Abbreviated Analysis

California Senate Bill 418: Prescription Hormone Therapy and Nondiscrimination

Report to the 2025–2026
California State Legislature

AUGUST 14, 2025

California Health Benefits
Review Program (CHBRP),
University of California, Berkeley

chbrp.org

KEY FINDINGS

Abbreviated Analysis of California Senate Bill 418 Prescription Hormone Therapy and Nondiscrimination

Summary to the 2025–2026 California State Legislature, August 14, 2025

CHBRP

Summary

The version of California Senate Bill (SB) 418 analyzed by California Health Benefits Review Program (CHBRP) would require health plans and policies to cover up to a 12-month supply of a U.S. Food and Drug Administration-approved prescription hormone therapy and the necessary supplies for self-administration. SB 418 would allow an enrollee to receive a covered hormone therapy, prescribed by a network provider and dispensed by a provider or pharmacist or at a location licensed or otherwise authorized to dispense drugs or supplies, for up to 12 months at one time.

In 2026, 23.5 million Californians (61.8% of all Californians) enrolled in state-regulated health insurance would have insurance subject to SB 418.

Benefit Coverage

While SB 418 would be unlikely to create a measurable number of new users due to broad baseline coverage of hormone therapies, CHBRP estimates that 0.09% of enrollees with health insurance subject to SB 418 would switch to a 12-month supply.

Cost and Health Impacts[1]

In 2026, SB 418 would lead to an increase in total net annual expenditures of $476,000 (<0.01%).

Although public health impacts of SB 418 are likely to affect a small number of people, CHBRP anticipates that receiving 12 months of hormone therapy at once could reduce barriers to accessing treatment and improve quality of life for some people.

Context

Per California state law, dispensing of "dangerous drugs" – which includes those that are labeled "rx only" – is limited to 90 days.[2] SB 418 would allow for longer durations of hormone therapy to be dispensed at once.

Hormone therapy is used in the treatment of several diseases and conditions to medically suppress, block, increase, or replace hormones that the body is not producing at intended levels. CHBRP's analysis of SB 418 discusses the following conditions for which hormone therapy is commonly used: menopause, breast cancer, prostate cancer, gender dysphoria and gender incongruence, hypothyroidism, and thyroid cancer. Hormone therapy may be used in the course of treatment for additional conditions not in the *Background* section of this analysis; however, all uses of hormone therapy are considered in the *Benefit Coverage, Utilization, and Cost Impacts* section.

Bill Summary

CHBRP was requested to analyze sections 4, 5, and 7 of SB 418 as amended on July 9, 2025, which would:

- Require health plans and policies to cover up to a 12-month supply of a U.S. Food and Drug Administration (FDA)-approved prescription hormone therapy, as well as the necessary supplies for self-administration, as prescribed by a network provider within their scope of practice;
- Allow an enrollee to receive a covered hormone therapy, dispensed by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies, for up to 12 months at one time;
- Allow – but not require – a provider to prescribe, furnish, or dispense 12 months of prescription hormone therapy at one time;
- Prohibit the use of utilization management or other forms of medical management to limit a

[1] Similar cost and health impacts could be expected for the following year, although possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

[2] BPC 4064.5, BPC 4022.

12-month supply of an FDA-approved prescription hormone therapy to a shorter duration; and

- Prohibit health plans from requiring an enrollee to make a formal request for coverage for hormone therapy, other than a pharmacy claim. This would effectively prohibit health plans from conducting prior authorization to determine medical necessity for prescription hormone therapies.

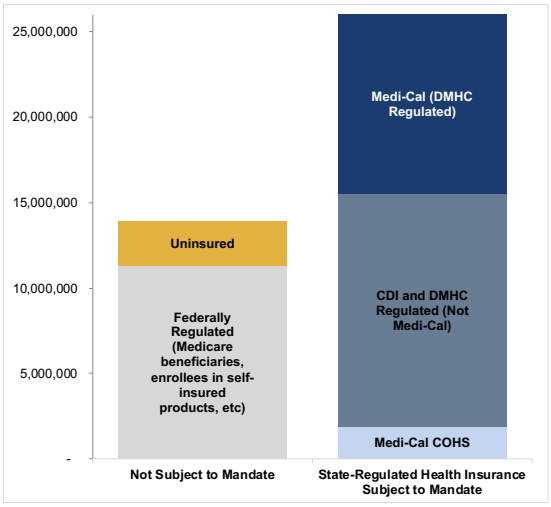
SB 418 defines prescription hormone therapy as "all drugs approved by the FDA that are used to medically suppress, increase, or replace hormones that the body is not producing at intended levels."

How does utilization impact premiums?

Health insurance, by design, distributes risk and expenditures across everyone enrolled in a plan or policy. It does so to help protect each enrollee from the full impact of health care costs that arise from that enrollee's use of prevention, diagnosis, and/or treatment of a covered medical condition, disease, or injury. Changes in utilization among any enrollees in a plan or policy can result in changes to premiums for all enrollees in that plan or policy.

SB 418 would not include hormone therapies that are controlled substances, require refrigeration, or fall under the definition of experimental or investigational treatments. SB 418 also would not prohibit a health care plan or policy 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. For example, a health care plan or policy would be permitted to refuse a refill in November for a patient who received a 12-month supply of hormone therapy earlier in the same plan year.

Figure A. Health Insurance in CA and SB 418



Source: California Health Benefits Review Program, 2025.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[3]
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

Impacts

Benefit Coverage

CHBRP estimates that at baseline, all Californians who are enrolled in state-regulated health insurance subject to SB 418 (23.5 million) are enrolled in plans or policies that are not compliant with the dispensing duration mandate of SB 418. Although coverage of prescription hormone therapy at baseline is broad, dispensing durations are currently restricted by state law to 90 days for "dangerous drugs."

Utilization

Postmandate, CHBRP assumes that access to 12-month dispensing supplies of prescription hormone therapy would increase to include all enrollees in plans and policies that have pharmacy benefits and are subject to state mandates. CHBRP assumes that overall utilization would not change measurably, except for changes in utilization driven by pharmaceutical waste.[4] CHBRP

[3] Although COHS plans are not subject to the Knox-Keene Act, DHCS generally updates Medi-Cal managed care plan contracts, All Plan Letters, and other appropriate authorities for alignment of managed care plan benefits, except in cases when the benefit is carved out of the Medi-Cal Managed Care plan contract or the law exempts specified Medi-Cal–contracted providers.

[4] Although SB 418 includes language restricting the use of utilization management to limit coverage of hormone therapy, CHBRP is unable to quantify the magnitude of this impact due to a lack of data on utilization management practices.

estimates that pharmaceutical waste would occur among a small proportion of enrollees who received a 12-month supply of their original prescription(s) and then switched to a new prescription before using all of their previously acquired drugs.

CHBRP estimates that 0.09% of enrollees with health insurance subject to SB 418 would opt for prescriptions that allow for 12-month supplies to be dispensed at once.

CHBRP estimates no impact on unit costs as a result of SB 418.

Expenditures

For Department of Managed Health Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies, SB 418 would increase total premiums paid by employers and enrollees for newly covered benefits. Enrollee expenses for covered benefits would increase. This would result in an increase of total net annual expenditures of $476,000 (<0.01%).

Commercial

Shifts in commercial annual premiums would range from $0.0011 to $0.0013.

Medi-Cal

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans and County Organized Health Systems (COHS), annual premiums would increase $0.0018.

CalPERS

For enrollees associated with California Public Employees' Retirement System (CalPERS) in DMHC-regulated plans, annual premiums would increase $0.0010.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 418.

Public Health

While CHBRP finds that SB 418 would have no measurable short-term public health impact, there is reason to believe that increased access to longer-duration prescription hormone therapy could address barriers to accessing treatment and improve quality of life for some people, particularly those facing restricted access to care as a result of federal actions.

Long-Term Impacts

CHBRP expects no long-term impacts on utilization or cost.

Essential Health Benefits and the Affordable Care Act

SB 418 would not exceed the definition of essential health benefits in California because SB 418 would expand existing benefit coverage and does not create a new coverage requirement.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation.

The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

Suggested citation

California Health Benefits Review Program (CHBRP). (2025). *Analysis of California Senate Bill 418 Prescription Hormone Therapy and Nondiscrimination.* Berkeley, CA.

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Lists of Tables and Figures

Acronyms and Abbreviations

AB – Assembly Bill
ACA – Affordable Care Act
CA – California
CalPERS – California Public Employees' Retirement System
CDC – Centers for Disease Control and Prevention
CDI – California Department of Insurance
CHBRP – California Health Benefits Review Program
CMS – Centers for Medicare and Medicaid Services
COHS – County Organized Health System
DHCS – Department of Health Care Services
DMHC – Department of Managed Health Care
EHB – essential health benefits
FDA – Food and Drug Administration
GAHT – gender-affirming hormone therapy
GSM – genitourinary syndrome of menopause
HB – House Bill
HMO – health maintenance organization
NAMS – North American Menopause Society
PMPM – per member per month
SB – Senate Bill
VMS – vasomotor symptoms
WHO – Word Health Organization

Introduction

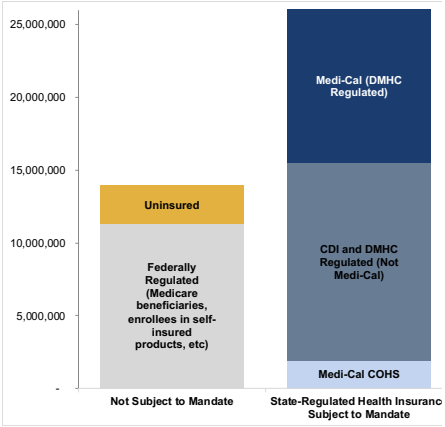
The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[5] conduct an abbreviated, evidence-based assessment of Sections 4 and 5 of Senate Bill (SB) 418 Prescription Hormone Therapy and Nondiscrimination as amended on June 23, 2025. CHBRP additionally analyzed Section 7 of SB 418 as amended on July 9, 2025, as it pertains to the same benefit mandate as Sections 4 and 5.

SB 418 Prescription Hormone Therapy and Nondiscrimination Bill Language

Sections 4, 5, and 7 of SB 418 as amended on July 9, 2025, would:

- Require health plans and policies to cover up to a 12-month supply of a U.S. Food and Drug Administration (FDA)-approved prescription hormone therapy, as well as the necessary supplies for self-administration, as prescribed by a network provider within their scope of practice;
- Allow an enrollee to receive a covered hormone therapy, dispensed by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies, for up to 12 months at one time;
- Allow – but not require – a provider to prescribe, furnish, or dispense 12 months of prescription hormone therapy at one time;
- Prohibit the use of utilization management or other forms of medical management to limit a 12-month supply of an FDA-approved prescription hormone therapy to a shorter duration; and
- Prohibit health plans from requiring an enrollee to make a formal request for coverage for hormone therapy, other than a pharmacy claim. This would effectively prohibit health plans from conducting prior authorization to determine medical necessity for prescription hormone therapies.

Figure 1. Health Insurance in CA and SB 418



SB 418 defines prescription hormone therapy as "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."

SB 418 would not:

- Include hormone therapies that are controlled substances;
- Include hormone therapies that require refrigeration (e.g., GLP-1s, infertility treatment);
- Require a health plan or policy to cover experimental or investigational treatments;
- Prohibit a health care plan or policy 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. For example, a health care plan or policy would be permitted to refuse a refill in November for a patient who received a 12-month supply of hormone therapy earlier in the same plan year;

[5] See CHBRP's authorizing statute.

- Impact other insurance requirements such as in-network pharmacies or providers; or
- Prevent patients from receiving hormone therapy through mail order

The sections of SB 418 analyzed by CHBRP would remain in effect until January 1, 2035. Additional sections of SB 418 not analyzed by CHBRP would require that 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 plan or policy licensed in the state of California on the basis of race, color, national origin, age, disability, or sex. CHBRP did not analyze these sections of SB 418 as they were not included in the request for analysis from the California Assembly Committee on Health and do not constitute a benefit mandate.

See the full text of SB 418 in Appendix A.

If enacted, SB 418 would apply to the health insurance of approximately 23,494,000 enrollees (61.8% of all Californians) (see Figure 1).

Includes: enrollees in commercial or California Public Employees' Retirement System (CalPERS) health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI), as well as Medi-Cal beneficiaries enrolled in DMHC-regulated plans and County Organized Health System plans (COHS).

See the following *Analytic Approach and Key Assumptions* section for additional information.

Appendix B provides an overview of the utilization management practices that are addressed by SB 418.

What Is Hormone Therapy?

Hormone therapy is used in the treatment of several diseases and conditions to medically suppress, block, increase, or replace hormones that the body is not producing at intended levels. CHBRP's analysis of SB 418 discusses the following conditions for which hormone therapy is commonly used: menopause, breast cancer, prostate cancer, gender dysphoria and gender incongruence, hypothyroidism, and thyroid cancer. For additional information on these conditions, see the *Background* section.

Hormone therapy may be used in the course of treatment for additional conditions not in the *Background* section of this analysis; however, all uses of covered hormone therapies are considered in the *Benefit Coverage, Utilization, and Cost Impacts* section. CHBRP's analysis includes FDA-approved hormone therapies that are self-administered and do not require refrigeration; other forms of hormone therapy and relevant conditions are not mentioned here.

What Are Current Dispensing Practices?

Per California state law, dispensing of "dangerous drugs" – which includes those that are labeled "rx only" – is limited to 90 days.[6] SB 418 would allow for longer durations of hormone therapy to be dispensed at once. As such, it is important to note the distinction between a prescription and a dispensed refill for self-administered hormone therapy. One prescription may authorize several dispensed refills. For example, a prescription valid for 1 year may be used to dispense four 3-month supplies throughout the year or one 12-month supply at one time. Prescriptions for self-administered hormone therapies are typically valid for 1 year.

Terminology

Prescription duration: The total length of time for which a health care provider may prescribe a medication.

[6] BPC 4064.5, BPC 4022

Dispensing duration: The period for which a pharmacist can dispense a medication at one time, commonly a smaller portion of the prescription duration. For example, a prescription duration of 12 months is commonly split into 12 30-day refills or four 90-day refills. Current law in California limits dispensing duration to 90 days for "dangerous drugs," which includes drugs labeled "rx only."

