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.

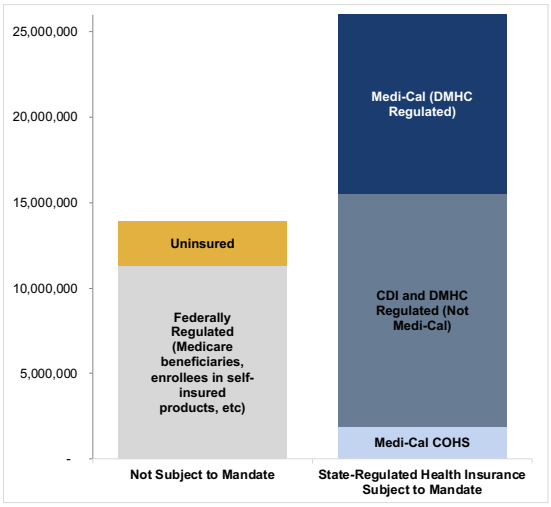
SB 418 defines prescription hormone therapy as "all drugs approved by the FDA that are used to medically suppress, increase, or replace hormones that the body is not producing at intended levels."

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.