Date of Hearing: June 28, 2022

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
SB 853 (Wiener) – As Amended June 2, 2022

SENATE VOTE: 39-0

SUBJECT: Prescription drug coverage.

SUMMARY: Prohibits a health plan or disability insurer that provides coverage for prescription drugs from limiting or declining to cover a drug or dose of a drug as prescribed, or imposing additional cost sharing for covering a drug as prescribed, if specified criteria apply. Provides that a reduction or termination of an ongoing and approved course of treatment before the end of the treatment or the end or amendment of the policy is an adverse benefit determination, and requires a health plan or insurer to notify an enrollee or insured, or their representative, and the enrollee's or insured's provider in writing, as specified. Requires a plan or insurer that has approved an ongoing course of treatment to provide continuing coverage pending appeal or review. Prohibits a health plan or insurer that provides coverage for prescription drugs from limiting or declining to cover a drug or dose of a drug as prescribed, or impose additional cost sharing for covering a drug as prescribed, if specified provisions apply, including that the drug was previously covered by the plan or insurer or the enrollees or insured's prior private or public health care coverage for the enrollees or insurer's medical condition. Specifically, **this bill**:

1) Prohibits a health plan contract or insurance policy that covers prescription drugs from limiting or excluding coverage for a drug, dose, or dosage form of a drug on the basis that the drug, dose, or dosage form of the drug is prescribed for a use, dose, or dosage form that is different from the use, dose, or dosage form for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), as specified; or, if the drug previously had been approved for coverage by the plan for a medical condition of the enrollee or insured and the plan or insurer's prescribing provider continues to prescribe the drug for the medical condition, provided that the drug, dose of the drug, or dosage form is appropriately prescribed and is considered safe and effective for treating the enrollee or insured's medical condition.

2) Specifies that, other than by lawful amendment or termination of a policy, a reduction or termination of an ongoing course of treatment approved by a health plan or insurer provided over a period of time or number of treatments, before the end of the period of time or number of treatments, constitute an adverse benefit determination.

3) Requires a health plan or insurer to notify the enrollee or insured or the authorized representative, and the provider, in writing of an adverse benefit determination in 2) above on a date sufficiently in advance of, and no fewer than seven calendar days before, the effective date of the reduction or termination to allow the enrollee or insured time to initiate an appeal of the adverse benefit determination.

4) Requires a request by an enrollee or insured, an authorized representative, or a provider to extend a course of treatment for urgent care beyond the period of time or number of treatments previously approved by a health plan or insurer be decided as soon as possible, taking into account the medical exigencies. Requires the plan or insurer to notify the enrollee

or insured, or authorized representative, and provider, of the benefit determination, whether adverse or not, within 24 hours after the plan or insurer's receipt of the request, if the request is made to the plan or insurer orally or in writing at least 24 hours before the expiration of the prescribed period of time or number of treatments. Allows the information required by 3) above to be provided to the enrollee or insured, or authorized representative, and the provider, orally within the 24-hour time limit, if a written notice of an adverse benefit determination is furnished to the enrollee or insured, or representative, and the provider, within 24 hours of the oral notification.

5) Provides that a health plan or insurer that has approved an ongoing course of treatment to be provided over a period of time or number of treatments provide continuing coverage pending the outcome of an internal appeal, as specified. Requires a plan or insurer to provide coverage during the entire course of the internal and external appeals process, including during successive appeals.

6) Does not prevent a health plan or insurer from continuing to apply generally applicable cost sharing under the terms of an enrollee or insured's policy during the appeals process.

7) Requires a health plan or insurer providing continuing coverage pending the outcome of the appeals process, with respect to an ongoing course of treatment with a prescription drug to which 11) below does not apply, to include covering any increase in the prescribed dose of a disputed drug during the appeals process.

8) Requires a health plan or insurer to include the content required in an adverse benefit determination notice, as specified.

9) Defines the following:

    a) Adverse benefit determination as the same meaning as in federal regulations, as specified.

    b) Urgent care consistent with existing law to mean health care for a condition that requires prompt attention. Requires plans and insurers to defer to the determination of a provider on whether a request or claim for benefits involves urgent care.

10) Applies to a health plan or insurer and health plan contract or insurance policy that provides coverage for hospital, medical, surgical, or prescription drug benefits. Exempts a specialized health plan contract or insurance policy that provides coverage only for dental or vision benefits, or a Medicare supplement.

