SENATE COMMITTEE ON HEALTH
Senator Caroline Menjivar, Chair

BILL NO: AB 1460
AUTHOR: Rogers
VERSION: June 27, 2025
HEARING DATE: July 16, 2025
CONSULTANT: Jen Flory

SUBJECT: Prescription drug pricing

SUMMARY: Prohibits a prescription drug manufacturer from engaging in discriminatory practices that would impose additional conditions, prohibit, restrict, deny, or interfere with a community clinic's purchase or delivery of a drug eligible for a 340b discount if a community clinic utilizes a specified pharmacy that dispenses the drug to an eligible patient of the clinic.

Existing state law:

1) Defines 340B as the discount drug purchasing program described in federal law. [WIC §14105.46]

2) Requires a covered entity to dispense only 340B drugs to Medi-Cal enrollees, and permits if a covered entity is unable to purchase a specific 340B drug, the covered entities to dispense a drug purchased at regular drug wholesale rates to a Medi-Cal beneficiary, and requires the covered entities to maintain documentation of their inability to obtain the 340B drug. Requires a covered entity to bill an amount not to exceed the entity's actual acquisition cost for the drug, as charged by the manufacturer at a price consistent with federal law plus the professional fee, as specified, or the dispensing fee, as specified. [WIC §14105.46]

3) Requires a covered entity to identify a 340B drug on the claim submitted to the Medi-Cal program for reimbursement. [WIC §14105.46]

4) Authorizes reimbursement to outpatient pharmacies for drugs in the Medi-Cal program for the drug ingredient cost plus a professional dispensing fee $10.05 or $13.20, depending on number of claims per year. Limits the drug ingredient cost to the lowest of the actual acquisition cost, the federal upper limit, or the maximum allowable ingredient cost. [WIC §14105.45]

5) Requires DHCS to establish, implement, and maintain a supplemental payment pool for nonhospital 340B community clinics, subject to an appropriation by the Legislature. [WIC §14105.467]

6) Defines a "qualifying nonhospital 340B community clinic" ("340B clinic") as a licensed center or clinic, as specified, or a clinic operated by a city, county, city and county, or hospital authority that is exempt from licensure, and that is a 340B covered entity under federal law for the duration of each applicable fiscal year for which DHCS implements a supplemental payment pool. [WIC §14105.467]

7) Prohibits pharmacy benefit managers (PBMs) from imposing requirements, conditions, or exclusions that discriminate against covered entities or pharmacies in connection with dispensing 340B covered drugs or prevent a covered entity from retaining the benefit of discounted pricing for the purchase of 340B covered drugs. [HSC §127471]

Existing federal law:

1) Requires drug manufacturers to limit the price of outpatient drugs purchased by a "covered entity" in order for the outpatient drugs to be covered by Medicaid. This is referred to as the federal 340B Drug Pricing Program (340B Program). [42 U.S.C. §256b]

2) Defines "covered entity" that prohibits duplicate discounts or rebates related to the Medicaid program, prohibits resale or transfer of covered drugs to a person who is not a patient of the entity, allows auditing by the Secretary of the federal Department of Health and Human Services (HHS) and a manufacturer of a covered drug, and is subject to liability to manufacturers in an amount equal to the reduction in the price of the drug and is one of the following types of entities: Federally Qualified Health Centers (FQHCs); entities receiving a grant under specified federal law; family planning projects receiving a grant or contract under federal law; entities receiving a grant for outpatient early intervention services for HIV disease; state-operated AIDS drug purchasing assistance programs; black lung clinics; comprehensive hemophilia diagnostic treatment centers; Native Hawaiian Health Centers; urban Indian organizations; certified entities receiving federal assistance; certified entities receiving federal funding relating to treatment of sexually transmitted disease or tuberculosis; and a variety of specified hospitals. [42 U.S.C. §256b]

This bill:

1) Prohibits a drug manufacturer from engaging in discriminatory practices that would impose additional conditions, or prohibit, restrict, deny or interfere with a 340B clinic's purchase or delivery of a drug eligible for discounts under the federal 340B pricing requirements if the 340B clinic utilizes a specified pharmacy, including a contract pharmacy, that dispenses the drug to an eligible patient of the 340B clinic.

2) Defines "discriminatory practices" as including, but not limited to, limiting a 340B clinic to one contract pharmacy or restricting the number of contract pharmacies a 340B clinic may use to dispense drugs to an eligible patient, restricting a 340B clinic from using a contract pharmacy if it has an in-house pharmacy, restricting a 340B clinic from being able to ship to eligible patients over a certain distance if it has an in-house pharmacy, limiting the type of medications eligible for discounts, or adding arbitrary distance limitations.

