The publication of a monograph or list covering items 1 and 2 above would be a slight modification of the recommendations which were made by the Drug Bioequivalence Study Panel, Office of Technology Assessment, to the Congress of the United States on July 15, 1974.

Another alternative which we feel would realize savings is the establishment of the maximum allowable cost price of drug product enjoying a high volume of usage based on the most commonly purchased package size of the drug product. For example, a product commonly purchased in 1000s by the pharmacy provider and reimbursed at the 1000s base price by Medicaid programs would not only encourage providers to attain savings through volume buying but would also tend to discourage price manipulation by the manufacturer (i.e., high cost for 100s, exceptionally low cost for 1000s).

Reimbursement at 98 percent of the average wholesale price of a specific product as listed in the Drug Topics Red Book or American Druggist Blue Book is another alternative to achieving savings. This method would ensure that the 2 percent trade discount would be passed on to the government as a volume purchaser meanwhile still providing the pharmacy provider an incentive to purchase economically in larger quantities. This system would not interfere with automated claim processing, and would not require large degree of monitoring and auditing.

A combination of the preceding recommendations, we feel, would be as effective if not more effective than actual acquisition cost in achieving savings with minimal amount of manpower, controlling, and auditing. It is our opinion that actual acquisition cost could prove to be counter-productive by tending to eliminate provider incentive to purchase as economically as possible.

We also respectfully oppose the 25 percent incentive for products with an MAC as being ineffective, and requiring as much controlling and auditing as actual acquisition cost. We believe this incentive at the provider level will not prevent manufacturers from increasing their prices to make the established MAC the floor as well as the ceiling. It has been our experience here in California, that manufacturers not only make the ceiling the floor but also manipulate prices on package sizes which they then use as a sales gimmick to gain advantage on the state Medicaid program. This leads us to believe that if incentives are to work they must be made available to manufacturers as well as to providers.

Our recommendation would be to set the MAC as low as possible at a participating manufacturer's product's AWP and enter into some type of price holding agreement as a condition of participation. Also, utilize the appropriate federal agency as a source of information to advise the individual states so that they may possibly set more stringent price ceilings at the state level.