AMENDED IN ASSEMBLY JULY 9, 2025

AMENDED IN ASSEMBLY JUNE 23, 2025

AMENDED IN SENATE APRIL 24, 2025

AMENDED IN SENATE MARCH 27, 2025

SENATE BILL No. 418

Introduced by Senator Menjivar
(Coauthor: Senator Cervantes)
(Coauthor: Assembly Member Bonta)

February 18, 2025

An act to amend Section 4064.5 of the Business and Professions Code, to add ~~Sections 1367.0435 and 1367.253 to~~ *Section 1367.0435 to, and to add and repeal Section 1367.253 of,* the Health and Safety Code, to add ~~Sections 10123.1963 and 10133.135 to~~ *Section 10133.135 to, and to add and repeal Section 10123.1963 of,* the Insurance Code, and to ~~amend Section 14000.01~~ *add and repeal Section 14132.04* of the Welfare and Institutions Code, relating to health care ~~coverage.~~ *coverage, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

SB 418, as amended, Menjivar. Health care coverage: prescription hormone therapy and nondiscrimination.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act's requirements a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law also provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under

which qualified low-income individuals receive health care services ~~through, among other things, managed care plans licensed under the act that contract with the State Department of Health Care Services.~~ *pursuant to a schedule of benefits.*

Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies. Existing law generally authorizes a health care service plan or health insurer to use utilization controls to approve, modify, delay, or deny requests for health care services based on medical necessity. Existing law requires health care service plans and health insurers, as specified, within 6 months after the relevant department issues specified guidance, or no later than March 1, 2025, to require all of their staff who are in direct contact with enrollees or insureds in the delivery of care or enrollee or insured services to complete evidence-based cultural competency training for the purpose of providing trans-inclusive health care for individuals who identify as transgender, gender diverse, or intersex.

This bill would require a health care service plan ~~contract, including a Medi-Cal managed care plan contract,~~ *contract* or health insurance policy issued, amended, renewed, or delivered on or after ~~January 1, 2026,~~ *the bill's operative date* to cover up to a 12-month supply of a United States Food and Drug Administration (FDA)-approved prescription hormone therapy, and the necessary supplies for self-administration, that is prescribed by a network provider within their scope of practice and dispensed at one time, as specified. *The bill would make the same prescription hormone therapy a covered benefit under the Medi-Cal program, as specified.* The bill would prohibit a ~~plan or insurer~~ *plan, an insurer, or the Medi-Cal program* from imposing utilization controls or other forms of medical management limiting the supply of this hormone therapy to an amount that is less than a 12-month supply, but would not prohibit a ~~contract or policy~~ *contract, a policy, or the Medi-Cal program* from limiting refills that may be obtained in the last quarter of the ~~plan or policy~~ *plan, policy, or coverage* year if a 12-month supply of the prescription hormone therapy has already been dispensed during that year. The bill would ~~require the State Department of Health Care Services to seek federal approval, if necessary, and to issue all-plan letters or similar instructions to implement these provisions for Medi-Cal managed care plans.~~ *repeal these provisions on January 1, 2035.*

This bill would prohibit a subscriber, enrollee, policyholder, or insured from being excluded from enrollment or participation in, being denied

the benefits of, or being subjected to discrimination by, any health care service plan or health insurer licensed in this state, on the basis of race, color, national origin, age, disability, or sex. The bill would define discrimination on the basis of sex for those purposes to include, among other things, sex characteristics, including intersex traits, pregnancy, and gender identity. The bill would prohibit a health care service plan or health insurer from taking specified actions relating to providing access to health programs and activities, including, but not limited to, denying or limiting health care services to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded. The bill would prohibit a health care service plan or health insurer, in specified circumstances, from taking various actions, including, but not limited to, denying, canceling, limiting, or refusing to issue or renew health care service plan enrollment, health insurance coverage, or other health-related coverage, or denying or limiting coverage of a claim, or imposing additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, or disability, as specified. Because a violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

Existing law requires a pharmacist to dispense, at a patient's request, up to a 12-month supply of an FDA-approved, self-administered hormonal contraceptive pursuant to a valid prescription that specifies an initial quantity followed by periodic refills.

