As price competition among drug producers proceeds, the MAC price will be revised progressively downward. This downward spiral of the MAC price should in the longer run provide great savings for HEW. Indeed, because of these potentially great savings for HEW and because of the great benefits which will be available to all consumers from the increased competition, the FTC urges that the process be hastened by making the pharmacist's incentive to locate low cost suppliers as