11) Prohibits a health plan or insurer that provides coverage for prescription drugs from limiting or declining to cover a drug or dose of a drug as prescribed, or impose additional cost sharing for covering a drug as prescribed, if all the following apply:

    a) An enrollee or insured is undergoing a current course of treatment with the prescription drug for a covered medical condition or is seeking an authorization for continued coverage within a month of the date of expiration of the last prescription or refill;

    b) The drug was previously covered by the plan or insurer or the enrollees or insured's prior private or public health care coverage for the enrollees or insurer's medical condition; and,

c) A prescribing provider prescribed the drug for the enrollee or insured's medical condition, and the drug is appropriately prescribed and considered safe and effective under generally accepted standards of medical care for treating the enrollee or insured's medical condition.

12) Prohibits a health plan or insurer that verifies that a condition in 11) above is satisfied from delaying or denying coverage during the verification process, except if a drug is unsafe as prescribed. Requires a plan or insurer to notify the provider of its coverage determination, as specified, if a drug is unsafe as prescribed. Specifies that if a plan or insurer determines that another condition in 11) above is unsatisfied, the plan or insurer comply with 2) above.

13) Provides that this bill does not do any of the following:

a) Preclude a provider from prescribing another drug that is clinically appropriate for an enrollee or insured; and,

b) Prohibit generic drug substitutions, as specified.

14) Specifies that 12) above applies to a prescription drug that is prescribed off-label in accordance with 1) above.

15) Applies this bill to a health plan or insurer and health plan contract or insurance policy that provides coverage for hospital, medical, surgical, or prescription drug benefits. Exempts a specialized health plan contract or insurance policy that provides coverage only for dental or vision benefits, or a Medicare supplement policy.

16) Makes technical, clarifying, and conforming changes.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans and California Department of Insurance (CDI) to regulate health insurers.

2) Mandates the 10 federally required essential health benefits (EHBs) in the individual and small group market and establishes the Kaiser Small Group health plan as California's EHB benchmark plan, including prescription drug benefits, as specified, and incorporates by reference state law and regulations related to outpatient prescription drug coverage.

3) Requires health plans that provide prescription drug benefits to provide coverage for all medically necessary outpatient drugs, except as specified.

4) Requires health plans to maintain an expeditious process by which prescribing providers may obtain authorization for a medically necessary non-formulary prescription drug.

5) Requires health plans and health insurers to use the standard formulary template developed by DMHC and CDI and to update their posted formularies with any change to those formularies on a monthly basis.

6) Requires health plans to maintain the following:

a) Complete drug formulary or formularies, including a list of prescription drugs on the formulary of the plan by major therapeutic category with an indication of whether any drugs are preferred over other drugs;
b) Records developed by the pharmacy and therapeutic committee of the health plan that fully describe the reasoning behind formulary decisions; and,
c) Health plan arrangements with entities that are associated with activities of the health plan to encourage formulary compliance or otherwise manage prescription drug benefits.

7) Requires DMHC and CDI to jointly develop a uniform prior authorization form that health plans and health insurers must accept when prescribing providers seek authorization for prescription drug benefits. Requires prescribers to use the standardized prior authorization form. Provides that if a health plan or health insurer fails to utilize or accept the prior authorization form, or fails to respond within 72 hours for non-urgent requests and within 24 hours when exigent circumstances exist, the prior authorization request is deemed granted.

8) Prohibits a health plan that covers prescription drugs from limiting or excluding coverage for a drug for an enrollee if the drug had been previously approved for coverage by the plan for a medical condition and the health plan's prescribing provider continues to prescribe the drug for the medical condition, provided that the drug is appropriately prescribed and is considered safe and effective for treating the enrollee's medical condition.

9) Requires, pursuant to regulation, a plan that requires step therapy, to have an expedited process in place to authorize exceptions to step therapy when medically necessary and to conform effectively and efficiently to continuity of care requirements, as specified. Prohibits when an enrollee changes plans, the new plan from requiring the enrollee to repeat step therapy when that enrollee is already being treated for a medical condition by prescription drug that is appropriately prescribed and that is safe and effective for the enrollee's condition.