This bill would additionally require a pharmacist to dispense, at a patient's request, up to a 12-month supply of an FDA-approved, prescription hormone therapy pursuant to a valid prescription that specifies an initial quantity followed by periodic refills, unless an exception is met.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ~~majority~~ *2/3*. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. It is the intent of the Legislature to expand the state's existing prescription hormone therapy coverage policy by requiring all health care service plan contracts and health insurance policies, ~~including both commercial and Medi-Cal managed care plan contracts and policies,~~ *and the Medi-Cal program* to cover a 12-month supply of prescription hormone therapy and necessary supplies for self-administration.

SEC. 2. Section 4064.5 of the Business and Professions Code is amended to read:

4064.5. (a) A pharmacist may dispense not more than a 90-day supply of a dangerous drug other than a controlled substance pursuant to a valid prescription that specifies an initial quantity of less than a 90-day supply followed by periodic refills of that amount if all of the following requirements are satisfied:

(1) The patient has completed an initial 30-day supply of the dangerous drug.

(2) The total quantity of dosage units dispensed does not exceed the total quantity of dosage units authorized by the prescriber on the prescription, including refills.

(3) The prescriber has not specified on the prescription that dispensing the prescription in an initial amount followed by periodic refills is medically necessary.

(4) The pharmacist is exercising their professional judgment.

(b) For purposes of this section, if the prescription continues the same medication as previously dispensed in a 90-day supply, the initial 30-day supply under paragraph (1) of subdivision (a) is not required.

(c) A pharmacist dispensing an increased supply of a dangerous drug pursuant to this section shall notify the prescriber of the increase in the quantity of dosage units dispensed.

(d) A pharmacist shall not dispense a greater supply of a dangerous drug pursuant to this section if the prescriber personally indicates, either orally or in their own handwriting, "No change to quantity," or words of similar meaning. Nothing in this subdivision shall prohibit a prescriber from checking a box on a prescription marked "No change to quantity," provided that the prescriber personally initials the box or checkmark. To indicate that an increased supply shall not be dispensed pursuant to this

section for an electronic data transmission prescription as defined in subdivision (c) of Section 4040, a prescriber may indicate "No change to quantity," or words of similar meaning, in the prescription as transmitted by electronic data, or may check a box marked on the prescription "No change to quantity." In either instance, it shall not be required that the prohibition on an increased supply be manually initialed by the prescriber.

(e) This section shall not apply to psychotropic medication or psychotropic drugs as described in subdivision (d) of Section 369.5 of the Welfare and Institutions Code.

(f) Except for this subdivision and subdivision (d), this section does not apply to FDA-approved, self-administered hormonal contraceptives.

(1) A pharmacist shall dispense, at a patient's request, up to a 12-month supply of an FDA-approved, self-administered hormonal contraceptive pursuant to a valid prescription that specifies an initial quantity followed by periodic refills.

(2) A pharmacist furnishing an FDA-approved, self-administered hormonal contraceptive pursuant to Section 4052.3 under protocols developed by the Board of Pharmacy may furnish, at the patient's request, up to a 12-month supply at one time.

(3) This subdivision does not require a pharmacist to dispense or furnish a drug if it would result in a violation of Section 733.

(g) Except for this subdivision and subdivision (d), this section does not apply to an FDA-approved prescription hormone therapy.

(1) A pharmacist shall dispense, at a patient's request, up to a 12-month supply of an FDA-approved prescription hormone therapy pursuant to a valid prescription that specifies an initial quantity followed by periodic refills, unless any of the following is true:

(A) The patient requests a smaller supply.

(B) The prescribing provider instructs that the patient must have a smaller supply.

(C) The prescribing provider temporarily limits refills to a 90-day supply due to an acute dispensing shortage.

(D) The prescription hormone therapy is a controlled substance. If the prescription hormone therapy is a controlled substance, the pharmacist shall dispense the maximum refill allowed under state and federal law to be obtained at one time by the patient.

