KEY FINDINGS

Analysis of California Assembly Bill 432: Menopause

Summary to the 2025–2026 California State Legislature, April 22, 2025

Summary

The version of California Assembly Bill (AB) 432 analyzed by the California Health Benefits Review Program (CHBRP) would require coverage for evaluation and treatment options for perimenopause and menopause without utilization management, per medical necessity as determined by the treating clinician.

In 2026, AB 432 would apply to the health insurance of approximately 22,207,000 enrollees (58.8% of all Californians). All 22,207,000 enrollees have a medical benefit subject to AB 432, and approximately 12,948,000 enrollees have a DMHC-regulated or CDI-regulated outpatient pharmacy benefit.

Benefit Coverage

At baseline, no enrollees are in plans or policies that are fully compliant with AB 432 because not all medications are included in benefit coverage as would be required by AB 432, and several medications or medication classes have utilization management at baseline. AB 432 would not exceed essential health benefits (EHBs).

Medical Effectiveness

Several treatments are endorsed by existing clinical practice guidelines *and* widely covered by insurance without utilization management. CHBRP reviewed the literature for medications that are not fully covered by insurance at baseline and/or have utilization management. CHBRP found that high-dose vaginal estrogen and fezolinetant are effective at treating vasomotor symptoms and that ospemifene, vaginal DHEA, and low-dose estrogen are effective at treating genitourinary syndrome of menopause. CHBRP also found that systemic testosterone therapy (oral and non-oral) can improve symptoms of hypoactive sexual desire disorder. Of the drugs that prevent and treat osteoporosis, CHBRP found that bisphosphonates are effective as first-line treatment and that monoclonal antibodies and synthetic parathyroid hormone are effective as second-line treatments.

Cost and Health Impacts[1]

In 2026, AB 432 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 noncovered 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 AB 432, CHBRP estimates that 86% (or $53.5 million) would be due to additional benefit coverage, whereas the other 14% (or $8.7 million) would be due to the removal of utilization management on medications impacted by AB 432.

Although many women already receive treatment for menopause symptoms at baseline, CHBRP projects that the bill would result in an additional ~22,274 women who may receive new prescriptions for menopause symptoms in the first year postmandate. This increase in utilization would improve quality of life for these women.

Context

Menopause is part of the normal aging process in which menstruation has ceased for 12 consecutive months. This transition to a new stage of life (rather than a condition or disease) is experienced by every woman and most often occurs naturally between ages 45 and 55 years but may occur between ages 40 and 64 years (median age 51 years). Some women experience

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

bothersome symptoms prompting requests for treatment.[2]

Perimenopause is the stage where menstruation becomes irregular in frequency, duration, and bleeding intensity for a variable amount of time (median duration 4 years) before periods stop completely. Menopause is the stage where there is a complete cessation of menstruation for 12 consecutive months. The period after the 12 consecutive months is sometimes referred to as “postmenopause”.

For simplicity in this report, CHBRP will use “menopause” to describe the perimenopause, menopause, and postmenopause stages, unless otherwise specified.

There are approximately 5 million women aged 40 to 64 years in California, many of whom experience mild, moderate, or severe menopause symptoms for a few months to more than 12 years.

Genitourinary (vaginal atrophy and/or dryness) and vasomotor symptoms (night sweats, hot flushes [colloquially called hot flashes]) are the two most commonly reported symptoms of menopause and can occur throughout the menopausal stages. The genitourinary syndrome of menopause (GSM) includes symptoms such as dysuria (burning, stinging, itching during urination), and dyspareunia (painful intercourse due to vaginal dryness or atrophy). For those who experience moderate-to-severe vasomotor symptoms (VMS), sleep disruption and insomnia can occur which, in turn, may affect memory, cognition, and mood (irritability or depression). Memory and cognition (without sleep disruption) may decline during the early menopausal stage, but decrements can reverse during later menopause.

Women may also experience decreased libido, which could be related to other menopause symptoms such as GSM or depression. A subset of menopausal women with low libido may be diagnosed with hypoactive sexual desire disorder (HSDD), which is defined as persistent or recurrent absence of desire for sexual activity which causes personal distress or interpersonal difficulties. Additionally, accelerated loss of bone density and strength occurs in early menopause but slows during the later stages; menopause experienced at younger ages produces lower bone density as women age, which results in more fractures.

Bill Summary

There are two primary sections of AB 432.

The first section would amend the Business and Professions Code and place requirements around continuing medical education for physicians, including requiring completion of a course in perimenopause or menopause if the physicians have a patient population composed of 25% or more women, and specifies that the Medical Board of California include a course in menopausal mental or physical health in the requirements.

The second section of AB 432 would require health insurance coverage for evaluation and treatment options for perimenopause and menopause. Specifically:

- Coverage, as deemed medically necessary by the treating provider without utilization management, would include, but is not limited to:
    - At least one option in each formulation of, and the associated method of administration for, federal Food and Drug Administration–approved systemic hormone therapy.
    - At least one option in each formulation of, and the associated method of administration for, nonhormonal medications for each menopause symptom.
    - At least one option in each formulation of, and the associated method of administration for, treatment for genitourinary syndrome of menopause (GSM).
    - At least one from each class of medications approved to prevent and treat osteoporosis.