10) Establishes the Independent Medical Review (IMR) process as part of the DMHC or CDI appeal process when a health plan or insurer denies, changes or delays a request for medical services, denies payment for emergency treatment, or refuses to cover experimental or investigational treatment for a serious medical condition. Requires medical professionals selected by the IMR organizations to review medical treatment decisions to be physicians or other appropriate providers that meet specified minimum requirements, including, that the medical professional must hold an nonrestricted license in any state and for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the condition or treatment under review. Requires the IMR organization to give preference to the use of a California licensed physician as the reviewer, except when training and experience with the issue under review reasonably requires the use of an out-of-state reviewer.

11) Requires a health plan or insurer to maintain telephone access for providers to request authorization for health care services.

12) Requires a health plan to establish and maintain a grievance system under which enrollees may submit their grievances to the plan. Defines grievance as a written or oral expression of dissatisfaction regarding the plan and/or provider, including quality of care concerns, and must include a complaint, dispute, request for reconsideration or appeal made by an enrollee

or the enrollee's representative. Specifies that if a plan is unable to distinguish between a grievance and an inquiry, the plan consider it a grievance.

FISCAL EFFECT: According to the Senate Appropriations Committee,

1) DMHC. Estimates indeterminate, limited-term costs, potentially over $150,000 (Managed Care Fund) for workload to review and update forms ensure compliance.
2) CDI. The CDI would need $7,000 (Insurance Fund) in fiscal year (FY) 2022-23 and $16,000 (Insurance Fund) in FY 2023-24 for increased workload to conduct form reviews to revise off-label coverage provisions and add that coverage for a prescribed drug must be provided immediately and during utilization reviews and appeals, and reimbursement cannot be sought.
3) CalPERS. Unknown. It would be difficult to predict or estimate potential drug utilization or changes in prescriptions during the utilization review process. CalPERS health plans have Utilization Management Programs in place with goals and methods to prevent members from being exposed to unnecessary risks.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill ensures that patients receive prompt access to medication and that they aren't forced to go without medication during appeals of insurance denials. It does so by requiring health plans and insurers to cover a drug, dose, and dosage form that was previously prescribed, for the duration of an appeals process. This bill also clarifies California's prohibition on non-medical switching, when a health plan forces a patient to switch from a prescribed drug to a different drug for non-medical reasons, by clarifying that the prohibition also applies to the prescribed dose or dose level of a drug. By expanding this coverage and these protections, this bill strengthens patient stability and wellbeing. When health plans and insurers refuse to cover medications, those actions can pose life-threatening health challenges. The author concludes that this bill allows patients to continue on their medication during an appeals process to ensure continuity of care and prioritize the safety of those living with chronic illnesses.

2) BACKGROUND.

a) SB 17 report. SB 17 (Hernandez), Chapter 603, Statutes of 2017, requires health plans in the commercial market to annually report their prescription drug costs to the DMHC. This report looks at the impact of the cost of prescription drugs on health plan premiums and compares this data across the reporting years. The DMHC considers the total volume of prescription drugs prescribed by health plans and the total cost paid by health plans for these drugs, on both an aggregate spending level and a per member per month (PMPM) basis and compares the annualized data. The DMHC also analyzes how the 25 most frequently prescribed drugs, the 25 most costly drugs, and the 25 drugs with the highest year-over-year increase in total annual spending impacted health plan premiums over the course of the last four years. The most recent report notes the following key findings:

i) Health plans paid more than $10.1 billion for prescription drugs in 2020, an increase of almost $500 million or 5.0% from 2019. On a PMPM basis, health plans paid $66.90 in 2020, which is an increase of $2.59 PMPM from 2019. Since 2017, prescription drug costs paid by health plans increased by $1.5 billion;

ii) Prescription drugs accounted for 12.7% of total health plan premiums in 2020, a slight decrease from 12.8% in 2019. Prescription drugs accounted for 12.7% and 12.9% of total health plan premiums in 2018 and 2017, respectively;