3) Specifies that a drug manufacturer is not prohibited from requesting a 340B covered entity provide the invoice number, unique identifier, and coding associated with a claim for the purposes of identifying and investigating a duplicate discount, diversion, or validating the eligibility of a claim for the 340B price. Requires claims to be deidentified and the information to be provided in accordance with federal and state medical privacy laws. Prohibits drug manufacturers from requesting this information more often than annually or from withholding 340B discounts while claims data is being reconciled.

4) Defines "340B clinic" as a 340B covered entity that is a licensed center or clinic; a clinic operated by a city, county, city and county, or hospital authority that is exempt from licensure; an intermittent clinic exempt from licensure; or, a rural health clinic.

5) Specifies that this bill does not alter, change, or diminish existing state law.

6) Specifies that to ensure compliance with the program rules and guidance from the federal Health Resources and Services Administration (HRSA), qualifying 340B clinics are required to perform the following annually:

   a) Conduct annual audits on contract pharmacies to be carried out by an independent audit firm and take appropriate action to address any deficiencies;
   b) Identify how 340B savings are being used to support patient care and report that information to HRSA; and
   c) Recertify their status as a covered entity.

7) States the intent of the Legislature that this bill does not change the 340B requirements imposed by federal statute or regulations, including the requirement that a 340B covered entity is required to permit the HHS Secretary and the manufacturer of a covered outpatient drug that is subject to an 340B agreement with the entity to audit at the Secretary's or manufacturer's expense the records of the entity that directly pertain to the entity's compliance with the requirements to prohibit duplicate discounts or rebates and prohibit the resale of the manufacturer's drugs.

FISCAL EFFECT: This bill is keyed non-fiscal.

PRIOR VOTES:

Assembly Floor:	44 - 6
Assembly Health Committee:	9 - 4

COMMENTS:

1) *Author's statement.* According to the author, during the height of the pandemic, when our health care system was most challenged, pharmaceutical companies began implementing contract pharmacy restrictions to limit access to the 340B program. These policies have been crippling to clinic systems that provide critical services to uninsured, underinsured, and vulnerable patients. Fewer contract pharmacy arrangements means less pass-through savings for clinics that are already struggling to meet the needs of their communities. Clinics rely on the pass-through savings from discount 340B drugs to fund a variety of patient centered services such as their unreimbursed/underfunded offerings, including having a sliding fee scale for patients with high deductible costs or no insurance, patient education, language access programs, expansion of hours, purchase of new equipment, meal programs, and patient transportation. And it's not just contract pharmacy restrictions, drug companies are restricting the 340B programs in other ways, including placing arbitrary distance restrictions on pharmacies and limiting the types of medications that are eligible for discount. All of these restrictions conflict with the program's intent which is to help clinics stretch scarce resources. At a time when we are facing a massive Medi-Cal shortfall and an increasingly uninsured and underinsured population, it would be negligent to allow pharmaceutical companies to continue restricting access to 340B pricing so that they can enjoy higher profits—especially when the state will be left to foot the bill.

2) *340B program.* According to a 2018 Legislative Analyst's Office (LAO) analysis related to a Budget proposal from then-Governor Brown, the 340B program, established in 1992, requires drug manufacturers to provide discounts on the outpatient prescription drugs they sell to certain eligible health care providers, referred to as "covered entities." Major health care providers that are generally eligible to participate in the program include certain

hospitals that serve large numbers of low-income patients (including both the uninsured and Medicaid enrollees), certain rural hospitals, and community health centers, such as FQHCs. Under the 340B program, discounted prescription drugs are available to a covered entity's patients regardless of payer. As such, the 340B discounts apply regardless of whether the covered entity is ultimately reimbursed for the dispensed prescription drugs by Medicaid, Medicare, commercial health insurance, or the patient. The 340B program provides significant discounts for covered entities, and requires them to receive prescription drug discounts that reduce the prices they pay to at least the lower of: a) the best price offered to most public and private entities; or, b) the average manufacturer sales prices minus a percentage of between 13% and 23.1% (depending on the type of the prescription drug).

Covered entities retain 340B savings by charging external payers of 340B prescription drugs, such as health insurers, prices that are higher than the 340B prices at which they acquired the drugs. The 340B program does not place restrictions on how covered entities may use any retained savings. To the extent covered entities charge external payers lower prices for prescription drugs than they would have if the drugs had been purchased without the 340B discounts, then these external payers benefit from the 340B discounts as well.