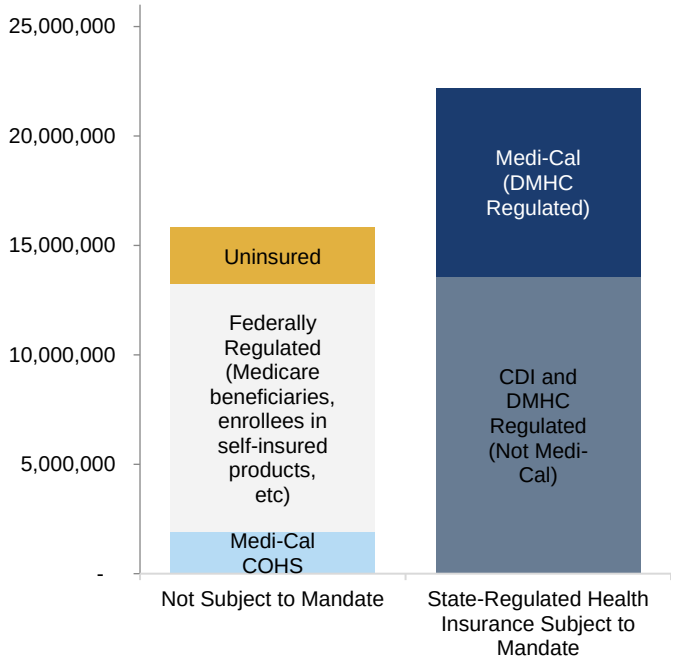
Additionally, plans and policies would be required to annually provide current clinical care recommendations for hormone therapy from the Menopause Society or other nationally recognized professional associations to all contracted primary care clinicians who treat enrollees with perimenopause and menopause, with the encouragement for the provider to review the recommendations.

[2] Refer to CHBRP’s full report for full citations and references.

To comply with AB 432, CHBRP assumes plans and policies would need to provide on-formulary coverage for at least one medication in each available formulation and route of administration for each category identified by the bill as well as each hormone type within that formulation and route of administration. For example, within systemic hormonal therapy, there are multiple formulations of medications that include oral systemic and topical systemic medications. Within those formulations, there are several categories of medications that are differentiated by type of hormone (e.g., estrogen only, progesterone only, or a combination). CHBRP assumes that plans and policies would be required to cover at least one medication of these hormone types.

Figure A notes how many Californians have health insurance that would be subject to AB 432.

Figure A. Health Insurance in CA and AB 432



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; DMHC = Department of Managed Health Care.

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.

Impacts

Benefit Coverage

All 22,207,000 enrollees have a medical benefit subject to AB 432, and approximately 12,948,000 enrollees have Department of Managed Health Care (DMHC)-regulated or California Department of Insurance (CDI)-regulated commercial/California Public Employees' Retirement System (CalPERS) coverage that includes an outpatient pharmacy benefit.

CHBRP estimates that at baseline, no enrollees are in plans or policies that are fully compliant with AB 432 because not all medications are included in benefit coverage as would be required by AB 432, and several medications or medication classes have utilization management at baseline.

Services for the Evaluation of Menopause Symptoms

- 100% of enrollees have coverage at baseline under the medical benefit.

Systemic and Local Hormone Drug Therapies

- 100% of enrollees have coverage at baseline without utilization management for most oral

[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.

systemic and topical systemic medications, as well as for both transdermal systemic formulations.

- Approximately 4% of enrollees have baseline coverage for combination estrogen–selective estrogen receptor modulator (SERM) (oral systemic) without utilization management.
- Along with some utilization management, 72% of enrollees have coverage for topical testosterone (topical systemic), 12% of enrollees have coverage for high-dose systemic vaginal estrogen, 96% of enrollees have coverage for low-dose local vaginal estrogen, and 3% have coverage for prasterone.

Nonhormonal Drug Therapies

- Along with some utilization management, 9% of enrollees have coverage for fezolinetant and 19% of enrollees have coverage for ospemifene
- 100% of enrollees have coverage at baseline for low-dose antidepressants and anticonvulsants without utilization management.

Osteoporosis Medications

- For medications covered under the medical benefit (some bisphosphonates and monoclonal antibodies), 100% of enrollees have baseline coverage.
- For medications covered under the pharmacy benefit, there is 100% coverage at baseline for bisphosphonates and synthetic parathyroid hormone. Approximately 28% of enrollees have coverage for SERMs at baseline.
- All medications in this category have some utilization management.

Utilization

CHBRP estimates no changes in utilization for evaluation of menopause symptoms and medications since lab tests used for evaluation are fully covered without utilization management at baseline.

Utilization of medications would increase due to 1) changes in baseline benefit coverage and/or 2) elimination of utilization management.