iii) Total prescription drug costs increased by 5.0% in 2020, whereas total medical expenses increased by 3.7%. Overall, total health plan premiums increased by 5.9% from 2019 to 2020. The information in this report relies on the data submitted by the health plans. While the prescription drug costs in the SB 17 report are not adjusted for any manufacturer rebates, this report includes the total manufacturer drug rebates collected by health plans. It should be noted that the SB 17 report includes only those prescription drugs dispensed through retail or mail order pharmacies, and do not include drugs that are provided in a hospital, administered in a doctor office, or otherwise paid for through capitated payments to delegated providers. Therefore, the 12.7% of premium in 2020 does not capture all costs of prescription drugs paid by health plans, rather only those that are itemized as part of the health plans' pharmacy benefit;

iv) On a PMPM basis, health plans' prescription drug costs increased by 4.0%, medical expenses increased by 2.8% and health plan premiums increased by 4.9% from 2019 to 2020. PMPM calculations display the portion of the premium that was spent on a PMPM basis and are calculated using the total number of covered enrollees. Since the number of covered enrollees can vary from year to year, the PMPM premium and cost percentages may be higher or lower when compared to the overall premium and cost percentages;

v) Manufacturer drug rebates totaled approximately $1.437 billion, up from $1.205 billion in 2019 and $1.058 billion in 2018. This represents about 14.2% of the $10.1 billion spent on prescription drugs in 2020. On a PMPM basis, manufacturer drug rebates equaled $9.51 PMPM, up from $8.06 PMPM in 2019. This also equates to 14.2% of the $66.90 PMPM health plans paid for prescription drugs in 2020;

vi) While specialty drugs accounted for only 1.6% of all prescription drugs dispensed, they accounted for 60.2% of total annual spending on prescription drugs;

vii) Generic drugs accounted for 89.1% of all prescribed drugs but only 18.1% of the total annual spending on prescription drugs;

viii) Brand name drugs accounted for 9.3% of prescriptions and constituted 21.7% of the total annual spending on prescription drugs;

ix) The 25 Most Frequently Prescribed Drugs represented 48.2% of all drugs prescribed and approximately 46.2% of the total annual spending on prescription drugs;

x) For the 25 Most Frequently Prescribed Drugs, enrollees paid 2.9% of the cost of specialty drugs, 11.5% of the cost of brand name drugs, and 59.2% of the cost of generics;

xi) Of the 12.7% of total health plan premium that was spent on prescription drugs, the 25 Most Costly Drugs accounted for 7.2%; and,

xii) Overall, health plans paid 92.8% of the cost of the 25 Most Costly Drugs across all three categories (generic, brand name and specialty).

a) California Health Benefits Review Program (CHBRP) analysis. AB 1996 (Thomson), Chapter 795, Statutes of 2002, requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on EHBs, and

legislation that impacts health insurance benefit designs, cost sharing, premiums, and other health insurance topics.

According to CHBRP, recent amendments to this bill would somewhat reduce impacts on cost sharing and somewhat increase impacts on premiums for enrollees in DMHC-regulated health plans and CDI-regulated health policies and that coverage for persons engaged with other CDI-regulated disability insurance is beyond the scope of CHBRP's analysis. CHBRP states the following in its initial analysis of this bill:

i) **Enrollees covered.** At baseline, the total annual number of scripts filled for drugs impacted by this bill (predominantly maintenance drugs with utilization review requirements) is 1,108,750. This figure represents less than 1% of scripts filled for enrollees with a pharmacy benefit regulated by DMHC or CDI. Postmandate, 22,851 additional scripts would be filled. This impact would primarily derive from the mandate to provide coverage during appeal, which would influence coverage for enrollees changing one plan or policy for another, a situation often referred to as enrollee "churn." At baseline, the average unit cost of a 30-day supply for a drug with coverage impacted by this bill that will ultimately be approved is estimated to be $1,336. Within this average, unit costs for particular drugs range from less than $50 to more than $6,000. Postmandate, the average unit cost would be higher, not because the unit costs of the drugs would change, but because the mix of covered script fills would include greater proportions of specialty and brand drugs, which are generally more expensive.

ii) **Impact on expenditures.** CHBRP estimates that this bill would increase total net annual expenditures by $83,735,000 (0.06%) for enrollees with health insurance subject to state-level benefit mandates. This is due to a $74,277,000 increase in total health insurance premiums and a $9,458,000 increase in enrollee cost sharing. CHBRP projects no change to copayments or coinsurance applicable to filled scripts for particular drugs (which vary from plan to plan and from policy to policy). However, CHBRP does project an increase in utilization of specialty and brand drugs, as well as off-formulary drugs (which are often associated with greater per-fill cost sharing) and therefore an increase in total enrollee cost sharing. At baseline, an unknown proportion of noncovered script fills may have been accessed by enrollees through self-pay. Given the high cost of many drugs impacted by this bill, this proportion may be limited by the willingness of enrollees to self-pay for high-cost drugs. Postmandate, such expenses would decrease (though there would be a concomitant increase in cost sharing). The impacts of this bill on expenditures would not be great enough to expect any change in the number of uninsured.