According to a federal HRSA update, in calendar year 2023, 340B covered entities purchased $66.3 billion in covered outpatient drugs under the 340B Program, enabling safety-net providers to stretch scarce federal resources as far as possible, reaching more eligible patients and providing more comprehensive services for the communities that they serve. Of that amount, only $10.3 billion was purchased by nonhospital entities, which are the subject of this bill. The update notes that prescription drug spending overall increased by 8.4% that year from 2022 and that care has increasingly shifted from inpatient to outpatient settings, causing spending on outpatient drugs to increase. The top 10 drugs, in terms of 340B purchases by covered entities, represents one third of the total spending.

3) *Medi-Cal.* Medi-Cal pharmacy services have been transitioned from managed care to fee-for-service under Medi-Cal Rx. Under Medi-Cal, 340B covered entities are required to identify a 340B drug on the claim submitted to the Medi-Cal program for reimbursement in order to avoid prohibited duplicate discounts. According to DHCS, California's rebate invoicing system automatically removes pharmacy- and physician-administered drug claims that include the appropriate 340B identifiers from the drug manufacturer's invoice. However, it is important to note that state law requires Medi-Cal Rx to pay for drugs with 340B discounts at their 340B discounted price, thus the covered entity cannot obtain revenues by charging Medi-Cal more than the discounted price of the drug, like they can for other payors.

   Separate from the Medi-Cal Rx program change, starting in 2020, DHCS sent letters to all 340B covered entities in California that participate in the Medi-Cal program demanding a self-audit of 340B program overpayments for Medi-Cal fee-for-service drugs (not those covered by Medi-Cal plans). According to a question and answer document posted by DHCS, updated letters were sent to expand the original time period of the self-audit of December 1, 2016 to December 31, 2019 to December 1, 2016 to August 31, 2021. Thus far, no information has been released publicly as a result of these self-audits.

4) *Federal rules and audits.* Participation in the 340B program has grown from nearly 9,700 covered entities in 2010 to 12,700 covered entities in 2020. According to HRSA, about 80% of covered entities are grantees (e.g., clinics), and 20% are hospitals. However, a covered

entity may have multiple sites of operation, thus about 75% of the approximately 37,500 covered entity *sites* participating in the program are affiliated with hospitals. HRSA has issued interpretive guidance and statements of policy to assist covered entities in complying. For example, covered entities must maintain compliance with the statutory definitions pertaining to eligibility to continue participating in the program. Covered entities are also prohibited from diverting/transferring 340B drugs to individuals who are not eligible patients of the covered entities. Finally, covered entities cannot subject manufacturers to duplicate discounts by which drugs prescribed to Medicaid beneficiaries are subject to both the 340B price and a rebate through the Medicaid Drug Rebate Program. To oversee compliance with these requirements, in 2012 HRSA implemented a systematic approach for auditing covered entities. HRSA issues findings for noncompliance based on information gathered through this audit process. Covered entities must address findings to avoid termination from the program. In 2024, HRSA finalized 163 audits of covered entities: 14 resulted in termination from the 340B program; 120 resulted in no findings; and, 29 resulted in repayments to the manufacturer. Twelve in California were audited: one resulted in termination from the program; five resulted in no findings; and, six resulted in repayments to the manufacturer. That same year, HRSA audited five drug manufacturers: three resulted in no adverse findings and two resulted in repayments to covered entities.

5) *Contract pharmacies.* The 2018 LAO report offered an example of complexities associated with the use of "contract pharmacies" in the 340B program. Contract pharmacies are pharmacies that are owned and operated separately from a covered entity but have a contract with a covered entity to dispense 340B drugs on the covered entity's behalf. The use of contract pharmacies has increased significantly following federal guidance, released in 2010, that authorized their expanded use. (Contract pharmacies were initially excluded from the 340B program, and then until 2010, covered entities could only use one contract pharmacy.) While covered entity arrangements with contract pharmacies vary, according to the LAO, an example of how the use of a contract pharmacy can work is as follows: the contract pharmacy purchases a prescription drug from a manufacturer at a negotiated sales price ($13), which generally would be higher than the 340B price at which that drug would have been sold to a covered entity. An enrollee visits a covered entity for a medical appointment and obtains a prescription. The enrollee then visits the contract pharmacy, which dispenses the prescribed drug. Without identifying, at the time of the transaction, that the enrollee was a patient of a contracted covered entity, the contract pharmacy bills the enrollee's plan at the customary non-340B drug reimbursement rate ($14) agreed to by the pharmacy and the plan. Later, the contract pharmacy and covered entity review the pharmacy's records to determine whether any prescription drugs were dispensed to patients of the covered entity. After it is determined that the enrollee who obtained the prescription was a patient of the covered entity, the covered entity and the contract pharmacy go through a reconciliation process with the manufacturer that effectively lowers the purchase price of the dispensed drug to its 340B price ($10). The contract pharmacy and covered entity share in the savings.