(2) This subdivision does not require a pharmacist to dispense or furnish a drug if it would result in a violation of Section 733.

(3) For purposes of this subdivision, "prescription hormone therapy" has the same meaning as in Section 1367.253 of the Health and Safety Code.

(h) This section does not require a health care service plan, health insurer, workers' compensation insurance plan, pharmacy benefits manager, or any other person or entity, including, but not limited to, a state program or state employer, to provide coverage for a dangerous drug in a manner inconsistent with a beneficiary's plan benefit.

SEC. 3. Section 1367.0435 is added to the Health and Safety Code, to read:

1367.0435. (a) A subscriber or enrollee shall not be excluded from enrollment or participation in, be denied the benefits of, or be subjected to discrimination by, any health care service plan licensed in this state on the basis of race, color, national origin, age, disability, or sex.

(b) (1) For purposes of this section, discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of any of the following:

(A) Sex characteristics, including intersex traits.

(B) Pregnancy or related conditions.

(C) Sexual orientation.

(D) Gender identity.

(E) Sex stereotypes.

(2) In providing access to health programs and activities, including arranging for the provision of health care services, a health care service plan shall not do any of the following:

(A) Deny or limit health care services, including those that have been typically or exclusively provided to, or associated with, individuals of one sex, to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded.

(B) Deny or limit, on the basis of an individual's sex assigned at birth, gender identity, or gender otherwise recorded, a health care professional's ability to provide health care services if the denial or limitation has the effect of excluding individuals from participation in, denying them the benefits of, or otherwise subjecting them to discrimination on the basis of sex under a covered health care service plan.

(C) Adopt or apply any policy or practice of treating individuals differently or separating them on the basis of sex in a manner that subjects any individual to more than de minimis harm, including by adopting a policy or engaging in a practice that prevents an individual from participating in a health care service plan consistent with the individual's gender identity.

(D) Deny or limit health care services sought for purpose of gender transition or other gender-affirming care that the health care service plan would otherwise cover if that denial or limitation is based on an individual's sex assigned at birth, gender identity, or gender otherwise recorded.

(3) A health care service plan, in providing or arranging for the provision of health care services or other health-related coverage, shall not do any of the following:

(A) Deny, cancel, limit, or refuse to issue or renew health care service plan enrollment or other health-related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, disability, or any combination thereof.

(B) Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, disability, or any combination thereof, in health care service plan coverage or other health-related coverage.

(C) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded.

(D) Have or implement a categorical coverage exclusion or limitation for all health care services related to gender transition or other gender-affirming care.

(E) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health care services related to gender transition or other gender-affirming care if such denial, limitation, or restriction results in discrimination on the basis of sex.

(F) Have or implement benefit designs that do not provide or administer health care service plan coverage or other health-related coverage in the most integrated setting appropriate to the needs of

qualified individuals with disabilities, including practices that result in the serious risk of institutionalization or segregation.

(c) This section does not require access to, or coverage of, a health care service for which the health care service plan has a legitimate, nondiscriminatory reason for denying or limiting access to, or coverage of, the health care service or determining that the health care service is not clinically appropriate for a particular individual, or fails to meet applicable coverage requirements, including reasonable medical management techniques, such as medical necessity requirements. A health care service plan's determination under this subdivision shall not be based on unlawful animus or bias, or constitute a pretext for discrimination.

(d) A health care service plan's evidences of coverage, disclosure form, and combined evidence of coverage and disclosure form shall include all of the following information in a notice to enrollees regarding the coverage requirements pursuant to subdivision (a):

(1) A statement that the health care service plan does not discriminate on the basis of a characteristic protected under applicable state law, including this section.

(2) How to file a grievance regarding discrimination pursuant to Section 1368.

(3) The health care service plan's internet website where an enrollee may file a grievance, if available.

(4) The health care service plan's telephone number that an enrollee may use to file a grievance regarding discrimination.

(e) This section does not limit the director's authority, a health care service plan's duties, or enrollees' rights pursuant to this chapter.

(f) The rights, remedies, and penalties established by this section are cumulative and do not supersede the rights, remedies, or penalties established under other laws, including Article 9.5 (commencing with Section 11135) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code and Section 51 of the Civil Code, and any implementing regulations.