3) **SUPPORT**. The Crohn's & Colitis Foundation, the sponsor of this bill, writes that this bill requires health plans and insurers to continue coverage of an ongoing course of treatment, including medication and the dose of the medication, that has been reduced or terminated, resulting in an adverse benefit determination, until the patient has exhausted all appeals of that determination. This bill also clarifies that California's law that prohibits "non-medical switching" applies to an optimized dose of a previously prescribed drug. Many chronic diseases are well-managed with the regular use of the right medication at the right dose. When providers work with patients to find an effective medication, over time they may require adjustment of the amount given, either by increasing the dose or decreasing the

dosing interval to achieve an effective therapeutic response. California law already prohibits health plans from forcing patients to switch medications that were previously approved, which allows patients who are stable on a drug to remain on that medication, even if the health plan changes their preferred treatments. However, this law does not currently apply to dose or frequency of administration. Additionally, most prescriptions that are initially denied are ultimately approved when appealed. For example, in 2019, 87.5% of Inflammatory Bowel Disease patients who appealed their insurance medication denials through DMHC IMR's process eventually had their request approved. Unfortunately, during the IMR review, health plans are not obligated to cover the drug and since many patients do not know this appeal is available to them, they are often left without their necessary medication for a period of time, which may be lengthy, until a final decision is made. According to the sponsor, this bill rectifies these problems by allowing patients to stay on their previously approved medications, including an increase in the dose of that medication, for the duration of any appeals. The sponsor concludes that this bill also expands California's "non-medical switching" law to include dose, so that when a provider is requesting only an increase in the dose, or the frequency of administration, of an already approved drug, the patient is not required to wait for a new approval.

4) **OPPOSITION**. The California Association of Health Plans (CAHP), the Association of California Life and Health Insurance Companies (ACLHIC), and America's Health Insurance Plans (AHIP), contend that this bill requires health plans and insurers to cover a denied medication or dosage of medication for the duration of an appeals process. Additionally, this bill would prohibit health plans and insurers from seeking reimbursement for prescription drug coverage when the final utilization review decision is to deny coverage for the prescription drug or dosage. Currently, health plans and insurers rely upon several critical utilization management protocols to ensure that patients receive the right care, at the right time, from the right provider. These protocols are critically important to promoting safe, effective, and affordable care for plan enrollees. Prior authorization and step therapy protocols are particularly important for prescription drug coverage, considering the potential for abuse and addiction, as well as the high cost of these drugs. This bill would broadly dismantle existing utilization management processes for prescription drugs by nullifying these existing processes for any drug or dosage of a drug when an enrollee appeals a coverage denial. This bill would require health plans or insurers to cover a drug or dosage of a drug throughout the appeals process, effectively negating our ability to ensure clinically appropriate use of prescription drugs. Additionally, this bill would encourage the use of expensive specialty and brand name drugs when a generic or lower cost brand equivalent is available and clinically appropriate. The opposition argues that this bill could also create significant patient safety concerns for our enrollees. When health plans and insurers choose to limit or deny a drug or specific dose of a drug, it is generally for safety reasons. Specific reasons include potential abuse or overuse, inconsistency with FDA-approved labeling or to prevent use at doses that have not been studied or shown to be efficacious. The opposition recommends that language be added to this bill that clearly states that if health plans and insurers deny a drug or dosage of a drug based on patient safety issues, that they would not be required to cover the drug or dosage increase through the appeals process to avert potentially adverse effects and harm to our enrollees. Additionally, this bill will layer on additional costs by prohibiting health plans and insurers from seeking reimbursement for a drug or dosage of a drug if the appeal is ultimately denied during the final determination.