6) *Pharmaceutical Research and Manufacturers of America (PhRMA) study.* A 2020 study funded by PhRMA suggests that the 340B program has evolved into a "profit-centric corporate initiative" and that half of the twenty largest for-profit corporations in the U.S. are active participants through contract pharmacy arrangements. The study says the average profit margin on 340B medicines commonly dispensed through contract pharmacies is an estimated 72%, compared with just 22% for non-340B drugs dispensed through independent pharmacies. According to the PhRMA study, covered entities and their contracted pharmacies generated an estimated $23 billion in gross profits nationwide on 340B purchased

medicines in 2018. The study says profits on 340B drugs are now distributed across a vertically integrated supply chain that includes covered entities, pharmacies, contract pharmacy administrators, PBMs, health plans, and employer groups. Covered entities are often in competition with contract pharmacies when these pharmacies offer lower cost-sharing to fill drugs than what a covered entity would charge at their own pharmacy. The study also says the outsized profit margins on 340B drugs may contribute to additional consolidation and vertical integration. According to the study, contract pharmacy administrators develop and operate the software algorithms that determine 340B eligibility and enable the for-profit pharmacies to influence which prescriptions are classified as 340B.

7) *Drug manufacturer restrictions on contract pharmacies.* In 1996, HRSA issued guidelines that permitted covered entities to use a single point for pharmacy services, either in-house or contract. In 2010, HRSA issued new guidelines to allow for multiple pharmacy arrangements, including multiple contract pharmacies, so long as they comply with guidance developed to help ensure against diversion of the drugs, duplicate discounts on the same prescription, policies regarding the definition of patient, and they maintain auditable records to demonstrate compliance. In this guidance, many issues of compliance were left up to the covered entities themselves. However, the guidance stated that to the extent a manufacturer believes there is a reasonable basis to conclude that the covered entity is in breach of 340B program requirements, it may audit the covered entity. In 2020, restrictions on contract pharmacies by drug manufacturers became more widespread. Some manufacturers announced they would no longer ship discounted drugs to contract pharmacies, others would only ship to one contract pharmacy per covered entity, and some required contract pharmacies to be within a certain distance to the covered entity. Letters were separately sent by 246 members of Congress, 28 Senators, and 29 attorneys general to HHS requesting that it issue monetary penalties and new guidance to address these restrictions. The general counsel of HHS issued an advisory opinion, but this did not change the situation. In 2021, HRSA issued violation letters to several manufacturers, informing them that their policies violated the 340B statute and threatening civil penalties. Several manufacturers sued HRSA, resulting in two federal appellate courts finding that the agency had overstepped. On the other hand, when drug manufacturers sued to overturn a state law in Arkansas prohibiting restrictions on the use of contract pharmacies, a federal appellate court upheld the law, and the Supreme Court declined review of that decision. Fourteen other states have passed laws designed to prohibit restrictions on contract pharmacies, which have also been challenged by manufacturers. One has been overturned due to a restriction on the review of claims data which was found to be inseverable from the statute as a whole. In response, Idaho has enacted legislation with covered entity reporting and transparency requirements, and several other states are considering similar legislation this session.

8) *Related legislation.* AB 1113 (Mark González) requires each FQHC to have an annual "mission spend ratio," of no less than 90% and would provide a methodology for calculation of that ratio until the Department of Public Health has adopted a methodology for this purpose; requires each FQHC or its parent corporation to report total revenues; and, Exempts an FQHC participating in a bona fide labor-management cooperation committee. *AB 1113 was made a two-year bill in the Assembly Appropriations Committee.*

SB 41 (Wiener, Wahab) establishes licensing requirements on PBMs and implements a number of contract limitations their contracts with health plans, insurers, pharmacies, and drug manufacturers. *SB 41 is pending in the Assembly Judiciary Committee.*