Drug formulary: List of generic and brand-name prescription drugs covered by a specific health insurance plan or policy.

Gender-affirming hormone therapy (GAHT): Transgender people may seek hormone therapy and/or surgical interventions as part of gender-affirming care. Gender-affirming hormone therapy (GAHT) is a treatment in which people take hormones such as estrogen or testosterone, or hormone blockers, that help achieve physical characteristics that are more masculine or feminine (Johns Hopkins Medicine, n.d.). GAHT can be part of a presurgical or postsurgical plan, or a stand-alone service.

Hormone therapy: Hormones are chemical messengers produced by the body that regulate certain bodily functions. Hormonal imbalances can lead to various medical conditions. Hormone therapy is treatment used to medically suppress, block, increase, or replace hormones that the body is producing at levels lower than needed.

Endocrine therapy: Treatment that adds, blocks, or removes hormones. "Endocrine therapy" is used synonymously with hormone therapy in CHBRP's analysis where citing research that uses this language.

Pharmaceutical waste: Discarded or expired drugs, syringes, or waste materials containing drug residues. This waste can include prescription and over-the-counter medications. People commonly change their drug treatment for medical reasons (i.e., change the prescribed drug within a class). This can sometimes lead to medications from an original prescription going unused – or "wasted" – if a patient makes a change before their current supply ends.

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Analytic Approach and Assumptions

For this analysis, CHBRP has assumed that mandates that reference plans and policies that cover self-administered prescription drugs are relevant to outpatient pharmacy benefit coverage. As such, this analysis applies to all commercial enrollees with a pharmacy benefit and all Medi-Cal Rx enrollees. Almost all (95.4%) of commercial and CalPERS enrollees in plans and policies regulated by DMHC or CDI have an outpatient pharmacy benefit regulated by DMHC or CDI that covers both generic and brand-name outpatient prescription drugs. CHBRP assumes that all Medi-Cal Managed Care enrollees have an outpatient pharmacy benefit through Medi-Cal Rx.

CHBRP has assumed that, as written, SB 418 is inclusive of all conditions and diseases that can be treated by a self-administered, nonrefrigerated, FDA-approved prescription hormone therapy that is not a controlled substance. More information about specific conditions commonly treated with hormone therapy is included in the *Background* section.

CHBRP has excluded from its analysis of SB 418:

- All FDA-approved, self-administered hormonal contraceptives, as the Affordable Care Act (ACA) already provides coverage of contraceptives as a preventive service and SB 999 (2016) already permits dispensing of a 12-month supply of FDA-approved, self-administered hormonal contraceptives all at once;
- Testosterone, as it is a Schedule III controlled substance, which are excluded per Section 2 of SB 418; and
- Hormone therapies that require refrigeration at any point (e.g., GLP-1s, infertility treatment), per bill language
- Experimental or investigational treatments

As SB 418 excludes but does not define "experimental or investigational treatment," CHBRP has assumed the California Department of Health Care Services (DHCS) definitions of experimental and investigational services in order to clarify which drugs are considered within the scope of the bill. Per DHCS, experimental services are drugs, equipment, procedures, or services that are in a testing phase undergoing laboratory and/or animal studies prior to testing in humans. Experimental services do not include services that are undergoing a clinical investigation. DHCS' definition of an investigational service is a drug, biological product, or device that has successfully completed phase one of a clinical investigation approved by the FDA, but that has not been approved for general use by the FDA and remains under investigation in an FDA-approved clinical investigation (DHCS, 2020).

Per sections 4064.5 and 4022 of the California Business and Professions Code, CHBRP has assumed that "dangerous drugs" includes prescription hormone therapy.

As of January 1, 2022, outpatient prescription drugs are covered on a fee-for-service basis by DHCS for all Medi-Cal beneficiaries through the Medi-Cal Rx program.[7] Their pharmacy benefit is "carved out" of the coverage provided by Medi-Cal Managed Care plans. However, CHBRP has included Medi-Cal Rx in its analysis of SB 418 per language in Section 7, which amends the Welfare and Institutions Code to require coverage of the benefit mandate by the Medi-Cal Program.

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[7] For more on outpatient prescription drug coverage among Californians with state-regulated health insurance, see CHBRP's resource, *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.

Policy Context

Health benefit mandates may interact and align with the following state and federal mandates, programs, and policies.

California Law and Regulations

Section 4064.5 of the California Business and Professions Code restricts dispensing of "dangerous drugs" to 90 days. Section 4022 of the Business and Professions code includes "any drug that bears the legend 'rx only'" in its definition of dangerous drugs, which includes prescription hormone therapies.

In 2013, California passed SB 493 Pharmacy Practice, which requires that a licentiate shall not obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. SB 493 allows a licentiate to refuse to dispense a drug or device on ethical, moral, or religious grounds only if they have previously notified their employer in writing and their employer can, without creating undue hardship, provide a reasonable accommodation of the licentiate's objection.

In 2016, California passed SB 999 Contraceptives: Annual Supply, which provides access to FDA-approved, self-administered hormonal contraception in 12-month supplies dispensed at one time.

In 2016, California passed AB 339 Outpatient Prescription Drugs, which caps copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for a supply of up to 30 days at $250.[8] AB 339 was made permanent by AB 948 Prescription Drugs in 2024.

Medications are FDA-approved for a specific purpose but can also be used "off-label" for other purposes. Off-label use refers to the practice of prescribing or using a medication for a purpose, dosage, route of administration, or patient population that is not explicitly approved by the FDA. Under existing law, plans and policies cannot limit or deny coverage for off-label use of prescription drugs.[9] More specifically, off-label use must be covered under state-regulated plans and policies provided that the drug is: 1) FDA-approved; 2) prescribed by a contracting licensed health care professional for the treatment of a life-threatening condition or for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the insurer's formulary; or 3) the drug has been recognized for treatment of that condition by the American Hospital Formulary Service's Drug Information or at least two articles from major peer-reviewed medical journals.

Similar Legislation in Other States

In April 2025, Washington state passed House Bill (HB) 1971 Increasing Access to Prescription Hormone Therapy, which requires health plans to provide reimbursement for a 12-month fill of prescription hormone therapy obtained at one time by an enrollee. HB 1971 defines prescription hormone therapy as "all drugs approved by the United States Food and Drug Administration that are used to medically suppress, increase, or replace hormones that the body is not producing at intended levels."[10]

Like SB 418, HB 1971 only includes hormone therapies that can be safely stored at room temperature without refrigeration and does not include controlled substances. HB 1971 specifically does not include glucagon-like peptide-1 and glucagon-like peptide-1 receptor agonists. Like SB 418, HB 1971 does not prohibit a health plan from limiting refills that may be obtained in the last quarter of the plan year if a 12-month supply of the prescription has already been

[8] This statute has different terms for enrollees in plans or policies with an actuarial value at or equivalent to bronze level and high-deductible health plans.
[9] HSC 1367.21 and INS 10123.195.
[10] Washington State Legislature House Bill No. 1971.

dispensed during the plan year. However, unlike SB 418, HB 1971 does not include language regarding utilization management.

Twenty-three states (including California) and the District of Columbia require insurers to cover an extended supply of 12 months of contraceptives at one time. Three states require insurers to cover an extended supply of six months at one time.

Federal Policy Landscape

Affordable Care Act

A number of Affordable Care Act (ACA) provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how SB 418 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[11,12]

Nondiscrimination

Section 1557 of the ACA prohibits discrimination based on sex, including gender identity, in healthcare programs that receive federal funding.

Essential Health Benefits

In California, nongrandfathered[13] individual and small-group health insurance is generally required to cover EHBs.[14] In 2026, approximately 11% of all Californians will be enrolled in a plan or policy that must cover EHBs.[15]

SB 418 would not require coverage for a new state benefit mandate and therefore appears not to exceed the definition of EHBs in California.

Relevant Federal Actions Regarding Gender-Affirming Care

Since January 2025, multiple federal actions have been taken to restrict access to treatment – including hormone therapy – for gender-affirming care.

On January 28, 2025, the White House announced Executive Order 14187, titled Protecting Children From Chemical and Surgical Mutilation, which directs agencies and programs to work towards significantly limited access to gender-affirming care for young people (defined as those under age 19 years) nationwide. In February 2025, two federal lawsuits were filed challenging this order. As of March 2025, one lawsuit was issued a preliminary temporary injunction, and the other was issued a restraining order (Dawson and Kates, 2025a).

On May 28, 2025, Centers for Medicare and Medicaid Services (CMS) sent a letter to unnamed institutions requesting documents and data, including policies, procedures, protocols, adverse event reports, and "complete financial data for all pediatric sex trait modifications performed at your institution and paid, in whole or in part, by the federal government" (Carney et al., 2025). The letter referred to surgeries and medication treatment. Around the same time, CMS updated its website to include a page entitled "Quality, Safety & Oversight – Enforcement", which details reasons why a provider

[11] The ACA requires nongrandfathered small-group and individual market health insurance – including, but not limited to, qualified health plans sold in Covered California – to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website.
[12] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.
[13] A grandfathered health plan is "a group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers."
[14] For more detail, see CHBRP's issue brief, *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*.
[15] See CHBRP's resource, *Sources of Health Insurance in California*.

agreement could be terminated, including a failure to supply payment information and refusal to permit examination of "fiscal and other records" (Carney et al., 2025).

On June 11, 2025, Assistant Attorney General Brett Shumate issued a memorandum (the Shumate Directive) to all United States Department of Justice civil division employees, directing them to use all available resources to "prioritize investigations of doctors, hospitals, pharmaceutical companies, and other appropriate entities" in pursuit of alleged violations "of the Food, Drug, and Cosmetic Act and other laws" for providing gender-affirming health care (California Office of the Attorney General, 2025; U.S. Department of Justice, 2025).

On June 18, 2025, the US Supreme Court ruled in *United States v. Skrmetti*, a case challenging Tennessee law SB1 banning gender affirming care, which often includes the use of hormone therapy. The court ruled that the law did not constitute sex-based discrimination and did not violate the US Constitution's 14th Amendment Equal Protection clause. As of this ruling, 25 state-level bans of this nature remain in place. Two bans – in Montana and Arkansas – are, as of June 18, permanently enjoined by court order (Dawson and Kates, 2025b). Although California has not passed similar legislation, several clinics in California have changed their services related to gender-affirming care, commonly citing federal actions as the reason for such changes. In June 2025, Stanford Medicine stopped offering gender-related surgical procedures for patients under age 19 years, citing an aim to protect patients and providers as federal oversight of gender-affirming care intensifies (McClurg, 2025). In July 2025, Children's Hospital of Los Angeles ended its care for transgender patients, citing pressure from the Trump administration. The clinic had provided transgender youth with puberty blockers and hormones as well as surgical procedures (Sharp, 2025). Also in July 2025, Kaiser Permanente announced that it would pause providing gender-affirming surgeries for patients under age 19 years, citing "significant focus by the federal government on gender-affirming care" (DeBenedetti, 2025).

On June 25, 2025, CMS finalized a rule prohibiting issuers of coverage subject to EHB requirements from providing coverage for "specified sex-trait modification procedures" (generally understood to mean gender-affirming care) as an EHB (Federal Register, 2025).

On July 31, 2025, California Attorney General Rob Bonta filed a lawsuit challenging the Trump Administration's efforts to restrict access to health care for transgender, intersex, and nonbinary youth. The lawsuit cites Executive Order 14187 and its implementing memoranda from the U.S. Department of Justice, including the Shumate Directive (California Office of the Attorney General, 2025).

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Background on Hormone Therapy and Conditions Commonly Treated With Hormone Therapy

As discussed in the *Policy Context* section, SB 418 would require health plans and policies to cover up to a 12-month supply of an FDA-approved prescription hormone therapy and the necessary supplies for self-administration. SB 418 would allow an enrollee to receive a covered hormone therapy, prescribed by a network provider and dispensed by a provider or pharmacist or at a location licensed or otherwise authorized to dispense drugs or supplies, for up to 12 months at one time.

Hormone therapy is used in the treatment of several diseases and conditions to medically suppress, block, increase, or replace hormones that the body is not producing at intended levels. Below is a summary of how hormone therapy is used for several diseases and conditions: menopause, breast cancer, prostate cancer, gender dysphoria and gender incongruence, hypothyroidism, and thyroid cancer. Hormone therapy may be used in the course of treatment for additional conditions not listed here. As noted in the *Policy Context* section, CHBRP's analysis includes FDA-approved hormone therapies that are self-administered and do not require refrigeration; other forms of hormone therapy and relevant conditions are not mentioned here.

Prevalence of Conditions Commonly Treated With Hormone Therapy

Menopause

Menopause is part of the normal aging process in which menstruation has ceased for 12 consecutive months (Endocrine Society, 2022). This transition to a new stage of life (rather than a condition or disease) is experienced by every woman[16] and most often occurs naturally between ages 45 and 55 years but may occur between ages 40 and 64 years (median age 51 years) (NLM, 2023). Approximately five million women aged 40 to 64 years live in California, many of whom experience mild, moderate, or severe menopause symptoms for a few months to more than 12 years. Symptoms that are commonly treated with hormone therapy include genitourinary syndrome of menopause (GSM), vasomotor symptoms (VMS), low libido, and bone loss. GSM, which is characterized by vaginal dryness, has a prevalence ranging from 30% to 50% of menopausal women nationally. VMS, characterized by hot flashes and/or night sweats, is prevalent in 80% of menopausal women (35% experiencing moderate-to-severe hot flashes), with 20% to 30% seeking medical attention. An estimated 50% of menopausal women may experience low libido. About 13% of women aged 50 to 64 years have bone loss (osteoporosis); this number increases to 27% for those 65 years and older, although some bone loss may be age-related rather than menopause-specific (Deecher and Dorries, 2007; Green and Santoro, 2009; Martin and Barbieri, 2023; Pesantez and Clayton, 2021; Salari et al., 2023; Sarafrazui et al., 2021; Shifren et al., 2008; SWAN, 2023; West et al., 2008).

Breast Cancer

Breast cancer develops when breast cells mutate and become cancerous cells that multiply and form tumors. Breast cancer is the most commonly diagnosed cancer among women in California. According to 5-year average data (2017–2021), the prevalence of breast cancer in California is estimated at 124 cases per 100,000 population, which is slightly lower than the national 5-year average of 129.8 cases per 100,000 population (National Cancer Institute, 2021).