SEC. 4. Section 1367.253 is added to the Health and Safety Code, to read:

1367.253. (a) (1) A health care service plan contract issued, amended, renewed, or delivered on or after ~~January 1, 2026,~~ *the operative date of this section* shall cover up to a 12-month supply

of ~~an FDA-approved~~ *a United States Food and Drug Administration (FDA)-approved* prescription hormone therapy, and the necessary supplies for self-administration, that is prescribed by a network provider within their scope of practice and dispensed at one time for an enrollee by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

(2) This subdivision does not require a health care service plan contract to cover prescription hormone therapy provided by an out-of-network provider, pharmacy, or location licensed or otherwise authorized to dispense drugs or supplies, except as may be otherwise authorized by state or federal law or by the plan's policies governing out-of-network coverage.

(3) This subdivision does not prohibit a health care service plan contract from limiting refills that may be obtained in the last quarter of the plan year if a 12-month supply of the prescription hormone therapy has already been dispensed during the plan year.

(4) This subdivision does not require a provider to prescribe, furnish, or dispense 12 months of prescription hormone therapy at one time.

(5) (A) A health care service plan subject to this subdivision shall not impose utilization controls or other forms of medical management limiting the supply of an FDA-approved prescription hormone therapy that may be dispensed by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply, and shall not require an enrollee to make a formal request for coverage, other than a pharmacy claim.

(B) If a health care service plan delegates responsibilities under this section to a contracted entity, including a medical group or independent practice association, the delegated entity shall comply with this section.

(6) This subdivision only applies to prescription hormone therapy that is able to be safely stored at room temperature without refrigeration.

(b) This section does not deny or restrict the department's authority to ensure plan compliance with this chapter when a plan provides coverage for prescription hormone therapy.

(c) This section does not require an individual or group health care service plan contract to cover experimental or investigational treatments.

~~(d) This section applies to Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code and their contracting providers, independent practice associations, preferred provider groups, and all delegated entities that provide physician services, utilization management, or utilization review.~~

~~(e)~~

(d) For purposes of this section:

(1) "Prescription hormone therapy" means all drugs approved by the ~~United States Food and Drug Administration~~ *FDA* that are used to medically suppress, increase, or replace hormones that the body is not producing at intended levels, and the necessary supplies for self-administration.

(2) "Provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(e) This section shall remain in effect only until January 1, 2035, and as of that date is repealed.

SEC. 5. Section 10123.1963 is added to the Insurance Code, to read:

10123.1963. (a) (1) A health insurance policy issued, amended, renewed, or delivered on or after ~~January 1, 2026,~~ *the operative date of this section* shall cover up to a 12-month supply of ~~an FDA-approved~~ *a United States Food and Drug Administration (FDA)-approved* prescription hormone therapy, and the necessary supplies for self-administration, that is prescribed by a network provider within their scope of practice and dispensed at one time for an insured by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

(2) This subdivision does not require a health insurance policy to cover prescription hormone therapy provided by an out-of-network provider, pharmacy, or location licensed or otherwise authorized to dispense drugs or supplies, except as may be otherwise authorized by state or federal law or by the insurer's policies governing out-of-network coverage.

(3) This subdivision does not prohibit a health insurance policy from limiting refills that may be obtained in the last quarter of the policy year if a 12-month supply of the prescription hormone therapy has already been dispensed during the policy year.

(4) This subdivision does not require a provider to prescribe, furnish, or dispense 12 months of prescription hormone therapy at one time.

(5) (A) A health insurer subject to this subdivision shall not impose utilization controls or other forms of medical management limiting the supply of an FDA-approved prescription hormone therapy that may be dispensed by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply, and shall not require an insured to make a formal request for coverage, other than a pharmacy claim.

(B) If a health insurer delegates responsibilities under this section to a contracted entity, including a medical group or independent practice association, the delegated entity shall comply with this section.

(6) This subdivision only applies to prescription hormone therapy that is able to be safely stored at room temperature without refrigeration.

