SENATE COMMITTEE ON HEALTH
Senator Caroline Menjivar, Chair

BILL NO: AB 432
AUTHOR: Bauer-Kahan
VERSION: July 9, 2025
HEARING DATE: July 16, 2025
CONSULTANT: Teri Boughton

SUBJECT: Menopause

SUMMARY: Requires health plans and insurers to include coverage for evaluation and treatment options for perimenopause and menopause, as is deemed medically necessary by the treating health care provider without utilization management.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Requires a health plan contract that provides coverage for outpatient prescription drugs to cover medically necessary prescription drugs, including nonformulary drugs determined to be medically necessary consistent with the Knox-Keene Act. [HSC §1342.71 and INS §10123.193]

3) Requires health plans that provide prescription drug benefits to maintain an expeditious process by which prescribing providers may obtain authorization for a medically necessary nonformulary prescription drug. Requires any plan that disapproves a request by a prescribing provider to obtain authorization for a nonformulary drug to provide the reasons for the disapproval in a notice provided to the enrollee. Requires the notice to indicate that the enrollee may file a grievance with the plan if the enrollee objects to the disapproval, including any alternative drug or treatment offered by the plan. [HSC §1367.24]

4) Requires, if a health plan or insurer that provides coverage for prescription drugs or a contracted physician group fails to respond to a prior authorization or step therapy exception request, within 72 hours for nonurgent requests, and within 24 hours if exigent circumstances exist, upon the receipt of a completed request form, the request to be deemed granted. [HSC §1367.241 and INS §10123.191]

5) Requires an external exception request review process for a denial of a prior authorization or step therapy exception request. Requires an independent review organization's reversal of a health plan or insurer denial of a request for an exception, prior authorization, or step therapy exception to be binding and apply for the duration of the prescription, and refills. [HSC §1367.241 and INS §10123.191]

6) Requires health plans to establish and maintain a system approved by DMHC under which enrollees may submit grievances to the plan. Requires a plan's response to also comply with federal requirements. [HSC §1368]

7) Establishes an Independent Medical Review (IMR) process, under which enrollee and insured grievances involving a disputed health care service are eligible for review. Defines "disputed health care service" as any health care service eligible for coverage and payment under the contract that has been denied, modified, or delayed by a decision of the plan/insurer, or contracting provider, in whole or in part due to a finding that the service is not medically necessary. [HSC §1374.30 and INS §10169]

This bill:

1) Requires a health plan contract or insurance policy, except for a specialized health plan contract or insurance policy, that is issued, amended, or renewed on or after January 1, 2026, to include coverage for evaluation and treatment options for perimenopause and menopause, as is deemed medically necessary by the treating health care provider without utilization management, including but not limited to:

    a) At least one option in each formulation of, and the associated method of administration for, federal Food and Drug Administration (FDA)-regulated systemic hormone therapy;
    b) At least one option in each formulation of, and the associated method of administration for, nonhormonal medications for each menopause symptom;
    c) At least one option in each formulation of, and the associated method of administration for, treatment for genitourinary syndrome of menopause; and,
    d) At least one from each class of medications approved to prevent and treat osteoporosis.

2) Requires this coverage to include authority for the treating provider to adjust the dose of a drug consistent with clinical care recommendations.

3) Requires health plans and insurers to annually provide current clinical care recommendations for hormone therapy from the Menopause Society or other nationally recognized professional associations to all contracted primary care providers who treat enrollees or insureds with perimenopause and menopause. Requires plans and insurers to encourage primary care providers to review those recommendations.

4) Defines "formulation" to mean: a tablet or capsule; a transdermal patch; a topical spray; a cream, gel, or lotion; and, a vaginal suppository, cream, or silicone ring. Defines "method of administration" to mean administering a formulation via an oral, topical, vaginal, subcutaneous, injectable, or intravenous route of administration.

5) Requires coverage for the evaluation and treatment options for perimenopause and menopause to be provided without discrimination on the basis of gender expression or identity.

6) Requires this bill not to be construed to limit coverage for medically necessary outpatient prescription drugs, as specified, or any other provision under the law.

7) Requires, beginning July 1, 2026, a physician or an osteopathic physician who completes continuing medical education (CME) courses in perimenopause, menopause, and postmenopausal care to receive two hours of credit for each hour completed of that coursework, for a total earned credit not exceeding eight course hours, toward the requirement set forth in regulations. Deletes a requirement that the Medical Board of California (MBC) consider including a continuing medical education course in menopausal mental or physical health.