[16] CHBRP uses the National Institutes of Health (NIH) distinction between "sex" and "gender": "'Sex' refers to biological differences between females and males, including chromosomes, sex organs, and endogenous hormonal profiles. 'Gender' refers to socially constructed and enacted roles and behaviors which occur in a historical and cultural context and vary across societies and over time." (NIH, 2019).

Prostate Cancer

Prostate cancer is the most common non-skin cancer among men in the United States. There is a 1 in 12 probability of developing prostate cancer among men. In 2024, prostate cancer accounted for an estimated 299,010 new cases of cancer and 35,250 deaths nationwide, with roughly 26,350 cases (8.8%) and 4,200 deaths (11.9%) occurring in California. Prostate cancer was one of the most commonly diagnosed cancers in 2024, accounting for 13.6% of all new cancer diagnoses in California. However, prostate cancer also had a lower mortality rate in comparison to all cancers, accounting for 7% of deaths from cancer at all sites in California in 2024. The incidence rate of prostate cancer is rising in California (98.6 per 100,000 males, 2017-2021 5-year average), though it remains lower than the national average (113.2 per 100,000 males, 2017-2021 5-year average) (National Cancer Institute, 2021).

Gender-Affirming Care

The population of people seeking gender-affirming care can be described using both identity and clinical terminology. Transgender is an identifying term describing people whose gender identity differs from their sex assigned at birth. Transgender is not a clinical diagnosis or a condition. Meanwhile, gender incongruence and gender dysphoria are clinical terms describing a persistent mismatch between gender identity and assigned sex. Gender dysphoria is a psychiatric diagnosis that refers to the psychological distress that results from an incongruence between one's sex assigned at birth and one's gender identity (American Psychiatric Association, 2025). Gender incongruence is the label for the World Health Organization (WHO) ICD-11 code that replaces outdated diagnostic codes for gender dysphoria. In the ICD-11, gender dysphoria has been moved out of the "mental and behavioral disorders" chapter and into the new "conditions related to sexual health" chapter (WHO, 2025). Not all transgender people experience or are diagnosed with gender incongruence or gender dysphoria, and not all people with these clinical diagnoses seek gender-affirming medical interventions.

There is a lack of robust, population-based prevalence data for clinically defined gender dysphoria or gender incongruence. Most available data are based on self-identified transgender status or on health system records of those who have received a clinical diagnosis, which underestimates the true prevalence of gender dysphoria and gender incongruence in the general population. Approximately 0.6% (1.6 million) of people ages 13 and older identify as transgender in the United States (Herman et al., 2022). In California, roughly 0.49% of the state population ages 18 and older identifies as transgender (Herman et al., 2022). Roughly 2% of people ages 13 to 17 years in California identify as transgender (Legislative Analyst's Office, 2023). One study found that while 1.9% of the population of youth ages 14 to 17 years self-identified as transgender, 0.9% were diagnosed with gender dysphoria (Kahn et al., 2024). Not all people who identify as transgender experience gender dysphoria or meet the clinical guidelines for the diagnosis.

Hypothyroidism and Thyroid Cancer

Hypothyroidism is a chronic endocrine condition characterized by insufficient production of thyroid hormones. There are two primary forms of endogenous hypothyroidism. Primary hypothyroidism is the most common form and results from intrinsic thyroid dysfunction, causes of which include autoimmune thyroid disease and, in iodine-deficient regions, dietary iodine insufficiency. Secondary hypothyroidism, which is less common than primary hypothyroidism, stems from pituitary or hypothalamic dysfunction impairing thyroid-stimulating hormone production.

In 2019, hypothyroidism prevalence was 11.7% among U.S. adults. Females represented a disproportionate share of cases (76.1%) compared to men (23.9%). Prevalence increases with age, particularly among people aged 50 years and older. Geographically, prevalence has stabilized in the Western United States but continues to rise in other regions (Wyne et al., 2022).

The 5-year average (2017-2021) incidence rate of thyroid cancer in California is 12.4 cases per 100,000, showing a downward trend over time. This is slightly lower than the national average of 12.9 cases per 100,000 (National Cancer Institute, 2021).

Hormone Therapy Recommendations

Menopause

In a 2022 evidence-based position statement, the North American Menopause Society (NAMS, now known as The Menopause Society) states that "[Systemic] Hormone therapy [including estrogen-only, combination estrogen-progesterone, and combination estrogen-SERM] remains the most effective treatment for VMS and GSM and has been shown to prevent bone loss and fracture. Hormone therapy risks depend on type, dose, duration of use, route of administration, timing of initiation, and whether a progestogen is used. For women aged younger than 60 years or who are within 10 years of menopause onset and have no contraindications, the NAMS states that the benefit-risk ratio is beneficial for treatment of VMS and prevention of bone loss. For women who initiate hormone therapy more than 10 years from menopause onset or who are aged older than 60 years, the NAMS states that the benefit-risk ratio is less advantageous because of the greater absolute risks of coronary heart disease, stroke, venous thromboembolism, and dementia" (NAMS, 2022).

The 2015 Endocrine Society clinical practice guidelines recommend women who decide to undergo menopausal systemic hormone therapy understand risks and benefits, including possible increased risk of breast cancer during and after discontinuing treatment. Transdermal estrogen therapy by patch, gel, or spray is recommended for women who request systemic menopausal hormone therapy and have an increased risk of venous thromboembolism. Progestogen treatment is recommended to prevent uterine cancer for women with an intact uterus taking estrogen for VMS relief but unnecessary for women who have undergone a hysterectomy (Stuenkel et al., 2015).

A recent study estimated 4.7% of postmenopausal women used hormone therapy to treat menopause symptoms (Yang and Toriola, 2024). Utilization of hormone therapy was highest among non-Hispanic White women (5.8%), followed by women of other race or ethnicity (2.8%) and Hispanic women (2.6%). Utilization rates were lowest among non-Hispanic Black women (0.5%). Of hormone therapy prescribed during the 2017-2020 period, estrogen-only formulations accounted for more than half of prescriptions (52.8%), progestogen-only formulations accounted for 10.5%, combined estrogen and progesterone accounted for 36.1%, and combined estrogen and testosterone accounted for 0.6% of prescriptions.

Breast Cancer

Hormone therapy is frequently used to help reduce the risk of hormone receptor-positive breast cancer recurrence (which accounts for about 80% of all breast cancer) and is usually taken for at least 5 years (American Cancer Society, 2024; Penn Medicine, 2025). Types of hormone therapy that may be used include selective estrogen receptor modulators (SERMs) (i.e., Tamoxifen), selective estrogen receptor degraders, and aromatase inhibitors.

Women who have been diagnosed with breast cancer may be on one medication for an extended period of time or may switch from one medication to another after a period of time. For example, a woman who has gone through menopause before diagnosis may be on tamoxifen for 2 to 3 years, followed by an aromatase inhibitor for another 2 to 3 years (American Cancer Society, 2024). The most common side effects include hot flashes, vaginal dryness or discharge, and changes in the menstrual cycle. Rare, but more serious side effects include blood clots, increased risk of developing endometrial cancer and uterine sarcoma, eye problems such as cataracts, and impacts on bone density (thinning in pre-menopausal women and strengthening in post-menopausal women) (American Cancer Society, 2024).

In a study of 7,777 women age 20+ years diagnosed with stage I-III hormone receptor-positive breast cancer between 2001 and 2016, 81.4% initiated any endocrine (hormone) therapy. Women in the study who were least likely to initiate hormone therapy were older, Black, and had stage I disease (Bowles et al., 2022).

Prostate Cancer

Hormone therapy may be used during the course of treatment for prostate cancer, including to shrink the size of the cancer to make treatment more effective (American Cancer Society, 2023). There are surgical and clinician-administered

forms of hormone therapy, as well as daily pills, such as anti-androgens (also called androgen receptor antagonists). These medications can cause side effects from lower levels of hormones such as testosterone, including low libido, erectile dysfunction, hot flashes, breast tenderness and growth of breast tissue, osteoporosis, anemia, decreased mental sharpness, loss of muscle mass, weight gain, fatigue, increased cholesterol levels, and depression or mood swings.

Gender-Affirming Care

Transgender people may seek hormone therapy and/or surgical interventions as part of their gender-affirming care. Gender-affirming hormone therapy (GAHT) is a treatment in which people take hormones such as estrogen or testosterone, or hormone blockers, that help achieve physical characteristics that are more masculine or feminine (Johns Hopkins Medicine, n.d.). GAHT can be part of a presurgical or postsurgical plan, or a stand-alone service. The Endocrine Society recommends that for the pediatric population on GAHT, patients are monitored every 3 to 6 months for physical assessment and every 6 to 12 months for lab assessment (Hembree et al., 2017). In the adult population on GAHT, monitoring is recommended one to two times per year for physical and lab assessments. An extended supply of hormone therapy may be appropriate for both adolescent and adult patients at the prescriber's discretion. "GAHT for gender affirmation is a lifelong treatment for some people. Other people may take hormones for a period of time, until they achieve their desired changes, then stop" (Johns Hopkins Medicine, n.d.). GAHT for those assigned female at birth (testosterone) or assigned male at birth (estrogens, progestins, and androgen blockers) may be associated with increased risk of cardiovascular events such as stroke, venous thromboembolism, and myocardial infarction (Poteat et al., 2023), although additional research has suggested that transgender people experience significant stressors that affect cardiovascular health across the lifespan, and these risks are not clearly attributable to GAHT (Streed et al., 2021) .

The share of people who identify as transgender and also receive hormone therapy varies by survey. One estimate finds that 31% of transgender adults have pursued hormone therapy as part of their gender transition (Kirzinger et al., 2023), while another finds that 56% received hormone therapy (Rastogi et al., 2025). Among the 56%, a majority (90%) were still taking hormones at the time of the survey.

Hormone therapy is generally less costly and more accessible than gender-affirming surgeries, making it a more commonly utilized intervention. Clinical studies suggest hormone therapy significantly improves mental health outcomes and quality of life (Restar et al., 2022).

Hypothyroidism and Thyroid Cancer

Hormone therapy is used to replace the function of a thyroid gland that is underactive or has been surgically removed (hypothyroidism, treated with replacement therapy) or to prevent further growth of thyroid tissue (suppression therapy), typically to prevent recurrence or progression of thyroid cancer (American Thyroid Association, n.d.). The medication dose may need to be adjusted periodically (American Thyroid Association, n.d.). There are several brand names of thyroid hormones available, but in general, it is recommended to stay on the same brand or the same manufacturer of a generic for consistency; hormone levels should be rechecked if a switch occurs. Most patients taking T4 tolerate the medication without adverse effects, but occasional patients experience headaches, palpitations, anxiety, and other nonspecific symptoms (Jonklaas et al., 2014).

According to a study combining data from the National Health and Nutrition Examination Survey and claims from 2009 to 2019 (Wyne et al., 2022), approximately 78.1% of patients diagnosed with hypothyroidism were treated with the hormone therapy levothyroxine (T4 replacement). A smaller share (3.3%) used T3/T4 combination therapy. According to another study using the National Health and Nutrition Examination Survey from 2007 to 2012, approximately 14% of people diagnosed with hypothyroidism remained untreated in 2019, an increase from 11.8% in 2012 (Wyne et al, 2022). Women and adults aged 70 years and older are more likely to receive thyroid hormone therapy, whereas Hispanic individuals, men, and younger adults show lower treatment rates (Ettleson et al., 2021). Health care access is strong associated with thyroid hormone use (Ettleson et al., 2021).

Disparities in Access to and Use of Hormone Therapy

Menopause

There is considerable variation in the treatment of menopause symptoms among racial/ethnic groups. Black women are half as likely compared to White women to use menopause hormone therapy (Hess et al., 2008; SWAN, 2023). Other evidence indicates that clinicians are less likely to prescribe menopause hormone therapy for Black women (Blanken et al., 2022). Racial/ethnic differences in menopause symptoms may be related to racial/ethnic differences in health problems, physical inactivity, stress, financial strain, and discrimination (Green and Santoro, 2009). For more detailed information, see CHBRP's analysis of AB 432 Menopause.

Breast Cancer

Research indicates that disparities also exist in breast cancer treatment. One study found that, in California, Medicaid enrollees and Black women were less likely to receive concordant care for breast cancer, across age groups, after controlling for factors such as race/ethnicity, income, education, and urbanicity (Hassett et al., 2016).

Prostate Cancer

Access and use of hormone therapy for prostate cancer varies by demographic factors. Over one in five patients (23.1%) with newly diagnosed prostate cancer in California did not receive hormone therapy. Rates of androgen deprivation therapy were lower among men residing in neighborhoods with lower socioeconomic status and non-Hispanic Black men, compared to those from higher socioeconomic levels or White and Asian men (Benjamin et al., 2024). Additionally, Black men have lower rates of novel hormone therapy treatment for advanced prostate cancer use compared to White men (Ma et al, 2023, Benjamin et al., 2024; Ma et al., 2023).

Gender Affirming Care

Transgender adults report barriers to consistent hormone therapy use for gender-affirming care. In a survey of transgender adults, reasons for underuse of prescribed hormone therapy included cost (17.7%), transportation barriers to get a prescription (13.0%), health insurance issues (e.g., lack of insurance, delay in approval, changes in in-network provider) (7.4%), and pharmacy-related issues (e.g., delays or unavailability of refills, being stigmatized by the pharmacist) (3.7%) (Restar et al., 2022). Inconsistent use or disruptions in care can lead to worse health outcomes. For instance, a study by Todorovic in 2021 found that disruptions in hormonal care among already depressed transgender and nonbinary people in Canada during the COVID-19 pandemic was associated with increased depressive symptoms (Todorovic, 2021).