5) **RELATED LEGISLATION**.

a) AB 1880 (Arambula) requires health plan's or health insurer's utilization management process to ensure that an appeal of a denial of an exception request is reviewed by a clinical peer of the health care provider or prescribing provider, as specified. Defines clinical peer as a physician or other health professional who holds an unrestricted license or certification from any state and whose practice is in the same or a similar specialty as the medical condition, procedures, or treatment under review. SB 1880 is pending in Senate Appropriations Committee.

b) AB 2352 (Nazarian) requires a health plan or health insurer to furnish specified information about a prescription drug upon request by an enrollee or insured, or their health care provider. Prohibits a health plan or health insurer from restricting a health care provider from sharing the information furnished about the prescription drug or penalizing a provider for prescribing a lower cost drug, as specified. AB 2352 is currently pending in Senate Appropriations Committee.

6) PREVIOUS LEGISLATION.

a) AB 347 (Arambula), Chapter 742, Statutes of 2021, requires a health plan or health insurer to expeditiously grant a step therapy exception if specified criteria are met, including that the health care provider submit necessary justification and supporting clinical documentation supporting the provider's determination that the required prescription drug is inconsistent with good professional practice for provision of medically necessary covered services, as specified.

b) AB 1268 (Rodriguez) of 2019 would have required a health plan or health insurer, on or before July 1, 2020, and annually on July 1 thereafter, to report to the appropriate department the number of times in the preceding calendar year that it approved or denied each of the 30 health care-services for which prospective review was most frequently requested. AB 1268 was held on suspense in the Assembly Appropriations Committee.

c) AB 1353 (Waldron) of 2017 would have required a health plan and health insurer that provides coverage for outpatient prescription drugs to establish an expeditious process, as described, by which enrollees and insureds, enrollees' and insureds' designees, or prescribing providers may request and obtain an exception to any prior authorization process or any other utilization management or medical management practices utilized by the plan or health insurer for medically necessary prescription drugs, and would have required a plan or health insurer to grant an exception request under these provisions under specified circumstances to ensure continuity of care for an enrollee or insured who is medically stable and was either previously prescribed the prescription drug within 100 days prior to enrollment or if, within 100 days prior to the exception request, the prescription drug was previously approved for coverage by the plan or insurer for the same medical condition. AB 1353 was never heard in Assembly Health Committee.

d) AB 2752 (Nazarian) of 2016 would have required a health plan or a health insurer to annually notify an enrollee or insured that the enrollee's or insured's drug treatment or provider is no longer covered by the plan or policy. AB 2752 was held in Assembly Appropriations Committee.

e) AB 2400 (Nazarian) of 2016 would have required health plans and health insurers to comply with a shortened internal grievance review process for formulary drugs. AB 2400 was held in Assembly Appropriations Committee.

f) AB 374 (Nazarian), Chapter 621, Statutes of 2015, authorizes a request for an exception to a health care service plan's or health insurer's step therapy process for prescription drugs to be submitted in the same manner as a request for prior authorization for prescription drugs. Requires the health plan or insurer to treat, and respond to, the request in the same manner as a request for prior authorization for prescription drugs.

g) AB 339 (Gordon), Chapter 619, Statutes of 2015, requires health plans and health insurers that provide coverage for outpatient prescription drugs to have formularies that do not discourage the enrollment of individuals with health conditions, and requires combination antiretrovirals drug treatment coverage of a single-tablet that is as effective as a multitablet regimen for treatment of Human immunodeficiency virus infection and acquired immune deficiency syndrome, as specified. Codifies in state law, federal requirements related to pharmacy and therapeutics committees, access to in-network retail pharmacies, standardized formulary requirements, formulary tier requirements similar to those required of health plans and insurers participating in Covered California and copayment caps of $250 and $500 for a supply of up to 30 days for an individual prescription, as specified.

REGISTERED SUPPORT / OPPOSITION:

Support

Crohns and Colitis Foundation (sponsor)

Alliance for Patient Access
American College of Obstetricians and Gynecologists District Ix
California Academy of Family Physicians
California Association of Orthodontists
California Chapter American College of Cardiology
California Chronic Care Coalition
California Forestry Association
California Life Sciences
California Pharmacists Association
California Podiatric Medical Association
California Retired Teachers Association
California Rheumatology Alliance
Children's Specialty Care Coalition
Dbsa California
National Multiple Sclerosis Society, Ms-can

Opposition

Association of California Life & Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce

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