FISCAL EFFECT: According to the Assembly Committee on Appropriations, the MBC and the Osteopathic Medical Board of California anticipate a minor and absorbable fiscal impact related to updating CME-related materials, web content, and procedures. DMHC estimates costs of approximately $980,000 in fiscal year (FY) 2026-27, and $970,000 in FY 2027-28 and annually thereafter for state administration. CDI estimated no new costs. CHBRP estimated annual increases of $748,000 to Medi-Cal managed care plans and $170,000 to Medi-Cal County Organized Health Systems, based on removal of utilization management requirements on drugs administered in a medical setting. The analysis notes that for AB 2467 (Bauer-Kahan, 2024), which had coverage requirements identical to those in this bill, the Department of Finance estimated costs for the Medi-Cal program likely in the millions to tens of millions of dollars General Fund to the extent Medi-Cal managed health plans cover services pursuant to this bill. For the California Public Employees Retirement System (CalPERS), CHBRP estimates premiums will increase by $3.49 million per year; approximately 54% of CalPERS enrollees are state-affiliated, so state costs could increase by about $1.89 million.

PRIOR VOTES:

Senate Business, Professions and Economic Development Committee:	9 - 0
Assembly Floor:	70 - 1
Assembly Appropriations Committee:	11 - 0
Assembly Health	15 - 0
Assembly Business and Professions Committee:	14 - 0

COMMENTS:

1) *Author's statement.* According to the author, although menopause is a natural occurrence that one million Americans experience every year, it has been treated as unworthy of proper care, research, and basic understanding. According to a recent survey, a majority of women felt that they were 'not informed at all' when it came to menopause and perimenopause. Additionally, medical students get less than one hour training in menopause, and 80% of graduating OB/GYN residents admit to feeling "barely comfortable" talking to their patients about menopause. Quality, evidence-based care is critical as the hormonal changes that occur at menopause have profound effects on health and wellbeing for the remainder of a woman's life. Menopause impacts women who are often in the peak of their careers and when not provided adequate treatment and support it can cause massive financial ramifications. According to Mayo Clinic, the annual cost of untreated menopause symptoms in workplace productivity and related health care costs is $150 billion globally and $26.6 billion in the U.S. This bill mandates coverage for healthcare treatment plans for people experiencing perimenopause and menopause related symptoms. Menopause isn't just a personal experience; it's a public health issue that deserves our attention and action. It is time we stop devaluing women after their reproductive years.

2) *Joint hearing.* The Senate Health Committee and the Assembly Select Committee on Reproductive Health held an informational hearing on May 8, 2024 titled Menopause: Access to Treatment and Coverage. During the hearing, medical and academic experts and community members provided testimony regarding menopause; its symptoms and available treatments and therapy; knowledge of healthcare providers' patients; disparities in experiences among people of color; and, health insurance coverage. A primary conclusion from the hearing was that California should prioritize destigmatizing menopause by

improving the educational curriculum for health care providers, researching the impact of menopause on a person's health, understanding the disparities of experiences among people of color, and continuing coverage of treatments proven to effectively treat menopause transition symptoms.

3) *California Health Benefits Review Program (CHBRP) report.* AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996, and reviewed this bill. Key findings include:

   a) *Coverage impacts and enrollees covered*. This bill would apply to the health insurance of approximately 22,207,000 enrollees (58.8% of all Californians). This includes enrollees in commercial or CalPERS, DMHC and CDI regulated products, and Medi-Cal beneficiaries enrolled in DMHC-regulated plans. CHBRP assumes enrollees in Medi-Cal county organized health system (COHS) plans would also have coverage that would be expected to comply with this bill.
   b) *Medical effectiveness.* The medical effectiveness review conducted by CHBRP includes findings from evidence on the effectiveness of high- and low-dose vaginal estrogens, systemic testosterone therapy (oral and non-oral), fezolinetant, ospemifene, and prasterone. CHBRP found that both high and low dose vaginal estrogens proved to be effective in reducing moderate-to-severe vasomotor symptoms (VMS) and improved urogenital symptoms in menopausal women. CHBRP also found very strong evidence that systemic testosterone therapy for the treatment of hypoactive sexual dysfunction disorder caused by menopause is effective, based on a systematic review and meta-analysis including 36 studies. The findings regarding the use of fezolinetant also suggest there is strong evidence that it is effective for treatment of VMS due to menopause based on four systematic reviews (of the same five randomized controlled trials) and one additional randomized controlled trial that compared it to placebo. Both ospemifine and prasterone have proven to be effective in improving symptoms of vaginal dryness and dyspareunia (painful intercourse) in menopausal women compared to placebo. CHBRP concluded that these medications have been proven effective in treating a variety of menopausal symptoms, with limited side effects. There is evidence of side effects and potential harms from drugs that treat menopause symptoms. However, for FDA-approved drugs, there is evidence that the benefits of symptom relief outweigh the potential harms (assuming the drugs are appropriately prescribed, and patients are monitored properly).
   c) *Utilization*. CHBRP assumed no changes in utilization due to no changes in coverage and no changes in utilization management for the following tests and drugs: Lab tests used for the evaluation of menopause symptoms; FDA-regulated oral systemic, topical systemic, transdermal systemic, and vaginal hormone therapy (with the exception of combination estrogen-selective estrogen receptor modulator (SERM) oral systemic therapy, testosterone systemic therapy, and high-dose systemic vaginal estrogen via the vaginal ring [e.g., Femring] and low-dose local vaginal estrogen via the vaginal ring [e.g., Estring]); low-dose antidepressants; and low-dose anticonvulsants (e.g., gabapentin). Baseline utilization for oral systemic combination estrogen and SERM therapy increases from an estimated 14 monthly 30-day prescriptions at baseline to 99 monthly 30-day prescriptions post-mandate (607 %). Similarly, utilization for high dose systemic vaginal estrogen increases from an estimated 299 monthly 30-day prescriptions at baseline to 891 monthly 30-day prescriptions post-mandate (198). Changes in utilization for fezolinetant

and ospemifene would increase 226% and 167%, respectively. For example, utilization of fezolinetant will increase from 4,246 monthly 30-day prescriptions at baseline to 13,837 monthly 30-day prescriptions post-mandate.

d) *Medi-Cal.* This bill includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. In addition, CHBRP estimates that there would also be a proportional increase of $170,000 for Medi-Cal beneficiaries enrolled in COHS managed care.

e) *Impact on expenditures.* For DMHC-regulated plans and CDI-regulated policies, this bill would increase total premiums by $74,501,000 (0.05%). Cost sharing for covered benefits for enrollees would increase by $21,083,000 and enrollee out-of-pocket expenses for non-covered benefits would decrease overall by $33,365,000. As a result, total net expenditures would increase by $62,220,000 (0.04%). Of the total expenditure impact due to this bill, CHBRP estimates that 86% (or $53.5 million) is due to additional benefit coverage, while the other 14% (or $8.7 million) is due to the removal of utilization management on medications impacted by this bill.

f) *Public health.* Within the first year postmandate, CHBRP finds that this bill would improve the health of ~22,274 women who may receive new prescriptions for menopause symptoms under new coverage and removal of utilization management. In the long run, management of VMS may also prevent or reduce the risk of cardiovascular disease and cognitive decline. Health benefits include improved quality of life through reduction in genitourinary syndrome symptoms (e.g., vaginal dryness, vulvovaginal atrophy, burning and itching during urination, and/or painful intercourse) and/or VMS such as hot flashes/night sweats. VMS can cause or exacerbate sleep problems and memory/cognitive function. Furthermore, some women experiencing moderate-to-severe VMS may experience reduced productivity, capacity to work, and poorer work experience. Use of the newly covered drugs may improve sleep and memory/cognitive function as symptoms abate. Additionally, some of these women may experience improved productivity or presentism as their VMS subside (and sleep improves).

g) *Essential health benefits (EHBs).* This bill does not exceed EHBs under the Affordable Care Act.

4) *Double referral.* The bill was heard in the Senate Business, Professions and Economic Development Committee on July 7, 2025 and passed with a 9-0 vote.

5) *Prior legislation.* AB 2467 (Bauer-Kahan of 2024) was substantially similar to this bill. *AB 2467 was vetoed by Governor Newsom, who stated:*

> *This bill would require health plans to cover the costs of evaluation and treatment options for perimenopause and menopause, without utilization review, and require this coverage to include at least one option in each formulation of specified perimenopause and menopause treatments. Health plans would also be required to provide clinical care recommendations for hormone therapy to contracted primary care providers annually. I appreciate the author's intent to ensure access to comprehensive and up-to-date treatment of perimenopause and menopause. However, this bill's expansive coverage mandate in conjunction with a prohibition on utilization management (UM) is too far-reaching. Health plans use UM to ensure enrollees receive the right care at the right time, which is especially important when there are new and emerging treatments. Further, a mandate to cover non-FDA approved treatments, without UM, is unprecedented. These factors, in conjunction with ambiguities in the bill for undefined terms, raise concerns for cost containment and bill implementation. I encourage the Legislature and stakeholders to continue to work towards a more tailored solution that can improve access to*

perimenopause and menopause care, inform patients of their options, and encourage providers to stay informed of the latest clinical care recommendations.