Research demonstrates that transgender and nonbinary people face a variety of financial, socioeconomic, cultural, and geographic barriers in accessing quality gender-affirming care, including transportation-related barriers and greater distances in access to care (Johnstone et al., 2023; McGarity-Palmer and Saw, 2022). One survey found that 35% of transgender people reported difficulty in finding health care at a location that is easy for them to get to, compared to 21% of cisgender people (Kirzinger et al., 2023). In another survey of 322 transgender and nonbinary people living in Los Angeles, 25% reported that they missed medical appointments due to transportation issues, and 32% did not agree that the distance and time it took them to get to a health center was appropriate (Herman et al., 2024). However, research on barriers to accessing to prescriptions, rather than clinic-based care, is sparse. Recent news suggests that transgender people may be experiencing new challenges in accessing care at preferred, nearby locations (Bisharyan, 2024). Recent federal actions aiming to restrict gender-affirming care, particularly for minors, have further impacted the availability of care in California (see *Policy Context* for more detail). CHBRP's consultation with experts also indicates that pharmacists are increasingly refusing to fill prescriptions for hormone therapy that may be used for gender-affirming care.[17]

[17] Content expert consultations, July 14 and July 29, 2025.

Hypothyroidism and Thyroid Cancer

Disparities are evident among rural populations, where people with thyroid cancer are more likely to present with advanced disease, experience higher mortality rates, and are more frequently lost to follow-up (Huston-Paterson et al., 2024). Medicaid expansion has been associated with improved surgical access for thyroid cancer patients in expansion states, including increased treatment at high-volume hospitals (Greenberg et al., 2022).

Summary of the Literature Regarding Disbursing Extended Duration of Medications

CHBRP searched for literature that examined the impact of disbursing extended duration of medications and identified a limited number of relevant articles. CHBRP did not identify any articles relevant to the universe of hormone therapies subject to SB 418 and, thus, included studies pertaining to conditions treated with other medications. Of the four articles identified, two articles examined the impact of laws that permitted dispensing of 12-month supply of contraceptives, and two articles examined the impact of extended duration dispensing for primary care or chronic condition management, one of which was a systematic review. CHBRP included descriptions of studies that compared shorter dispensing periods as compared with 1-month dispensing periods to provide a sense of potential impacts that would occur due to SB 418. The search was limited to studies published from 2015 to the present. Outcomes of interest included utilization of medications, adherence, adverse events and harms, health outcomes, and medication wastage.

Medication adherence

A 2018 systematic review examined the impact of longer-duration (2 to 4 months) versus shorter-duration (28 day) prescriptions on medication adherence, medication waste, health outcomes, and adverse events in primary care settings (King et al., 2018). The review identified 13 studies conducted in the United States, of which nine studies reported on medication adherence. The studies consistently found longer prescription lengths were associated with greater medication adherence. Three cohort studies found that prescription lengths of <90 days were associated with poorer adherence across a range of therapeutic areas based on adherence using a <80% threshold. An additional three cohort studies found similar associations based on mean reduction in adherence. The last three studies identified in the systematic review also included statistically significant findings regarding improved medication adherence with longer duration length. Although the authors did not identify any direct evidence examining health outcomes or adverse events – nor did CHBRP – indirect evidence suggests that medication adherence is positively correlated with health outcomes, and therefore, longer duration prescriptions may be associated with improved health outcomes (King et al., 2018).

As summarized in CHBRP's analysis of Senate Bill 999 Contraceptives: Annual Supply in 2016, findings from a 2011 study indicated that women who were given a 12-month supply of oral contraception had a reduced risk of unintended pregnancy (1.2% of women who received a 12-month supply and 3.3% of women who received a 3-month supply) (Foster et al., 2011). There was an associated 30% decrease in the odds of having an unintended pregnancy, as well as a 46% decrease in the odds of an abortion when dispensing a 12-month supply compared to dispensing 1- or 3-month supplies (Foster et al., 2011).

In a retrospective cohort study examining claims data from a large pharmacy benefit manager for commercially insured women from 2018 to 2019, Peasah et al. (2021) examined the impact of benefit mandates that permitted up to a 12-month supply of contraceptives to be dispensed at one time. Approximately 34% of the women included in the study lived in states with a benefit mandate (total number of women with oral contraceptive claims, excluding those with emergency contraceptive claims, were 874,420 in 2018 and 875,914 in 2019). In states with mandates, <1% of women with an oral contraceptive claim received a 6- or 12-month supply of oral contraceptive pills. This study examined the share of women with oral contraceptive claims who had a gap in prescription supply of 7 or more days and 14 or more days, indicating lack of full adherence. Women who received a 12-month supply of contraception were significantly less likely to experience a

gap in their prescription supply.[18] Approximately 29% of women who received a 12-month supply of contraceptive experienced a gap of 7 or more days, while 63% of women who received a 30-day supply experienced a gap of more than 7 days. When looking at gaps of 14 or more days, 23% of women who received a 12-month supply and 40% of women who received a 30-day supply had a gap in medication.

Evidence suggests that dispensing extended durations of medications may improve adherence to medications and lead to improved health outcomes. CHBRP identified one systematic review that included nine studies that found longer-duration prescriptions were associated with higher medication adherence for specified chronic conditions and one study that found longer-duration of oral contraception was associated with improved adherence and decreased rates of unintended pregnancy. One additional study found that extended-duration dispensing of contraception resulted in fewer gaps in prescription supply. However, the generalizability of these studies to the hormone therapies that would be impacted by SB 418 is limited because the medications are different types of medications, and the time periods included within the study that examined chronic condition medication use was substantially shorter than 12 months.

Pharmaceutical waste

Patients commonly change their drug treatment for medical reasons. Changes can occur for reasons including (but not limited to) adjustments to prescribed dosage, drug form, or prescribed drug within a class. This can sometimes lead to medications going unused – or wasted – if a patient makes a change before their current supply ends.

Peasah et al. (2021) reported women who received a 6- or 12-month supply were significantly less likely to experience an interruption in or discontinue their prescription as compared with women who received a 1- or 3-month supply. Approximately 8% of women who received a 6- or 12-month supply (fewer than 20 women) switched to a generic and 2% of women switched to an alternative method of contraceptive. This resulted in an average days' supply wasted of 12 days for those who switched to generics and 3 days for those who switched to an alternative method. These rates are higher than for women who received a 3-month supply of oral contraceptive pills (average days' supply wasted was 1.6 days for those who switched to generics and 0.3 for those who switched methods), although overall rates of switching among women who received a 3-month supply were lower (2% of women switched to a generic alternative and <1% of women switched to an alternative method). While adherence rates are higher among women with longer duration prescriptions as compared with women with shorter prescriptions, medication waste is also higher because of the amount of medication the women have received.

A retrospective, multiple cohort study of primary care prescriptions in the United Kingdom examined medication wastage due to longer supply dispensing (<60 days compared with ≥60 days) of oral drugs for five categories among random samples of 50,000 patients each: glucose control in type 2 diabetes, hypertension in type 2 diabetes, statins in type 2 diabetes, secondary prevention of myocardial infarction, and depression (Doble et al., 2017). For four of the five medication types, the proportion of days' supply wasted was larger for the longer prescription group as compared with the shorter prescription group; for the cohort taking depression medications, the shorter prescription group had a higher proportion of medication wastage as compared with the longer prescription group. When looking at total unnecessary costs (defined as the cost of medication wastage, dispensing fees, and prescriber time), the authors also found that there was an overall annual savings for the longer prescription group of $44.90 to $64.62[19] per patient per year, assuming patients would receive three prescriptions of 120-day supply instead of 12 prescriptions of 30-day supply.

In King et al.'s 2018 systematic review, six studies included outcomes of medication waste, and the results varied by study. Two studies generally found there was a non-statistically significant difference in medication wastage between patients with shorter-duration and longer-duration prescriptions, and three studies found that shorter-duration prescriptions were statistically significantly associated with a mean reduction in waste days as compared with longer-

[18] Unpublished data provided by S. Peasah on July 22, 2025.
[19] Authors reported a savings of £25.14-£36.18 in 2017. CHBRP converted these estimates to 2025 £, then to US Dollars.

duration prescriptions. Two studies did not report information on statistical significance. These studies were also of very low quality, according to King et al.

There is a dearth in literature that examines the impact of dispensing extended duration of medications on pharmaceutical waste. Among the conditions included in the identified studies, two studies found that pharmaceutical wastage was statistically significantly higher among patients with longer-duration prescriptions and a systematic review including six studies of low quality found mixed results. The available evidence suggests that medication waste exists when patients are given a longer duration; however, the generalizability to the medications that would be impacted by SB 418 is limited.

Reasons for Treatment Interruptions and Impact on Health Outcomes

Patients may discontinue medications for a variety of reasons. Among women diagnosed with breast cancer taking hormone therapy, hormone therapy related symptoms were the most reported reasons for interrupting or discontinuing medication (Mao et al., 2020). Mao et al. found just over one-quarter of women (27.9%, n = 56 women) experienced at least one treatment interruption (defined as a gap of 14 or more days and <180 days) or early discontinuation. Five women experienced a refill-related issue, and three self-initiated a hold on their treatment. Most patients who experienced a treatment interruption did so within the first year of treatment (63.8%) and <15% experienced an interruption within the second year of treatment. Another study found approximately 42% of younger women (mean age 37 years) who were treated with tamoxifen interrupted treatment within the first 2 years, and 40% of those women did not restart therapy during the study period (Cluze et al., 2012). Treatment interruptions within the first 16 months after breast cancer diagnosis, which occurred among 13% of women, were more frequent among women with less social support and those who considered the information they received about hormone therapy was not understandable. Interruptions within the next 16 to 28 months after breast cancer diagnosis, which occurred among 34% of women, were associated with poor social support, treatment side effects, and no longer fearing cancer relapse. Both studies found the median time to interruption was more than 6 months.

CHBRP found one study that examined the health impacts of treatment interruptions for women who have been diagnosed with breast cancer. Hsieh et al. (2014) found that treatment interruptions of hormone therapy for breast cancer were significantly associated with increased mortality (hazard ratio 1.32, P<0.0001). Analysis also showed that the number of prescription gaps were associated with an increased mortality risk, as were interruptions in the first or second year of treatment.

A 2024 systematic review found that among persons using GAHT, <10% of the study population in five of six studies discontinued GAHT (Gupta et al., 2024). Of the two studies that included reasons of discontinuation, one study found the 5.3% discontinuation rate among a pediatric population was due to changes in gender identity, while the other study that included both pediatric and adult participants found the discontinuation rate of <2% was due to changes in gender identity, financial barriers, venous thrombosis, bullying by peers, and desire for pregnancy. In a recent 2025 study, Boskey et al. examined GAHT discontinuation among transgender adolescents. Of the study population (N = 1,050), 93% had been on GAHT continuously, 2% had an interruption of more than 3 months before restarting treatment, and 4% discontinued GAHT. Reasons for discontinuation included that the person achieved gender expression or embodiment goals (n = 14), gender evolution (n = 6), return to gender identity associated with assigned sex at birth (n = 5), concerns about side effects or undesired effects (n = 5), other or unknown reasons (n = 5), and difficulty in taking GAHT (n = 2). Among participants who restarted GAHT after the interruption, reasons for the interruption were difficulty accessing GAHT (n = 6), other or unknown reasons (n = 6), difficulty taking GAHT (n = 5), and concerns about side effects or undesired effects (n = 3).

Among patients who experience an interruption in treatment, some patients reported the reason for the interruption was related to difficulty accessing the medication or refill-related issues. Additionally, one study found treatment interruptions for women who have been diagnosed with breast cancer and are taking hormone therapy were significantly associated with an increase in mortality.

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Benefit Coverage, Utilization, and Cost Impacts

As discussed in the *Policy Context* section, SB 418 would require health plans and policies regulated by DMHC or CDI, CalPERS health plans, and Medi-Cal Rx beneficiaries enrolled in DMHC-regulated plans or County Organized Health System plans (COHS) to cover up to a 12-month supply of an FDA-approved prescription hormone therapy and the necessary supplies for self-administration. SB 418 would allow an enrollee to receive an eligible hormone therapy, prescribed by a network provider and dispensed by a provider or pharmacists or at a location licensed or otherwise authorized to dispense drugs or supplies, for up to 12 months at one time.

This section reports the potential incremental impacts of SB 418 on estimated baseline benefit coverage, utilization, and overall cost.

How does utilization impact premiums?

Health insurance, by design, distributes risk and expenditures across everyone enrolled in a plan or policy. It does so to help protect each enrollee from the full impact of health care costs that arise from that enrollee's use of prevention, diagnosis, and/or treatment of a covered medical condition, disease, or injury. Changes in utilization among any enrollees in a plan or policy can result in changes to premiums for all enrollees in that plan or policy.

Analytic Approach and Key Assumptions

Given the breadth of hormone therapies subject to SB 418, CHBRP used publicly available drug formularies to estimate the baseline level of coverage for FDA-approved prescription hormone therapies. Formularies indicated that all enrollees in regulated plans or insurance policies had broad coverage for dispensing 30-day or 90-day supplies. At baseline, no enrollees are estimated to have coverage for dispensing 12-month (360-day) supplies. SB 418 would increase the amount of hormone therapy that can be dispensed at once, but it would not impact the number of refills that clinicians may include on a prescription (prescriptions may be up to one year under current law).[20]

CHBRP made several assumptions to inform its analysis of SB 418 cost impacts, separated below by those that apply to baseline utilization and cost and those that apply to postmandate utilization and cost.

The following assumptions were made to model baseline utilization and cost:

- Mandates that reference plans and policies that cover prescription drugs, such as the mandates addressed by SB 418, are only relevant to outpatient pharmacy benefit coverage and not medical benefit coverage. Drugs that are clinician-ordered and administered under the supervision of a clinician (generally in a hospital, a provider's office, infusion center, or similar medical facility), along with the hospital stay or office visit, are generally covered through a medical benefit. Pharmacy benefits cover outpatient prescription drugs by covering scripts that are generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy.
- Given the breadth of drugs subject to SB 418, CHBRP is unable to confirm that every insurer subject to the bill covers every possible hormone therapy subject to SB 418 that is currently on the market.[21] Based on information provided in Medi-Cal Rx (DHCS, 2025), Kaiser Commercial HMO (Kaiser Permanente, 2025b), and Kaiser Marketplace (Kaiser Permanente, 2025a) drug formularies as well as responses to carrier surveys, CHBRP has assumed that all plans and policies subject to SB 418 cover all FDA-approved prescription hormone therapies applicable to SB 418.