(b) This section does not deny or restrict the department's authority to ensure insurer compliance with this chapter when an insurer provides coverage for prescription hormone therapy.

(c) This section does not require an individual or group health insurance policy to cover experimental or investigational treatments.

(d) For purposes of this section:

(1) "Prescription hormone therapy" means all drugs approved by the ~~United States Food and Drug Administration~~ *FDA* that are used to medically suppress, increase, or replace hormones that the body is not producing at intended levels, and the necessary supplies for self-administration.

(2) "Provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(e) This section shall remain in effect only until January 1, 2035, and as of that date is repealed.

SEC. 6. Section 10133.135 is added to the Insurance Code, to read:

10133.135. (a) A policyholder or insured shall not be excluded from enrollment or participation in, be denied the benefits of, or be subjected to discrimination by, any health insurer licensed in this state on the basis of race, color, national origin, age, disability, or sex.

(b) (1) For purposes of this section, discrimination on the basis of sex includes, but is not limited to, discrimination on the basis of any of the following:

(A) Sex characteristics, including intersex traits.

(B) Pregnancy or related conditions.

(C) Sexual orientation.

(D) Gender identity.

(E) Sex stereotypes.

(2) In providing access to health programs and activities, a health insurer shall not do any of the following:

(A) Deny or limit health care services, including those that have been typically or exclusively provided to, or associated with, individuals of one sex, to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded.

(B) Deny or limit, on the basis of an individual's sex assigned at birth, gender identity, or gender otherwise recorded, a health care professional's ability to provide health care services if the denial or limitation has the effect of excluding individuals from participation in, denying them the benefits of, or otherwise subjecting them to discrimination on the basis of sex under a covered health insurance policy.

(C) Adopt or apply any policy or practice of treating individuals differently or separating them on the basis of sex in a manner that subjects any individual to more than de minimis harm, including by adopting a policy or engaging in a practice that prevents an individual from participating in a health insurance policy or activity consistent with the individual's gender identity.

(D) Deny or limit health care services sought for purpose of gender transition or other gender-affirming care that the health insurance policy would otherwise cover if that denial or limitation is based on an individual's sex assigned at birth, gender identity, or gender otherwise recorded.

(3) A health insurer, in providing or administering health insurance coverage or other health-related coverage, shall not do any of the following:

(A) Deny, cancel, limit, or refuse to issue or renew health insurance coverage or other health-related coverage, or deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, on the basis of race, color, national origin, sex, age, disability, or any combination thereof.

(B) Have or implement marketing practices or benefit designs that discriminate on the basis of race, color, national origin, sex, age, disability, or any combination thereof, in health insurance coverage or other health-related coverage.

(C) Deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, to an individual based upon the individual's sex assigned at birth, gender identity, or gender otherwise recorded.

(D) Have or implement a categorical coverage exclusion or limitation for all health care services related to gender transition or other gender-affirming care.

(E) Otherwise deny or limit coverage, deny or limit coverage of a claim, or impose additional cost sharing or other limitations or restrictions on coverage, for specific health care services related to gender transition or other gender-affirming care if such denial, limitation, or restriction results in discrimination on the basis of sex.

(F) Have or implement benefit designs that do not provide or administer health insurance coverage or other health-related coverage in the most integrated setting appropriate to the needs of qualified individuals with disabilities, including practices that result in the serious risk of institutionalization or segregation.

(c) This section does not require access to, or coverage of, a health care service for which the health insurer has a legitimate, nondiscriminatory reason for denying or limiting access to, or coverage of, the health care service or determining that the health care service is not clinically appropriate for a particular individual, or fails to meet applicable coverage requirements, including reasonable medical management techniques, such as medical necessity requirements. A health insurer's determination under

this subdivision shall not be based on unlawful animus or bias, or constitute a pretext for discrimination.

(d) A health insurer's evidences of coverage, disclosure form, and combined evidence of coverage and disclosure form shall include all of the following information in a notice to insureds regarding the coverage requirements pursuant to subdivision (a):

(1) A statement that the health insurer does not discriminate on the basis of a characteristic protected under applicable state law, including this section.