AB 2270 (Maienschein, Chapter 636, Statutes of 2024) requires various health professional licensing boards to consider including a course in menopausal mental or physical health to standards and requirements for licensee continuing education.

6) *Support.* The American Association of University Women of California (AAUW of California) believe that access to quality health care is a right that should be extended to all members of society, particularly women experiencing the complex impacts of menopause and perimenopause. AAUW of California writes that menopause and perimenopause affect approximately 50% of the population, although it continues to be a taboo subject, forcing women to "tough it out" in silence rather than seek professional medical advice and treatment, and, these women should instead be receiving quality, evidence-based care that is critical as the hormonal changes that occur at menopause have profound effects on the health and wellbeing for the remainder of a woman's life. AAUW of California also writes that the annual cost of untreated menopause symptoms in workplace productivity and related health care costs is $150 billion globally and $26.6 billion in the United States. Other groups also write in support arguing that according to a recent survey, a majority of women felt that they were 'not informed at all' when it came to menopause and perimenopause. Additionally, medical students get less than one hour of training in menopause, and 80% of graduating OB/GYN residents admit to feeling "barely comfortable" talking to their patients about menopause. For these reasons, it's crucial to ensure that all California women at midlife have access to the menopause education and care they deserve. The California Medical Association (CMA) believes by offering enhanced CME credit rather than imposing a one-size-fits-all requirement, this bill promotes broader engagement in this critical area of menopausal care while respecting the diversity of medical specialties. The Osteopathic Medical Board writes, "The historic lag in medical research dedicated to women's unique health conditions has largely been ignored which has widened this gap further. However, the marketplace has not ignored the needs and has created a variety of unregulated products. There is still much unknown about how this condition presents in women and physicians do need more training to better care for their women patients. The bill's recommendation for insurance coverage of menopause treatment is also needed because these treatments may not be available for physicians to recommend. Without this bill, women are left to navigate the wellness market of products that may or may not have physician recommendations. Insurance coverage would not only make these products be part an insurance coverage, but it would add the credibility of insurance review of products they cover."

7) *Opposition.* The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) argue that this bill mandates broad coverage, without the use of any utilization management tools. Additionally, CAHP and ACLHIC write the broad criteria encourages the use of riskier drugs based on a wide range of symptoms and clinical standards that negate the important oversight role health plans and other medical societies have endorsed. CAHP and ACLHIC believe these drugs include everything from expensive GLP1 drugs for weight management to ketamine for treating depression to pain management drugs such as oxycodone for joint pain without allowing plans to employ the simplest of oversight, such as quantity limits. CAHP and ACLHIC say there is a path forward that will allow all patients to access critically important healthcare services; however, they are very concerned that this bill, as drafted, will dramatically open the care model to dangerous levels of waste, fraud, and abuse, causing

unknown spikes in the cost of care. The California Rheumatology Alliance (CRA) and the California Society of Plastic Surgeons (CSPS) also write in opposition of this bill because they argue that CME courses should be picked by physicians based on the needs of their patients related to the specialty in which their physician is trained. For rheumatologists or plastic surgeons to be required to take a CME course which may not be a central part of the scope of services they provide, it would take away from CME courses aimed at providing better care for their patients. The California Orthopedic Association also argues in opposition of this bill because they believe that the California Medical Board is far better suited to determine continuing education requirements than the Legislature.

8) *Amendments.* The author is requesting the committee adopt amendments to indicate that utilization management is not required for treatments approved by the FDA, and other clarifying changes. The committee may wish to further clarify that the treating provider is in network with the health plan contract or health insurance policy.

SUPPORT AND OPPOSITION:

Support: American Association of University Women - California
Astellas Pharma Us, Inc.
Bayer US
Black Women for Wellness Action Project
California Behavioral Health Association
California Legislative Women's Caucus
California Life Sciences Association
California Medical Association
California Retired Teachers Association
National Women's Political Caucus of California
Osteopathic Medical Board of California
Women Lawyers of Sacramento

Oppose: Association of California Life & Health Insurance Companies
California Association of Health Plans
California Chapter American College of Cardiology (unless amended)
California Orthopedic Association
California Rheumatology Alliance
California Society of Plastic Surgeons
Medical Board of California (unless amended)

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