[20] Some exclusions apply. See the *Policy Context* section for details on which hormone therapies are and are not subject to SB 418.
[21] This is inclusive of, but not limited to, hormone therapies for the diseases and conditions listed in the *Background* section above: menopause, breast cancer, prostate cancer, gender dysphoria and gender incongruence, hypothyroidism, and thyroid cancer. Additional conditions treated with hormone therapy are captured here.

- CHBRP has assumed that no enrollees have coverage for a 12-month (360-day) supply of an FDA-approved prescription hormone therapy to be dispensed all at once (other than hormonal contraceptives, which are currently covered for 12-month dispensing under state law).
- SB 418 includes language that restricts the use of utilization management to deny coverage for hormone therapy. This could have cost implications for health plans that currently deny coverage using these practices. CHBRP is unable to quantify the magnitude of this impact due to a lack of data on utilization management practices.
- SB 418 is inclusive of all conditions and diseases that can be treated by a self-administered, non-refrigerated, FDA-approved prescription hormone therapy being used as indicated or as supported by clinical recommendations or expert consensus. SB 418 is not inclusive of testosterone, as it is a controlled substance.
- As of January 1, 2022, outpatient prescription drugs are covered on a fee-for-service basis by DHCS for all Medi-Cal beneficiaries through the Medi-Cal Rx program. Their pharmacy benefit is "carved out" of the coverage provided by Medi-Cal managed care plans. However, CHBRP has included Medi-Cal Rx in its analysis of SB 418 per language in Section 7, which amends the Welfare and Institutions Code to require coverage of the benefit mandate by the Medi-Cal Program. CHBRP's Medi-Cal unit cost data comes from the California Medicaid LOB contributor Rx database. CHBRP's estimate of the cost impact of SB 418 on Medi-Cal is susceptible to change dependent upon negotiations between DHCS and Medi-Cal Rx contractors.

Should any of these assumptions listed above be incorrect – in particular, if plans and policies do not include coverage for certain high-cost hormone therapies or new high-cost hormone therapies enter the market and are not covered – the impact of the bill may be different.

The following assumptions were made to model postmandate utilization and cost:

- Visits to clinicians, during which patients usually obtain prescriptions for additional refills, would occur as often postmandate, since dispensing a 12-month (360-day) supply would not alter drug side effects or patient monitoring schedules.
- As SB 418 does not require clinicians to issue prescriptions that dispense a 12-month drug supply, CHBRP has assumed that postmandate, clinicians would largely maintain prescribing patterns that they deemed medically appropriate and may change these as needed on a patient-by-patient basis.
- The change in the timing of prescriptions may alter pharmacy dispensing costs but would be too small to alter the unit cost of each drug affected by SB 418.
- While some people would switch to a 12-month supply of hormone therapy dispensed at once postmandate, CHBRP has assumed that the total amount of hormone therapy prescribed would only change due to changes in pharmaceutical waste. While there is a broader definition of pharmaceutical waste (see *Policy Context* section), CHBRP's analysis considers waste to be dispensed but unused drugs. Waste may occur when changes in prescribed dose (which includes ceasing use of a given drug, thus essentially switching to a zero dose), drug form, or drug type within a therapeutic class occur before the previously dispensed medication has been fully used. For example, a person who receives a 12-month supply of hormone therapy in January but switches to a different drug within the same therapeutic class[22] in March would waste 9 months of medication, since the previously dispensed drug is no longer appropriate for the patient to continue taking. For this analysis, waste is identified through claims-based reported changes within therapeutic classes among people continuously using prescription hormone therapy for at least 10 months. CHBRP is not accounting for people who stop hormone therapy altogether, since such individuals are unlikely to switch to a 12-month supply.
- CHBRP has assumed that a small proportion of people currently receiving hormone therapy for 10 to 12 months per year via multiple refills in 1 year are likely to switch to 12-month prescriptions postmandate. CHBRP has

[22] See Appendix C for a list of therapeutic classes used.

assumed that 2%[23] of these people would switch to a 12-month supply postmandate, with the exception of those receiving hormone therapy for gender-affirming care. CHBRP has estimated that approximately 10% of people receiving gender-affirming care would be deemed medically appropriate to receive a prescription with an extended dispensing period and that, of those individuals, 90% are likely to opt for 12-month dispensing, given current restrictions in access to hormone therapy for this population (see *Policy Context* for details).[24] CHBRP estimates such individuals make up approximately 0.015% and 0.014% of enrollees in commercial and Medi-Cal plans, respectively. Thus, CHBRP assumes 0.09% of all enrollees with health insurance subject to SB 418 in commercial and Medi-Cal plans would opt for 12-month prescriptions.

For further details on the underlying data sources and methods used in this analysis, please see Appendix C.

Baseline and Postmandate Benefit Coverage

As discussed in the *Policy Context* section, SB 418 would apply to state-regulated health insurance, including commercial enrollees, enrollees with insurance through CalPERS, and Medi-Cal beneficiaries enrolled in DMHC-regulated plans. It should be noted that DMHC regulates the plans and policies of approximately 74% of enrollees associated with CalPERS, and 80% of Medi-Cal beneficiaries, in addition to commercial enrollees.[25]

Of the total enrollees subject to state benefit mandates, most but not all are enrolled in plans with pharmacy benefits. Only those plans with pharmacy benefits can be considered out of compliance with SB 418. Of those with a pharmacy benefit, no plans currently cover 12 months dispensed at once of the hormone therapies addressed in SB 418. Under the SB 418 mandate, all of these plans would cover 12-month prescriptions of eligible hormone therapies to be dispensed at once.

Below, Table 1 provides estimates of how many Californians have health insurance that would be required to comply with SB 418 in terms of benefit coverage.

Table 1. Impacts of SB 418 on Benefit Coverage, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	24,116,000	24,116,000	0	0.00%
Total enrollees with health insurance subject to SB 418	23,494,000	23,494,000	0	0.00%
Percentage of enrollees with coverage for 12-month dispensing of hormone prescriptions (% of total) (b)	0%	100%	100%	100.00%
Number of enrollees with fully compliant coverage for 12-month dispensing of hormone prescriptions	0	23,494,000	23,494,000	100.00%

Source: California Health Benefits Review Program, 2025.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal. The 655,000 difference reflects enrollees without pharmacy benefits.[26]

[23] When Californians on Medicaid were offered the opportunity to obtain up to 12 months of hormonal contraception at a time, switchers were estimated at 7.17 percentage points (Rodriguez et al., 2024). Apart from those receiving hormone therapy as part of gender-affirming care, CHRBP assumes a smaller proportion of all hormone users, approximately 2%, who have used hormone therapy for at least 10 months (sum of all hormone therapy dispensed) in the previous year would choose to switch to 12-month (360-day) prescription dispensing. This lower estimate is consistent with expert opinion and is used given a lack of known literature applicable to the conditions examined in this analysis. In addition, most patients are able to get refills that cover 12 months without extra out-of-pocket drug costs or excessive utilization management and thus would be using larger amounts of hormones dispensed at once for convenience. The actual percentage of patients who switch to a 12-month supply of hormone therapy may be higher or lower than 2%.
[24] Content expert consultations, July 14 and July 29, 2025.
[25] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*.
[26] For more detail, see CHBRP's resource, *Sources of Health Insurance in California*.

(b) Excluding hormonal contraceptives, as they are covered for 12 months at once by existing law.

Baseline and Postmandate Utilization and Unit Cost

Baseline utilization of 12-month dispensing of hormone prescriptions is currently zero due to existing limits on prescribing and coverage (for additional information, see the *Policy Context* section). Access to 12-month dispensing supplies would increase postmandate to include all enrollees in plans and policies subject to state mandates that have pharmacy benefits. CHBRP assumes that overall utilization would not change, except for changes in utilization that are due to pharmaceutical waste.

CHBRP estimates that pharmaceutical waste would occur among a small proportion of enrollees who received a 12-month supply of their original prescription(s) and then switched to a new prescription before using all of their previously acquired drugs. As noted in the *Background* section, switches in drug treatment commonly occur for medical reasons including, but not limited to, changes in the prescribed dosage of the drug(s) currently used, changes in the form of the drug(s) currently used, or changes in prescribed drug(s) within a therapeutic class.[27] These common, medically based reasons for changing treatment would not be impacted by SB 418. However, among people who opt for 12-month (360-day) dispensed drug supplies, SB 418 may result in additional drug costs postmandate that may not occur if prescriptions were limited to a shorter time period, as waste is currently limited by the smaller amounts of drugs that can be dispensed at once. CHBRP estimated pharmaceutical waste using actuarial models based on claims data to determine the total population impacted, the percent of scripts wasted at baseline, the average day waste begins, and assumed changes postmandate,

Based on these models, CHBRP estimates that 0.09% of all enrollees with health insurance subject to SB 418 would opt for prescriptions that allow for 12-month supplies to be dispensed at once. Since additional waste is commensurate with shifts in the distribution of dispensing periods, waste measured by total days of wasted drugs would increase by approximately 0.10% among commercial enrollees and 0.11% among Medi-Cal beneficiaries who use hormone therapy and who opted for 12-month supplies to be dispensed at once.

No impact on unit cost is expected due to SB 418.[28] This is because clinician drug prescribing activities are not a separately billed expenditure to health insurance. In addition, while drug dispensing fees by pharmacies are indirectly included in drug costs, CHBRP assumes any change in the volume of prescriptions would be too small to appreciably alter these costs for any given drug. CHBRP also assumes that visits to clinicians, during which patients usually obtain prescriptions for additional refills, would occur just as often postmandate, as SB 418 would not alter drug side effects or patient monitoring schedules, nor would it extend the validity of a prescription beyond one year.

Baseline and Postmandate Expenditures

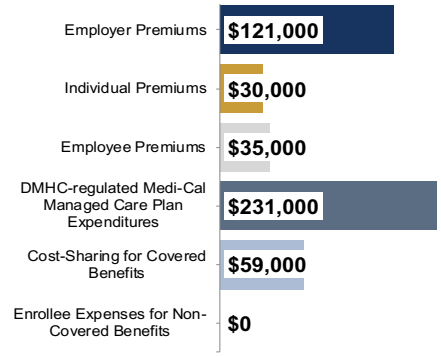
For DMHC-regulated plans and CDI-regulated policies, SB 418 would increase total premiums paid by employers and enrollees for newly covered benefits. Enrollee expenses for covered benefits would increase. This would result in an increase of total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies (Figure 2).

[27] Therapeutic classes are listed in Appendix C.
[28] While this assumption is contrary to the findings of Doble et al. (2017), Doble et al were analyzing the completely socialized medical system of the United Kingdom, where all prescribing costs, pharmacy dispensing costs, and drug costs were covered by the same payer. In the California medical system analyzed here, prescribing costs are not a separately billed activity to health insurance and pharmacy dispensing costs are not directly covered by health insurance.

CHBRP estimates total expenditures would increase by $476,000 (<0.01%) due to SB 418.

Below, Table 2 provides estimates of the impacts of SB 418 on expenditures, which include premiums, enrollee cost sharing, and enrollee expenses for noncovered benefits.

Figure 2. Expenditure Impacts of SB 418



Source: California Health Benefits Review Program, 2025.
Key: DMHC = Department of Managed Health Care.

Table 2. Impacts of SB 418 on Expenditures, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$68,752,638,000	$68,752,750,000	$112,000	<0.01%
CalPERS employer (b)	$7,881,873,000	$7,881,882,000	$9,000	<0.01%
Medi-Cal (includes COHS) (c)	$38,851,492,000	$38,851,723,000	$231,000	<0.01%
Enrollee premiums				<0.01%
Enrollees, individually purchased insurance	$21,757,790,000	$21,757,820,000	$30,000	<0.01%
Outside Covered California	$6,011,399,000	$6,011,408,000	$9,000	<0.01%
Through Covered California	$15,746,391,000	$15,746,412,000	$21,000	<0.01%
Enrollees, group insurance (d)	$21,712,866,000	$21,712,901,000	$35,000	<0.01%
Enrollee out-of-pocket expenses				<0.01%
Cost sharing for covered benefits (deductibles, copays, etc.)	$18,992,422,000	$18,992,481,000	$59,000	<0.01%
Expenses for noncovered benefits (e) (f)	$0	$0	$0	<0.01%
Total expenditures	$177,949,081,000	$177,949,557,000	$476,000	<0.01%

Source: California Health Benefits Review Program, 2025.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.

(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 54.0% are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes Medi-Cal beneficiaries enrolled in DMHC-regulated plans and COHS managed care. CHBRP assumes that premiums for Medi-Cal beneficiaries in COHS managed care are comparable to those for Medi-Cal beneficiaries in DMHC-regulated plans.
(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.

(e) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
(f) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

Premiums

At the end of this section, Table 3 and Table 4 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

Changes in premiums as a result of SB 418 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 1, Table 3, and Table 4), with health insurance that would be subject to SB 418.

Commercial

The largest shifts in annual premiums would occur among CDI-regulated small group and individual plans as well as DMHC-regulated small group plans, with an increase of $0.0013. The smallest shift in annual premiums would occur among DMHC-regulated large group and individual plans and CDI-regulated large group plans, with an increase $0.0011.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, the increase in annual premiums would be exactly one-tenth of a cent ($0.0010).

Medi-Cal

For Medi-Cal Rx beneficiaries enrolled in DMHC-regulated plans and COHS, the increase in annual premiums would be almost two-tenths of a cent ($0.0018). This is due to differences in the age distribution of people covered by Medi-Cal relative to other plans.

Enrollee Expenses

CHBRP projects no change to copayments or coinsurance rates but does project an increase in utilization of 12-month supplies of prescription hormone therapy and, therefore, an increase in enrollee cost sharing due to pharmaceutical waste. Some enrollees would likely purchase more pharmaceuticals than they will use, thus incurring additional expenses from copayment and coinsurance.

It is possible that some enrollees currently incur expenses related to hormone therapy for which coverage is denied (i.e., through utilization management). CHBRP cannot estimate the frequency with which such situations occur and so cannot offer a calculation of impact.

Average enrollee out-of-pocket expenses per user

Postmandate, the average enrollee expense would be $0.0003 to $0.0004 among DMHC-regulated and CDI-regulated plans, $0.0003 for CalPERS plans, and zero for Medi-Cal. Only enrollees who procured 12-month supplies of prescribed hormone therapy and then switched to a different dose, drug format, or drug type before their previously prescribed therapy was used up would experience increased annual out-of-pocket expenses. CHBRP is unable to estimate change in annual out-of-pocket expenses due to the large variation in drugs used.