(2) How to file a grievance regarding discrimination.

(3) The health insurer's internet website where an insured may file a grievance, if available.

(4) The health insurer's telephone number that an insured may use to file a grievance regarding discrimination.

(e) This section does not limit the commissioner's authority, a health insurer's duties, or insureds' rights pursuant to this division.

(f) The rights, remedies, and penalties established by this section are cumulative and do not supersede the rights, remedies, or penalties established under other laws, including Article 9.5 (commencing with Section 11135) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code and Section 51 of the Civil Code, and any implementing regulations.

~~SEC. 7. Section 14000.01 of the Welfare and Institutions Code is amended to read:~~

~~14000.01. The department shall seek federal approval, if necessary, and shall issue all-plan letters or similar instructions to implement subdivision (d) of Section 1367.25 of, and Section 1367.253 of, the Health and Safety Code.~~

SEC. 7. Section 14132.04 is added to the Welfare and Institutions Code, to read:

14132.04. (a) (1) Up to a 12-month supply of a United States Food and Drug Administration (FDA)-approved prescription hormone therapy and the necessary supplies for self-administration are a covered benefit under the Medi-Cal program. Coverage under this section shall be limited to a prescription by a provider within their scope of practice and dispensed at one time for a beneficiary by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

(2) This subdivision does not prohibit the Medi-Cal program from limiting refills that may be obtained in the last quarter of the

coverage year if a 12-month supply of the prescription hormone therapy has already been dispensed during the coverage year.

(3) This subdivision does not require a provider to prescribe, furnish, or dispense 12 months of prescription hormone therapy at one time.

(4) The Medi-Cal program shall not impose utilization controls or other forms of medical management limiting the supply of an FDA-approved prescription hormone therapy that may be dispensed by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply, and shall not require a beneficiary to make a formal request for coverage, other than a pharmacy claim.

(5) This subdivision only applies to prescription hormone therapy that is able to be safely stored at room temperature without refrigeration.

(b) This section does not require the Medi-Cal program to cover experimental or investigational treatments.

(c) For purposes of this section:

(1) "Prescription hormone therapy" means all drugs approved by the FDA that are used to medically suppress, increase, or replace hormones that the body is not producing at intended levels, and the necessary supplies for self-administration.

(2) "Provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(d) This section shall remain in effect only until January 1, 2035, and as of that date is repealed.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SEC. 9. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within

the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

With each day, we are getting new updates about the ways that the Trump administration is looking to eliminate gender-affirming care. The ongoing attacks, alongside the United States Supreme Court's recent ruling to uphold a state law banning gender-affirming care for children, are yet another setback for the protections that exist for Californians. The Trump administration has spread dangerous misinformation about the safety and efficacy of gender-affirming care, attempted to restrict federal funding for hospitals and clinics that provide this care, and even threatened health care providers with criminal penalties simply for providing medically necessary care to transgender youth. These threats are not only chilling access to care, but also creating fear and uncertainty for patients, providers, and entire health care systems.

Several states working to restrict gender-affirming care in 2021 led to the closure of 70 clinics by 2023. In a June 12, 2025, email to patients, the Children's Hospital of Los Angeles, one of the largest clinics for gender-affirming care in the country, said it will cease operating its gender-affirming clinic on July 22, 2025. Essential care includes hormone replacement therapy, which affects a large community of individuals, such as transgender individuals, individuals undergoing cancer treatment, and individuals experiencing perimenopause, menopause, osteoporosis prevention treatment, or other hormone deficiencies, and medications to treat conditions like hyperthyroidism. Due to the federal administration and its attack on our transgender community, individuals have to stockpile their prescription hormone therapy, ration or stockpile medications to avoid treatment gaps, or seek care in an unregulated market. There is data confirming the behavioral health concerns that come from not having access to this essential care, among these being increased anxiety, depression, and suicidal ideation. This bill is responding to this issue in real time by applying the exact mechanism that exists for contraception, under which a person can get up to a 12-month supply at one time. This bill and its urgency will ensure that California remains a leader in health care equity and ensure access to essential care.

O