AB 910 (Bonta) requires a PMB to hold a fiduciary duty in the performance of its contracted duties to a health plan, and specifies the obligations to carry out that duty. It requires PBMs to report to the Department of Managed Health Care (DMHC) specified information, and requires DMHC to compile the information into a report that demonstrates the overall effects of drug costs, rebates, PBMs, and their relationships with affiliated entities on health care costs. *AB 910 was made a two-year bill in the Assembly Appropriations Committee.*

9) *Prior legislation.* SB 786 (Portantino, Chapter 414, Statutes of 2023) prohibits a PBM from imposing any requirements, conditions, or exclusions that discriminate against a 340B covered entity or a specified pharmacy in connection with dispensing covered drugs, or, prevent a covered entity from retaining the benefit of discounted pricing for the purchase of covered drugs.

   SB 939 (Pan of 2022) would have prohibited payers and drug manufacturers from imposing requirements, conditions, or exclusions that discriminate against certain health care entities participating in the 340B program, including contracted pharmacies of the health care entities. *SB 939 was not heard in the Assembly Health Committee at the request of the author.*

   AB 1050 (Gray of 2021) would have prohibited DHCS from taking any action that materially increases the administrative burden or cost of dispensing 340B drugs by FQHCs and rural health clinics, including, but not limited to, changes that adversely impact the use of contract pharmacy arrangements. AB 1050 would have required DHCS, before taking an action that materially impacts the 340B program, to prepare a detailed report describing the proposed action, including a determination that the action does not violate this provision. AB 1050 would have required the application for enrollment for Medi-Cal to include a statement that permits DHCS, the county welfare department, and a Medi-Cal managed care organization or health care provider to which the person is assigned to communicate with the applicant regarding appointment reminders or outreach efforts through Free to End User text messaging, unless the person opts out. *AB 1050 was held in the Assembly Appropriations Committee.*

   AB 80 (Committee on Budget, Chapter 12, Statues of 2020) among other provisions, requires DHCS, contingent on an appropriation by the Legislature, to make available fee-for-service-based supplemental payments from a fixed-amount payment pool to qualifying nonhospital 340B community clinics, beginning January 1, 2021. AB 80 requires DHCS to establish a stakeholder process on or before July 15, 2020, to develop and implement the methodology for distribution of payments, including the eligibility criteria for receipt of payments, the aggregate amount of pool funding, the criteria for apportioning the funding, and timing of payments.

10) *Support.* Co-sponsors, CPCA Advocates write that since 2020, many drug manufacturers have introduced restrictions that diminish the ability of covered entities to use 340B contract pharmacies to dispense medications to their patients. These restrictions often limit covered entities to one contract pharmacy location and restrict which drugs qualify for 340B pricing at those pharmacies. This makes it harder for covered entities to leverage contract pharmacies for greater access to affordable medications for their patients. They state that they are required to invest all 340B savings into activities that support the goal of expanding access for medically underserved patients. They also point out that recent changes to immigration policy have made patients who are undocumented or in mixed-status households are not

coming in for care, thus access to additional pharmacies is more important. The Community Clinic Association of Los Angeles County write that as federal funding cuts threaten the viability of safety-net providers and affordability becomes a growing concern, access to contract pharmacies is vital. Such access not only enhances accessibility but also improves operational efficiency, allowing eligible providers to optimize their resources and deliver more comprehensive benefits and services to their communities.

11) *Opposition.* PhRMA writes that there is little evidence to suggest that patients have benefited from contract pharmacy growth. In California, only 11% of contract pharmacies are located in medically underserved areas. Expanding the use of contract pharmacies will line the pockets of PBMs that own the vast majority of pharmacies and directly increase costs for employers due to reduced rebates from manufacturers. A number of chronic disease patient advocacy groups and SEIU California write to urge that any changes to the 340B program include transparency and accountability requirements to ensure that 340B dollars go directly to lowering medication costs and patient care rather than pharmacy benefit middlemen and executive salaries.

12) *Oppose unless amended.* The Chronic Care Policy Alliance writes with similar concerns regarding contract pharmacies' use of PBMs and requests an amendment that would limit payment to these managers to reasonable dispensing fees. The Alliance for Health Innovation writes requesting that covered entities be required to submit claims-level data and otherwise sharing the same concerns as the opposition.