Postmandate Administrative and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 2, Table 3, and Table 4), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 418.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of SB 418.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

CHBRP does not expect lack of benefit coverage to result in cost shift to other payers as a result of SB 418.

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Table 3. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Includes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65 Years	*65+ Years*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,034,000	2,076,000	2,181,000	914,000	9,508,128	1,037,872	264,000	65,000	36,000	24,116,000
Total enrollees in plans/policies subject to SB 418	8,034,000	2,076,000	2,181,000	914,000	9,508,128	1,037,872	264,000	65,000	36,000	24,116,000
Premiums										
Average portion of premium paid by employer (e)	$557.33	$507.76	$0.00	$718.62	$276.79	$583.72	$609.11	$567.83	$0.00	$115,486,003,000
Average portion of premium paid by enrollee	$145.58	$212.63	$818.51	$139.09	$0.00	$0.00	$224.25	$185.49	$777.47	$43,470,656,000
Total premium	**$702.91**	**$720.39**	**$818.51**	**$857.71**	**$276.79**	**$583.72**	**$833.35**	**$753.32**	**$777.47**	**$158,956,659,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$64.42	$164.36	$272.54	$81.59	$0.00	$0.00	$122.99	$249.30	$173.93	$18,992,422,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0
Total expenditures	**$767.33**	**$884.75**	**$1,091.05**	**$939.30**	**$276.79**	**$583.72**	**$956.34**	**$1,002.63**	**$951.40**	**$177,949,081,000**

Source: California Health Benefits Review Program, 2025.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[29] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes Medi-Cal beneficiaries enrolled in DMHC-regulated plans and COHS managed care. CHBRP assumes that premiums for Medi-Cal beneficiaries in COHS managed care are comparable to those for Medi-Cal beneficiaries in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[30]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

[29] For more detail, see CHBRP's resource *Estimates of Pharmacy Benefit Coverage in State-Regulated Health Insurance.*
[30] For more detail, see CHBRP's resource *Sources of Health Insurance in California.*

Table 4. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Includes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65 Years	*65+ Years*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,034,000	2,076,000	2,181,000	914,000	9,508,128	1,037,872	264,000	65,000	36,000	24,116,000
Total enrollees in plans/policies subject to SB 418	8,034,000	2,076,000	2,181,000	914,000	9,508,128	1,037,872	264,000	65,000	36,000	24,116,000
Premiums										
Average portion of premium paid by employer (e)	$0.0009	$0.0009	$0.0000	$0.0008	$0.0018	$0.0018	$0.0008	$0.0010	$0.0000	$352,000
Average portion of premium paid by enrollee	$0.0002	$0.0004	$0.0011	$0.0002	$0.0000	$0.0000	$0.0003	$0.0003	$0.0013	$65,000
Total premium	$0.0011	$0.0013	$0.0011	$0.0010	$0.0018	$0.0018	$0.0011	$0.0013	$0.0013	**$416,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0004	$0.0004	$0.0004	$0.0003	$0.0000	$0.0000	$0.0003	$0.0004	$0.0004	$58,000
Expenses for noncovered benefits (f)	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$0
Total expenditures	$0.0015	$0.0016	$0.0015	$0.0013	$0.0018	$0.0018	$0.0015	$0.0017	$0.0017	**$475,000**
Percent change										
Premiums	0.0002%	0.0002%	0.0001%	0.0001%	0.0007%	0.0003%	0.0001%	0.0002%	0.0002%	0.0003%
Total expenditures	0.0002%	0.0002%	0.0001%	0.0001%	0.0007%	0.0003%	0.0002%	0.0002%	0.0002%	0.0003%

Source: California Health Benefits Review Program, 2025.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents. About one in five of these enrollees has a pharmacy benefit not subject to DMHC.[31] CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).
(c) Includes Medi-Cal beneficiaries enrolled in DMHC-regulated plans and COHS managed care. CHBRP assumes that premiums for Medi-Cal beneficiaries in COHS managed care are comparable to those for Medi-Cal beneficiaries in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[32]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.

[31] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance.*
[32] For more detail, see CHBRP's resource *Sources of Health Insurance in California.*

Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Public Health Impacts

As discussed in the *Policy Context* section, SB 418 would require health plans and policies to cover up to a 12-month supply of an FDA-approved prescription hormone therapy and the necessary supplies for self-administration. SB 418 would allow an enrollee to receive a covered hormone therapy, prescribed by a network provider and dispensed by a provider or pharmacist or at a location licensed or otherwise authorized to dispense drugs or supplies, for up to 12 months at one time.

Estimated Public Health Outcomes

CHBRP finds that SB 418 would have no measurable short-term public health impact due to no measurable change in utilization. The long-term public health outcomes are unknown.

No Utilization Change

While 100% of enrollees (23,494,000) in state-regulated insurance subject to SB 418 would gain coverage for a 12-months-at-once supply of hormone prescriptions, the change resulting from SB 418 would be in the prescription and dispensing duration of hormone therapy only, not in coverage of certain hormone therapies. As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, there would be no changes in utilization or unit cost of hormone therapies. Only enrollees who procured 12-month supplies of prescribed hormone therapy and then switched to a different dose, drug format, or drug type before their previously prescribed therapy was used up would experience increased annual out-of-pocket expenses.

CHBRP assumes that for the population with health insurance subject to SB 418, a small share may switch from their current medication duration dispensing amounts to a 12-month supply. To the extent that increased durations of prescription medication may lead to improved access and adherence, there may be some potential impact at the person level, but it is not measurable in this analysis.

Potential Impacts on Quality of Life

Though CHBRP finds no measurable short-term public health impact of SB 418, there is potential for improvement in quality of life at the person level from securing longer-term access to treatment through a 12-month supply and from a reduction in visits to a pharmacy or clinic for a refill of prescription hormone therapy.

Accessing prescription medication can pose a challenge for some people: 1.8% of U.S. adults reported delaying medical care in 2017 due to lack of transportation, with higher rates among Hispanic people, people living below the poverty threshold, Medicaid enrollees, and those with functional limitations (Wolfe et al., 2020). While most people in the United States (88.9%) live within 5 miles of a pharmacy (Berenbrok et al., 2022), racial and ethnic disparities exist in some rural or suburban areas (Appolon et al., 2024, Guadamuz et al., 2021). Some regions may also be in a medication desert even though a pharmacy is present, as availability of common drugs may be low (Amstislavski et al, 2012).

As described in the *Background* section, transgender people are more likely than cisgender people to report transportation as a barrier to accessing care. Transgender people are also less likely than cisgender people to have health insurance, report limited access to knowledgeable providers, and experience discrimination or mistreatment from healthcare professionals (Carreño et al., 2023; Koma et al., 2020). Transgender adults are nearly three times as likely as cisgender adults to delay or forego prescribed medications (32% vs. 11%) (Herman et al., 2017). According to a survey conducted by Kachen and Pharr (2020) of people who identify as transfeminine, transmasculine, or nonbinary[33], 29.3% of

[33] Transfeminine defines people who were assigned male at birth but identify more with a feminine identity. Transmasculine defines people whose gender identity is partially or fully masculine and differs from the sex the person was identified as having at birth. Nonbinary defines people whose gender identity lies outside of the male/female gender binary.

respondents reported experiencing health care discrimination. Additionally, 29.9% of respondents reported being unable to see a doctor due to cost and 21.6% reported being unable to see a doctor due to fear of mistreatment (Kachen and Pharr, 2020).

There is potential for SB 418 to contribute to a reduction in barriers to access, particularly among those who use hormone therapy for gender-affirming care. This could lead to improvements in quality of life (i.e., reductions in stress and anxiety that come with the certainty of having access to longer durations of treatment). However, CHBRP found little evidence of how increased dispensing amounts would promote public health as a whole; the current data are not extractable to the population and use case under this bill.

Impact on Disparities[34]

As described in the *Background* section, transgender adults are nearly three times as likely to delay getting medications prescribed to them compared to cisgender adults (Herman et al., 2017). To the extent that a 12-month supply can reduce delays and interruptions in accessing prescription hormone therapy, there may be a potential positive impact on public health for transgender people, in particular.

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[34] For details about CHBRP's methodological approach to analyzing disparities, see the *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts* document.

Long-Term Impacts

In this section, CHBRP estimates the long-term impact of SB 418, which CHBRP defines as impacts occurring beyond the first 12 months after implementation. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

CHBRP expects no long-term (after initial 12 months) change in utilization due to SB 418.

Cost Impacts

CHBRP expects no long-term (after initial 12 months) change in cost due to SB 418.

Long-Term Public Health Impacts

As presented in the *Background* section, increased durations for prescriptions may have person-level benefits including improving medication adherence by decreasing interruptions or delays in prescription use, when related to issues to filling prescriptions (King et al., 2018). Such improvements in adherence can improve health outcomes in the long term, such as reducing mortality in the long-term. However, there are no known studies on the impact of a 12-month supply of hormone therapy on health outcomes for conditions relevant to SB 418 to draw such inference or estimates from. As such, CHBRP finds that long-term public health impacts of SB 418 may be possible but are unknown.

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Appendix A. Text of Bill Analyzed

On June 25, 2025, the California Assembly Committee on Health requested that CHBRP analyze SB 418 as amended on June 23, 2025. CHBRP's analysis incorporates amendments made on July 9, 2025.

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.

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Appendix B. Utilization Management

Utilization Management

Utilization management techniques are used by health plans and insurers to control costs, ensure medication compatibility, and manage safety. Examples include benefit coverage requirements related to prior authorization, step therapy, quantity limits, and limits related to the age or sex of the enrollee (such as prescription-only infant formula or prostate cancer screening for men). A brief description of some key utilization management techniques follows.

Prior authorization

Prior authorization[35] – also known as precertification, prior approval, or prospective review – is a utilization management technique commonly used by health insurance carriers to ensure that a given medical intervention meets the insurance plan or policy's criteria for coverage (Newcomer et al., 2017). Prior authorization developed as a tool for insurers to assess the appropriateness of treatment that would result in a hospital admission or a high-cost procedure (Resneck, 2020). The process typically requires providers to establish eligibility and submit documentation demonstrating medical need to the plan/insurer for approval of coverage before either medical services are provided or a prescription is filled in order to qualify for payment. Health plans/insurers may also impose prior authorization requirements on nonpreferred medications in an effort to promote the use of preferred medications that they can procure at lower prices.

The primary uses of prior authorization are as follows:

- **Coverage evaluation:** Allows evaluation of whether a test, treatment, or service is medically necessary and otherwise covered.
- **Safety:** Acts as a safeguard to confirm that a patient's medications are compatible and provides an opportunity to check that proper diagnostic testing has been completed to ensure patient safety prior to use of a requested treatment. Prior authorization also reduces inappropriate patient care by stopping unsafe or low-value care that is inconsistent with the most recent clinical evidence.
- **Cost control:** Imposition of prior authorization for nonpreferred medications can encourage the use of preferred medications that can be procured at lower price.

Step therapy

Step therapy or "fail-first" protocols may be applied to prescription medications by health plans and insurers to control costs, ensure medication compatibility, and manage safety. Health plans/insurers may use step therapy protocols to apply clinical guidelines established by professional societies and other recognized organizations to treatment plans. They require an enrollee to try and fail one or more medications prior to receiving coverage for the initially prescribed medication. Step therapy protocols usually recommend starting with a medication that is less expensive (generics) and/or has more "post-marketing safety experience" (PBMI, 2015). In addition, they sometimes require starting with a less potent medication or dosage, perhaps with fewer side effects, and graduating to more potent medications as necessary (e.g., from prescription ibuprofen to oxycodone to treat pain). Generally, more expensive or more potent medications are covered when the patient fails to respond to the step therapy–required medication (PBMI, 2018).

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[35] More information about prior authorization is available in CHBRP's 2023 analysis, *Prior Authorization in California*.

Appendix C. Cost Impact Analysis: Data Sources, Caveats, and Assumptions

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc., the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[36] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses, are available on CHBRP's website.[37]

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Baseline coverage of 12-month hormone therapy coverage for commercial enrollees was determined using publicly available drug formularies to estimate the baseline level of coverage for FDA-approved prescription hormone therapies. CHBRP supported its baseline coverage assumptions with a survey of the largest (by enrollment) providers of health insurance in California. In addition, CalPERS, DHCS, and the four largest (by enrollment) DMHC-regulated plans enrolling Medi-Cal beneficiaries were queried regarding related benefit coverage. As necessary, CHBRP extrapolated from responses of similarly situated plans/policies.

Consolidated Health Cost Guidelines Sources Database

Milliman maintains benchmarking and analytic databases that include health care claims data for nearly 60 million commercial lives and over 3 million lives of Medicaid managed care data. This dataset is routinely used to evaluate program impacts on cost and other outcomes.

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable. The analysis of SB 418 was developed using the cost and utilization of hormone therapies as defined by the following therapeutic classes:

Therapeutic Class	Description
Antineoplastic – Hormonal	Luteinizing Hormone Releasing-Hormone (LHRH/GnRH)
Androgens	Growth Hormones
Estrogens	Growth Hormone Releasing Hormones (GHRH)
Estrogen Combinations	Growth Hormone Receptor Antagonists
Progestins	Posterior Pituitary Hormones
Progestin Combinations	Vaginal Estrogens

[36] CHBRP's authorizing statute requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[37] See CHBRP's Cost Impact Analysis landing page; in particular, see *Cost Impact Analyses: Data Sources, Caveats, and Assumptions*.

Thyroid Hormones	Vaginal Progestins
Hormone Receptor Modulators	Prostatic Hypertrophy

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes people covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, CalPERS, and Medi-Cal plans subject to the requirements of the Knox-Keene Health Care Service Plan Act.
- CHBRP assumed no fully compliant baseline coverage for the mandated benefit. CHBRP assumed that while hormone therapies are currently a mandated benefit, there is no existing requirement that scripts of a specified duration be covered.

Methodology and Assumptions for Baseline Utilization

- CHBRP calculated the average utilization rate and average total script length of hormone therapies for commercial and Medi-Cal members using Milliman's proprietary 2023 Consolidated Health Cost Guidelines™ Sources Database (CHSD).
    - The average number of members utilizing hormone therapies per 1,000 were calculated as the number of members utilizing hormone therapies divided by the total number of members with pharmacy coverage times 1,000.
    - The average number of hormone therapies prescribed to each member who utilized at least one hormone therapy was calculated as the average number of drugs for each utilizer, aggregated at the therapeutic class level.
    - The percent distribution of hormone therapies by aggregate annual script length was calculated across all members utilizing hormone therapies.
- Baseline utilization of hormone therapy was estimated by script duration in months by multiplying the utilization rate, the therapy count per utilizer estimate, and the estimated number of members in each market category with outpatient drug coverage.

Methodology and Assumptions for Baseline Cost

- CHBRP calculated the average hormone therapy cost per day for commercial and Medi-Cal members using CHSD. The average cost per day of hormone therapy was estimated by dividing the sum of plan paid and the sum of days prescribed.
- The average commercial cost of hormone therapy per day was trended from 2023 to 2026 using an 11.35% annual trend. The average Medi-Cal cost of hormone therapy per day was trended from 2023 to 2026 using a 3.0% annual trend.

Methodology and Assumptions for Baseline Cost Sharing

- CHBRP calculated the average hormone therapy cost sharing per day for commercial members using CHSD by dividing the sum of member cost sharing and the sum of days prescribed.

- Medi-Cal members were assumed to have no cost sharing for hormone therapy.
- The average commercial cost sharing per day was trended from 2023 to 2026 using an 11.35% annual trend.

Methodology and Assumptions for Postmandate Utilization

- CHBRP assumed no change in the number of utilizers (enrollees using hormone therapy) and no change in the number of therapies per utilizer postmandate.
- CHBRP assumed that a portion of enrollees receiving hormone therapy for at least 10 months in the preceding year will switch to a prescription allowing 12 months to be dispensed at once in the postmandate period. CHBRP has assumed that 2%[38] of these people would switch to a 12-month supply postmandate, with the exception of those receiving hormone therapy for gender-affirming care. CHBRP assumes, based on information obtained from a content expert,[39] that of those receiving gender-affirming care, approximately 10% would be medically eligible for extended prescriptions (prescriptions allowing 12 months to be dispensed at once), of which 90% would switch to a 12-month supply of dispensed drugs. The following data and calculations were used to determine the size of this group. In California, approximately 0.49% of the state population ages 18 and older identifies as transgender (Herman et al., 2022), and nationally approximately 43.5% of transgender adults have pursued hormone therapy as part of their gender transition.[40] According to a national study of privately insured children, approximately 0.1% of those ages 12 to 17 who identify as transgender or gender diverse use estrogen or testosterone for gender-affirming care.[41] CHBRP applied these estimates to determine overall estimates by using information from the latest (2023) California Health Interview Survey on the proportion of children aged 12-17 in Medi-Cal (12.6%) and private insurance (8.6%) and proportion of adults aged 18 and older in Medi-Cal (69%) and private insurance (73.7%).[42] This yields adjustment factors of 0.015% and 0.014% of enrollees in commercial and Medi-Cal plans, respectively, for people receiving gender-affirming care.[43]

Methodology and Assumptions for Postmandate Cost

- CHBRP assumed the average hormone therapy cost per day would not change as a result of SB 418. However, members who switch to a 12-month script will have a higher annual cost in proportion to the additional prescribed days.

Methodology and Assumptions for Postmandate Cost Sharing

- CHBRP assumed the average cost sharing per day would not change as a result of SB 418. However, members who switch to a 12-month script will pay higher cost sharing per year in proportion to the additional prescribed days.

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[38] When Californians on Medicaid were offered the opportunity to obtain up to 12 months of hormonal contraception at a time, switchers were estimated at 7.17 percentage points (Rodriguez et al., 2024). Apart from those receiving hormone therapy as part of gender-affirming care, CHRBP assumes a smaller proportion of all hormone users, approximately 2%, who have used hormone therapy for at least 10 months (sum of all hormone therapy dispensed) in the previous year would choose to switch to 12-month (360-day) prescription dispensing. This lower estimate is consistent with expert opinion and is used to there being no known literature to guide this for the conditions examined. In addition, most patients are able to get refills that cover 12 months without extra out-of-pocket drug costs or excessive utilization management and thus would be using larger amounts of hormones dispensed at once for convenience. The actual percentage of patients who switch to a 12-month supply of hormone therapy may be higher or lower than 2%.

[39] Content expert consultations, July 14 and July 29, 2025.

[40] This an average across two surveys from Kirzinger et al, 2023 and Rastogi et al., 2025.

[41] Hughes et al, 2025. CHBRP applied this estimate to all market segments given a lack of data for additional populations.

[42] AskCHIS™. Accessed July 23, 2025. https://healthpolicy.ucla.edu/our-work/askchis.

[43] Medi-Cal: 0.014% = (0.126 children x 0.001 transgender who also use hormone therapy x 0.10 eligible for extended prescription x 0.90 switching) + (0.69 adults x 0.0049 transgender x 0.435 hormone use x 0.10 eligible for extended prescription x 0.90 switching); Private: 0.015% = (0.086 children x 0.001 transgender who also use hormone therapy x 0.90 switching) + (0.737 adults x 0.0049 transgender x 0.435 hormone use x 0.90 switching).

Methodology and Assumptions for Postmandate Wasted Scripts

- CHBRP assumed some portion of prescribed 90 day or longer scripts are wasted when other similar treatments are prescribed before the first script is completed. Postmandate, CHBRP assumes some of these 90 day or longer scripts will become 12-month scripts and will have more script days wasted.
- CHBRP calculated the additional cost of wasted scripts if some scripts switch to 12-month, as the additional wasted days beyond the original script when a second treatment is prescribed within the same therapeutic class times the average cost per day.
- Wasted scripts were estimated based on the assumption that 2% of all people (not receiving gender-affirming care) receiving 10-12 months of prescribed hormone therapy in 2025 (aggregated across refill periods) would shift to prescriptions allowing 12-months (360 days) of drugs to dispensed at once in 2026. Of those receiving gender affirming care, approximately 9% (90% of the 10% deemed medically eligible) would shift prescriptions allowing 12-months (360 days) of drugs to dispensed at once in 2026. When accounting for the distribution of total days of scripts across the commercial and Medicaid populations, the overall size of the shift into scripts allowing 12-months-dispensed-at once is estimated to be 0.10% for Commercial plans and 0.11% for Medi-Cal.

Variability of Results

Differences between our estimates and actual amounts depend on the extent to which future experience conforms to the assumptions made in this model. It is almost certain that actual experience will not conform exactly to the assumptions used in this model. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Model and Data Reliance

Milliman has developed certain models to estimate the values included in this report. The intent of the models was to estimate the impact of proposed bill SB 418. Milliman has reviewed this model, including its inputs, calculations, and outputs for consistency, reasonableness, and appropriateness to the intended purpose and in compliance with generally accepted actuarial practice and relevant actuarial standards of practice (ASOP).

The models rely on data and information as input to the models. We have relied upon certain data and information for this purpose and accepted it without audit. To the extent that the data and information provided is not accurate, or is not complete, the values provided in this report may likewise be inaccurate or incomplete.

Milliman's data and information reliance includes:

- Data publicly available from the California Department of Managed Healthcare, California Department of Insurance, CalPERS, and other official state organizations;
- Population and other metrics prepared for use in this model by CHBRP; and
- All sources mentioned above in the Analysis-Specific Caveats and Assumptions section.

The models, including all input, calculations, and output may not be appropriate for any other purpose.

We have performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our investigation.

Qualifications to Perform Analysis

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The developer of this model and author of this paper is a member of the American Academy of Actuaries and meets the qualification standards for performing the analyses supported by this model.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

Second-Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of SB 418 would have a substantially different impact on utilization of either the tests, treatments, or services for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP reviewed the literature and consulted content experts about the possibility of varied second-year impacts and determined the second year's impacts of SB 418 would be substantially the same as the impacts in the first year (see Tables 1, 2, and 3). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

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References

American Cancer Society. Hormone Therapy for Breast Cancer. 2024. Available at: https://www.cancer.org/cancer/types/breast-cancer/treatment/hormone-therapy-for-breast-cancer.html. Accessed July 10, 2025.

American Cancer Society. Hormone Therapy for Prostate Cancer. 2023. Available at: https://www.cancer.org/cancer/types/prostate-cancer/treating/hormone-therapy.html. Accessed July 10, 2025.

American Psychiatric Association. What Is Gender Dysphoria? 2025. Available at: https://www.psychiatry.org/patients-families/gender-dysphoria/what-is-gender-dysphoria. Accessed on July 11, 2025.

American Thyroid Association. Thyroid Hormone Treatment. Available at: https://www.thyroid.org/thyroid-hormone-treatment/. Accessed July 14, 2025.

Amstislavski P, Matthews A, Sheffield S, Maroko AR, Weedon J. Medication deserts: survey of neighborhood disparities in availability of prescription medications. *International Journal of Health Geographics*. 2012;11:48.

Appolon G, Tang S, Gabriel N, et al. Racial and ethnic inequities in spatial access to pharmacies: A geographic information system analysis. *Journal of the American Pharmacists Association.* 2024;64(4):102131.

Benjamin DJ, Shrestha A, Fellman D, Cress RD, Lythgoe MP, Rezazadeh Kalebasty A. Hormonal treatment for newly diagnosed metastatic prostate cancer: a population-based study from the California cancer registry. *Prostate Cancer and Prostatic Diseases.* 2024;27(4);680-685. https://doi.org/10.1038/s41391-023-00732-9

Berenbrok LA, Tang S, Gabriel N, et al. 2022. Access to community pharmacies: a nationwide geographic information systems cross-sectional analysis. *Journal of the American Pharmacists Association*. 2022;62(6):1816-1822.e2 Volume 62, Issue 6,

Bisharyan J. Transgender Patients Report Obstacles Since Golden Valley's Takeover of Modesto Clinic. Modesto Bee. 2024. Available at: https://www.modbee.com/living/health-fitness/article297206064.html. Accessed August 5, 2025.

Blanken A, Gibson CJ, Li Y, et al. Racial/ethnic disparities in the diagnosis and management of menopause symptoms among midlife women veterans. *Menopause*. 2022;29(7):877-882. https://doi.org/10.1097/GME.0000000000001978

Boskey ER, Scheffey KL, Pilcher S, et al. A retrospective cohort study of transgender adolescents' gender-affirming hormone discontinuation. *Journal of Adolescent Health*. 2025;76(4):584-591.

Bowles EJA, Ramin C, Buist DSM, et al. Endocrine therapy initiation among women with stage I-III invasive, hormone receptor-positive breast cancer from 2001-2016. *Breast Cancer Research and Treatment*. 2022;193(1):203-216.

California Department of Health Care Services (DHCS). California Children's Services Program and Genetically Handicapped Persons Program Policy on Coverage of Experimental and Investigational Services. 2020. Available at: https://www.dhcs.ca.gov/services/ccs/Documents/CCS-NL-05-1020-Experimental-and-Investigational-Services.pdf. Accessed July 15, 2025.

California Department of Health Care Services (DHCS). Medi-Cal Rx Contract Drugs List. 2025. Available at: https://medi-calrx.dhcs.ca.gov/cms/medicalrx/static-assets/documents/provider/forms-and-information/cdl/Medi-Cal_Rx_Contract_Drugs_List_FINAL.pdf. Accessed July 8, 2025.

California Office of the Attorney General. Attorney General Bonta Files Lawsuit Against Trump Administration's Unlawful Attacks on Gender-Affirming Care. 2025. Available at: https://oag.ca.gov/news/press-releases/attorney-general-bonta-files-lawsuit-against-trump-administration%E2%80%99s-unlawful. Accessed August 4, 2025.

Carney JM, Fried AJ, Neiman EJ, Pelkey E. Latest Moves by Federal Agencies Regarding Gender-Affirming Care: Risks Mount for Providers. Health Law Advisor. 2025. Available at: https://www.healthlawadvisor.com/latest-moves-by-federal-agencies-regarding-gender-affirming-care-risks-mount-for-providers. Accessed July 30, 2025.

Carreño MF, Salcedo B, Ortega QV, Conron KJ. A Quality of Life Study with Transgender, Gender Nonconforming, and Intersex (TGI) Adults in the City of Los Angeles. Williams Institute. 2023. Available at: https://williamsinstitute.law.ucla.edu/publications/qol-tgi-los-angeles/. Accessed July 8, 2025.

Cluze C, Rey D, Huiart L, et al. Adjuvant endocrine therapy with tamoxifen in young women with breast cancer: determinants of interruptions vary over time. *Annals of Oncology*. 2012;23(4):882-890.

Dawson L, Kates J. Overview of President Trump's Executive Actions Impacting LGBTQ+ Health. Kaiser Family Foundation. 2025a. Available at: https://www.kff.org/other/ fact-sheet/overview-of-president-trumps-executive-actions-impacting-lgbtq-health/. Accessed on July 11, 2025.

Dawson L. Kates J. Policy Tracker: Youth Access to Gender Affirming Care and State Policy Restrictions. Kaiser Family Foundation. 2025b. Available at: https://www.kff.org/other/dashboard/gender-affirming-care-policy-tracker/. Accessed on July 11, 2025.

DeBenedetti K. Kaiser to Stop Gender-Affirming Surgeries for Minors, Leaving Trans Kids With Fewer Options. KQED. 2025. Available at: https://www.kqed.org/news/12049555/kaiser-to-stop-gender-affirming-surgeries-for-minors-leaving-trans-kids-with-fewer-options. Accessed July 21, 2025. ƒ

Deecher DC, Dorries K. Understanding the pathophysiology of vasomotor symptoms (hot flushes and night sweats) that occur in perimenopause, menopause, and postmenopause life stages. *Archive of Women's Mental Health*. 2007;10(6):247-257.

Doble B, Payne R, Harshfield A, Wilson ECF. Retrospective, multicohort analysis of the Clinical Practice Research Datalink (CPRD) to determine differences in the cost of medication wastage, dispensing fees and prescriber time of issuing either short (<60 days) or long (≥60 days) prescription lengths in primary care for common, chronic conditions in the UK. *BMJ Open.* 2017;7(12):e019382.