SUPPORT AND OPPOSITION:

Support: California Partnership for Health (co-sponsor)
California Primary Care Association Advocates (co-sponsor)
Achievable Health
AIDS Healthcare Foundation
Alameda Health Consortium
Alexander Valley Healthcare
Aliados Health
Alliance Medical Center
AltaMed Medical Center
Altura Centers for Health
APLA Health
Aria Community Health Center
Arroyo Vista Family Health Center
Asian Health Services
Bienestar Human Services
California Academy of Child and Adolescent Psychiatry
California Farmworker Foundation
California Retired Teachers Association
CalPACE
Centers for Family Health and Education
Central Neighborhood Christian Health Clinics
Central Valley Health Network
Central Valley Opportunity Center
Chinatown Service Center
Clinica Romero

Clinicas del Camino Real
Coalition of Orange County Community Health Centers
CommuniCare+OLE
Community Clinic Association of Los Angeles County
Community Health Centers of the Central Coast
Community Health Partnership
Community Health Systems, Inc.
Comprehensive Community Health Centers
Desert AIDS Project
East Valley Community Health Center
Eisner Health
El Dorado Community Health Centers
El Proyecto Del Barrio, Inc.
Family Health Centers of San Diego
Gardner Health Services
Golden Valley Health Centers
Gracelight Community Health
Green Policy Initiative
Harbor Community Health Centers
Health Alliance of Northern California
Health and Life Organization, Inc.
Health Center Partners of Southern California
Hill County Community Clinic
Humboldt County Board of Supervisors
Innercare
JWCH Institute, Inc.
Kheir Clinic
La Clinica de la Raza
La Maestra Family Clinic
Latino Coalition for a Healthy California
Livingston Community Health
Loma Linda University Adventist Health Sciences Center
Los Angeles LGBT Center
Marin City Health and Wellness Clinics
Merced County Board of Supervisors
Merced Union High School District
Mountain Valleys Health Centers
Neighborhood Healthcare
North Coast Clinics Network
North East Medical Services
Northeast Valley Health Corporation
OCHIN, Inc.
Omni Family Health
One Community Health
Open Door Community Health Centers
Petaluma Health Center, Inc..
Planned Parenthood Affiliates of California
Rural County Representatives of California
Saban Community Clinic
Salud Para la Gente

Samuel Dixon Family Health Center, Inc.
San Fernando Community Health Center
San Ysidro Health
Santa Cruz Community Health
Santa Rosa Community Health
Share Our Selves
Shasta Community Health Center
Shingletown Medical Center
South Central Family Health Center
Southside Coalition of Community Health Centers
St. Jude Neighborhood Health Center
St. Vincent De Paul Villages, Inc.
T.H.E. Health and Wellness Centers
Tarzana Treatment Centers, Inc.
The Children's Clinic
The Roads Foundation, Inc.
TrueCare
United Health Centers
Universal Community Health Care
Valley Community Healthcare
Venice Family Clinic
Via Care Community Health Center
Vista Community Clinic
Watts Healthcare Corporation
WellSpace Health
Wesley Health Centers
Westside Family Health Center
White Memorial Community Health Center
Wilmington Community Clinic

Oppose:
ADAP Advocacy
Alliance for Health Innovation (unless amended)
Aiarthritis
Arming Minorities Against Addiction & Disease Institute
Association of Hidradenitis Suppurativa and Inflammatory Diseases
Axis Advocates
Biocom California
Biomarker Collaborative
Biotechnology Innovation Organization
Black Women's Health Imperative
Blackdoctor.org
California Chronic Care Coalition
California Life Sciences Association
California Manufacturers and Technology Association
California-Hawaii State Conference of the NAACP
California State League of United Latin American Citizens
California State Council of Service Employees International Union (SEIU)
Carrie's Touch
Chronic Care Policy Alliance (unless amended)
Coalition of Hematology & Oncology Practices

Community Access National Network
Community Health Action Network
Community Oncology Alliance
Connecting to Cure Crohn's and Colitis
Exon 20 Group
International Cancer Advocacy Network
Infusion Access Foundation
Johnson & Johnson Services, Inc.
Latino Diabetes Association
Let's Kick Ass Palm Springs
Liver Coalition
Liver Health Foundation
Lupus and Allied Diseases Association, Inc.
Lupus Foundation of Southern California
Lupus LA
Met Crusaders
Mexican American Opportunity Foundation
National Infusion Center Association
Neuropathy Action Foundation
Patient Advocates United in San Diego County
Pd-l1 Amplifieds
Pharmaceutical Research and Manufacturers of America
The Wall Las Memorias Project
Tigerlily Foundation (unless amended)

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