Endocrine Society. Menopause. January 24, 2022. Available at: https://www.endocrine.org/patient-engagement/endocrine-library/menopause. Accessed March 2, 2024.

Ettleson MD, Bianco AC, Zhu M, Laiteerapong N. Sociodemographic disparities in the treatment of hypothyroidism: NHANES 2007-2012. *Journal of the Endocrine Society*. 2021;5(7):bvab041.

Federal Register. Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability. 2025. Available at: https://www.federalregister.gov/documents/2025/06/25/2025-11606/patient-protection-and-affordable-care-act-marketplace-integrity-and-affordability. Accessed July 30, 2025.

Foster DG, Hulett D, Bradsberry M, Darney P, Policar M. Number of oral contraceptive pill packages dispensed and subsequent unintended pregnancies. *Obstetrics and Gynecology*. 2011;117(3):566-572.

Green R, Santoro N. Menopausal symptoms and ethnicity: the Study of Women's Health across the Nation. *Women's Health*. 2009;5(2):127-133.

Greenberg JA, Thiesmeyer JW, Ullmann TM, et al. (). Association of the Affordable Care Act with access to highest-volume centers for patients with thyroid cancer. *Surgery*. 2022;171(1):132-139.

Guadamuz JS, Wilder JR, Mouslim MC, Zenk SN, Alexander GC, Qato DM. Fewer pharmacies In Black and Hispanic/Latino Neighborhoods compared with White or diverse neighborhoods, 2007-15. *Health Affairs (Project Hope)*. 2021;40(5):802-811.

Gupta P, Cunha LM, Diego D, Tangpricha V. Continuation of gender-affirming hormone therapy in transgender and gender-diverse individuals: a systematic review. *Endocrine Practice*. 2024;30(12):1206-1211.

Hassett MJ, Schymura MJ, Chen K, Boscoe FP, Gesten FC, Schrag D. Variation in breast cancer care quality in New York and California based on race/ethnicity and Medicaid enrollment. *Cancer*. 2016;122(3):420-431.

Hembree WC, Cohen-Kettenis PT, Gooren L, et al. Endocrine treatment of gender-dysphoric/gender-incongruent persons: an Endocrine Society clinical practice guideline. *Journal of Clinical Endocrinology and Metabolism*. 2017;102(11):3869-3903.

Herman JL, Wilson B DM, Becker T. Demographic and Health Characteristics of Transgender Adults in California: Findings from the 2015-2016 California Health Interview Survey, Williams Institute. 2017. Available at: chrome-

extension://efaidnbmnnnibpcajpcglclefindmkaj/https://williamsinstitute.law.ucla.edu/wp-content/uploads/CHIS-Transgender-Adults-Oct-2017.pdf. Accessed July 8, 2025.

Herman JL, Flores AR, O'Neill KN. How Many Adults and Youth Identify as Transgender in the United States? Williams Institute. 2022. Available at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Pop-Update-Jun-2022.pdf. Accessed July 8, 2025.

Herman JL, Salcedo B, Cantham K, Mahowald L, Ortega QV, Redfield E. Para Mi Punto de Vista/ From My Point of View: Results of the 2023 LA County Trans & Nonbinary Survey. Williams Institute. 2024. Available at: https://williamsinstitute.law.ucla.edu/publications/tnb-la-county-survey. Accessed on July 7, 2025.

Hess R, Colvin A, Avis NE, et al. The impact of hormone therapy on health-related quality of life: longitudinal results from the Study of Women's Health Across the Nation. *Menopause*. 2008;15(3):422-428.

Hsieh KP, Chen LC, Cheung KL, Chang CS, Yang YH. Interruption and non-adherence to long-term adjuvant hormone therapy is associated with adverse survival outcome of breast cancer women--an Asian population-based study. *PLoS One.* 2014;9(2):e87027.

Hughes LD, Charlton BM, Berzansky I, Corman JD. 2025. Gender-affirming medications among transgender adolescents in the US, 2018-2022. *JAMA Pediatrics*. 2025;179(3):342-344.

Huston-Paterson HH, Mao Y, Tseng CH, et al. Rural-urban disparities in the continuum of thyroid cancer care: analysis of 92,794 cases. *Thyroid.* 2024;34(5):635-645.

Johns Hopkins Medicine. Gender-Affirming Hormone Therapy (GAHT). Available at: https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/gender-affirming-hormone-therapy-gaht. Accessed July 14, 2025.

Johnstone T, Thawanyarat K, Eggert GR, et al. Travel distance and national access to gender-affirming surgery. *Surgery*. 2023;174(6):1376-1383.

Jonklaas J, Bianco AC, Bauer AJ, et al. Guidelines for the treatment of hypothyroidism: prepared by the American Thyroid Association Task Force on Thyroid Hormone Replacement. *Thyroid.* 24(12):1670-1751.

Kachen A, Pharr JR. Health care access and utilization by transgender populations: a United States Transgender Survey Study. *Transgender Health*. 2020;5(3):141-148.

Kahn NF, Sequeira GM, Asante PG, et al. Estimating transgender and gender-diverse youth populations in health systems and survey data. *Pediatrics*. 2024;153(6):e2023065197. https://doi.org/10.1542/peds.2023-065197

Kaiser Permanente. 2025 Commercial Marketplace Formulary. 2025a. Available at: https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/ca/commercial-marketplace-formulary-ca-en.pdf. Accessed July 8, 2025.

Kaiser Permanente. 2025 Northern California Commercial HMO Formulary. 2025b. Available at: https://healthy.kaiserpermanente.org/content/dam/kporg/final/documents/formularies/ca/commercial-hmo-formulary-ncal-en.pdf. Accessed July 8, 2025.

King S, Miani C, Exley J, Larkin J, Kirtley A, Payne RA. Impact of issuing longer- versus shorter-duration prescriptions: a systematic review. *British Journal of General Practice.* 2018;68(669):e286-e292.

Kirzinger A, Kearney A, Montero A, Sparks G, Dawson L, Brodie M. *2023.KFF/The Washington Post Trans Survey: Trans in America*. KFF. Available at: https://www.kff.org/report-section/kff-the-washington-post-trans-survey-trans-in-america/. Accessed July 8, 2025.

Koma W, Rae M, Ramaswamy A, Neuman T, Kates J, Dawson L. Demographics, Insurance Coverage, and Access to Care Among Transgender Adults. Kaiser Family Foundation. 2020. Available at: https://www.kff.org/affordable-care-act/issue-brief/demographics-insurance-coverage-and-access-to-care-among-transgender-adults/. Accessed July 8, 2025.

Legislative Analyst's Office. A.G. File No. 2023-020. 2023. Available at: https://lao.ca.gov/BallotAnalysis/Initiative/2023-020. Accessed on July 11, 2025.

Ma TM, Agarwal N, Mahal B, et al. Racial and ethnic disparities in use of novel hormonal therapy agents in patients with prostate cancer. *JAMA Network Open*. 2023;6(12):e2345906

Martin KA, Barbieri RL. Treatment of menopausal symptoms with hormone therapy. UpToDate. November 20, 2023. Available at: https://www.uptodate.com/contents/treatment-of-menopausal-symptoms-with-hormone-therapy. Accessed March 6, 2024.

Mao D, Hachem H, Chang H, et al. Treatment interruption and discontinuation of hormonal therapy in hormone receptor-positive breast cancer patients. *Breast Cancer Research and Treatment.* 2020;184:665-674.

McClurg L. Stanford Scales Back Trans Care for Minors Amid Federal Crackdown. KQED. 2025. Available at: https://www.kqed.org/science/1997491/stanford-scales-back-trans-care-for-minors-amid-federal-crackdown. Accessed July 21, 2025.

McGarity-Palmer R, Saw A. Transgender clients' travel distance to preferred health care: a clinic-specific study. *Transgender Health*. 2022;7(3):282-286.

National Cancer Institute. State Cancer Profiles. 2021. Available at: https://statecancerprofiles.cancer.gov/incidencerates/index.php?stateFIPS=06&areatype=county&cancer=080&race=00&sex=0&age=001&stage=999&type=incd&sortVariableName=rate&sortOrder=default&output=0#results. Accessed July 22, 2025.

National Library of Medicine (NLM). Menopause. MedLinePlus. July 12, 2023. Available at: https://medlineplus.gov/ency/article/000894.htm. Accessed March 2, 2024.

Newcomer LN, Weininger R, Carlson RW. Transforming prior authorization to decision support. *Journal of Oncology Practice*. 2017;13(1):e57-e61.

North American Menopause Society (NAMS). The 2022 hormone therapy position statement of The North American Menopause Society. *Menopause*. 2022;29(7):767-794.

Peasah SK, Kohli M, Munshi KD, et al. Twelve month oral contraceptive pill prescriptions: role of policy mandates on utilization. *Exploratory Research in Clinical and Social Pharmacy.* 2021;5:100094..

Penn Medicine. Hormone receptor-positive (HR+) breast cancer. Available at: https://www.pennmedicine.org/conditions/hr-positive-breast-cancer. Accessed July 22, 2025 .

Pesantez GSP, Clayton AH. Treatment of hypoactive sexual desire disorder among women: general considerations and pharmacological options. *Focus*. 2021;19(1):39-45.

Pharmacy Benefits Management Institute (PBMI). 2014-2015 Prescription Drug Benefit Cost and Plan Design Report. Plano, TX: PBMI; 2015.

Pharmacy Benefits Management Institute (PBMI). 2018 Trends in Specialty Drug Benefits Report. Plano, TX: PBMI; 2018.

Poteat T, Davis AM, Gonzalez A. Standards of care for transgender and gender diverse people. *JAMA.* 2023;329(21):1872-1874.

Rastogi A, Menard L, Miller GH, et al. *Health and Wellbeing: A Report of the 2022 U.S. Transgender Survey*. Advocates for Transgender Equality. 2025. Available at: chrome-extension://efaidnbmnnnibpcajpcglclefindmkaj/https://transequality.org/sites/default/files/2025-06/USTS_2022Health%26WellbeingReport_WEB.pdf. Accessed July 8, 2025.

Resneck JS. Refocusing medication prior authorization on its intended purpose. *JAMA*. 2020;323(8):703-704.

Restar A, Dusic EJ, Garrison-Desany H, et al. Gender affirming hormone therapy dosing behaviors among transgender and nonbinary adults. *Humanities & Social Sciences Communications.* 2022;9(1):304.

Rodriguez MI, Meath THA, Daly A, Watson K, McConnell KJ, Kim H. "Twelve-Month Contraceptive Supply Policies and Medicaid Contraceptive Dispensing." *JAMA Health Forum* 2024;5(8):e242755.

Salari N, Hasheminezhad R, Hosseinian-Far A, et al. Global prevalence of sleep disorders during menopause: a meta-analysis. *Sleep & Breathing.* 2023;27(5):1883-1897.

Sarafrazui N, Wambogo EA, Shepherd JA. *Osteoporosis or Low Bone Mass in Older Adults: United States, 2017–2018*. Centers for Disease Control and Prevention, NCHS Data Brief No. 405. March 2021. Available at: https://www.cdc.gov/nchs/products/databriefs/db405.htm. Accessed March 6, 2024.

Sharp S. End of transgender care at Children's Hospital L.A. signals nationwide shift under Trump. Los Angeles Times. 2025. Available at: https://www.latimes.com/california/story/2025-07-23/childrens-hospital-los-angeles-ends-transgender-care-program. Accessed July 21, 2025.

Shifren JL, Monz BU, Russo PA, Segreti A, Johannes CB. Sexual problems and distress in United States women: prevalence and correlates. *Obstetrics and Gynecology*. 2008;112(5):970-978.

Streed CG Jr, Beach LB, Caceres BA, et al; American Heart Association Council on Peripheral Vascular Disease; Council on Arteriosclerosis, Thrombosis and Vascular Biology; Council on Cardiovascular and Stroke Nursing; Council on Cardiovascular Radiology and Intervention; Council on Hypertension; and Stroke Council. Assessing and addressing cardiovascular health in people who are transgender and gender diverse: a scientific statement from the American Heart Association. *Circulation*. 2021;144(6):e136-e148.

Stuenkel CA, Davis SR, Gompel A, et al. Treatment of symptoms of the menopause: an Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinology and Metabolism*. 2015;100(11):3975-4011.

Study of Women's Health Across the Nation (SWAN). SWAN Fact Sheet: Bone Health over the Menopause Transition. 2023. Available at: https://www.swanstudy.org/wps/wp-content/uploads/2023/12/SWANFactSheets2023.pdf. Accessed March 4,2024.

Todorovic S. The Impact of Interruptions in Gender-Affirming Medical Care during COVID-19 on Anxiety and Depression among Trans and Non-binary People in Canada: A Longitudinal Study. (2021). Electronic Thesis and Dissertation Repository. 8202. https://ir.lib.uwo.ca/etd/8202

U.S. Department of Justice. Memorandum: Civil Division Enforcement Priorities. 2025. Available at: https://www.justice.gov/civil/media/1404046/dl. Accessed July 30, 2025.

Yang L, Toriola AT. Menopausal hormone therapy use among postmenopausal women. *JAMA Health Forum.* 2024;5(9):e243128.

West SL, D'Aloisio AA, Agans RP, Kalsbeek WD, Borisov NN, Thorp JM. Prevalence of low sexual desire and hypoactive sexual desire disorder in a nationally representative sample of US women. *Archives of Internal Medicine*. 2008;168(13):1441-1449.

Wolfe MK, McDonald NC, Holmes GM. Transportation barriers to health care in the United States: findings from the National Health Interview Survey, 1997-2017. *American Journal of Public Health*. 2020;110(6):815-822.

World Health Organization (WHO). Gender Incongruence and Transgender Health in the ICD. 2025. Available at: https://www.who.int/standards/classifications/frequently-asked-questions/gender-incongruence-and-transgender-health-in-the-icd. Accessed July 11, 2025.

Wyne KL, Nair L, Schneiderman CP, et al. Hypothyroidism prevalence in the United States: a retrospective study combining National Health and Nutrition Examination Survey and Claims Data, 2009-2019. *Journal of the Endocrine Society*. 2022;7(1):bvac172. https://doi.org/10.1210/jendso/bvac172

California Health Benefits Review Program Committees and Staff

CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs CHBRP reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with a certified actuary, **Milliman, Inc.**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at chbrp.org.

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