Systemic and Local Hormone Drug Therapies

Utilization for the oral systemic combination estrogen-SERM therapy increases from an estimated 14 monthly prescriptions at baseline to 99 monthly prescriptions postmandate. High-dose systemic vaginal systemic therapy utilization would increase from an estimated 299 monthly prescriptions at baseline to 891 monthly prescriptions postmandate. Utilization of prasterone would increase from an estimated 106 monthly prescriptions at baseline to 394 monthly prescriptions postmandate.

CHBRP estimates that utilization for topical systemic testosterone, and low-dose local vaginal estrogen would increase more modestly due to higher existing coverage at baseline, with the changes driven by the removal of utilization management postmandate. Utilization of topical systemic testosterone would increase from an estimated 276 monthly prescriptions at baseline to 385 monthly prescriptions postmandate. Utilization of low-dose local vaginal estrogen would increase by 3% postmandate.

Nonhormonal Drug Therapies

Utilization for fezolinetant and ospemifene would increase substantially due to both an increase in coverage and the removal of utilization management. Changes in utilization for these two therapies would be 226% and 167%, respectively. For example, utilization of fezolinetant would increase from 4,246 monthly prescriptions at baseline to 13,837 monthly prescriptions postmandate. Additionally, a portion of baseline utilization would shift from noncovered to being covered postmandate.

Osteoporosis Medications

CHBRP assumed a small (2%) increase in utilization due to the removal of utilization management for the following drugs for the prevention and treatment of osteoporosis that had 100% coverage at baseline: bisphosphonates, monoclonal antibodies, and synthetic parathyroid hormone. CHBRP assumed a larger (190%) increase in the utilization of SERMs from baseline to postmandate due to both increased coverage and the removal of utilization management.

Expenditures

For DMHC-regulated plans and CDI-regulated policies, AB 432 would increase total premiums by $74,501,000

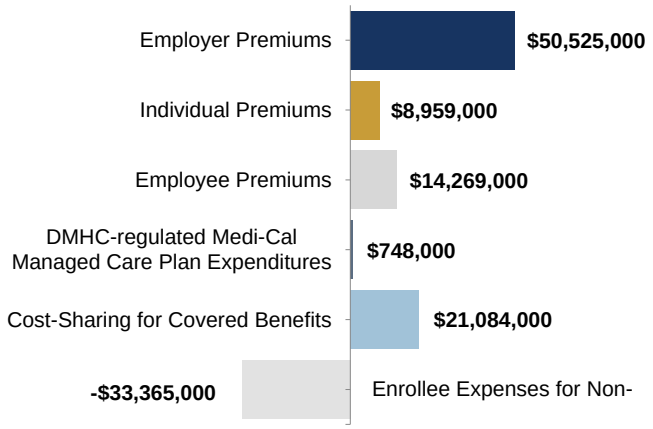
(0.05%). Cost sharing for covered benefits for enrollees would increase by $21,083,000, and enrollee out-of-pocket expenses for noncovered benefits would decrease overall by $33,365,000. As a result, total net expenditures would increase by $62,220,000 (0.04%) (Figure B).

Of the total expenditure impact due to AB 432, CHBRP estimates that 86% (or $53.5 million) would be due to additional benefit coverage, whereas the other 14% (or $8.7 million) would be due to the removal of utilization management on medications impacted by AB 432.

Premiums would increase among DMHC-regulated commercial plans, ranging from $0.34 per member per month (PMPM) for individual plans to $0.50 PMPM for large group plans. Among CDI-regulated policies, premiums would increase from $0.36 PMPM for small-group plans to $0.45 PMPM for large-group plans.

Enrollee expenses for cost sharing for covered benefits would increase between $0.08 PMPM for enrollees in DMHC-regulated large-group plans and $0.28 PMPM for enrollees in CDI-regulated small-group policies. Decreases in out-of-pocket costs for noncovered benefits would range from $0.21 PMPM for enrollees in CDI-regulated small-group plans to $0.17 PMPM for DMHC-regulated CalPERS plans. These decreases largely result from a shift in out-of-pocket costs for drug therapies that are not covered at baseline, such as fezolinetant, ospemifene, and prasterone, to premiums and enrollee cost sharing.

Figure B. Expenditure Impacts of AB 432



Source: California Health Benefits Review Program, 2025.

Medi-Cal

For Medi-Cal Managed Care plans, CHBRP assumed that increases in utilization would only apply to services and drugs covered under the medical benefit such as drugs infused in a doctor's office or in an infusion center.

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans, CHBRP estimates there would be an overall increase of $748,000 in premiums based upon removal of utilization management requirements on drugs administered in a medical setting. CHBRP estimates that County Organized Health Systems (COHS) would be similarly impacted, as CHBRP assumes the two populations to be relatively similar and to have relatively similar benefit coverage. CHBRP estimates an increase of $170,000 in premiums for Medi-Cal beneficiaries enrolled in COHS managed care.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, CHBRP estimates that premiums would increase $3,491,000 postmandate, or $0.38 PMPM.

Covered California – Individually Purchased

Premiums for enrollees purchasing coverage through Covered California would increase by $6,566,000 (0.04%), or $0.34 PMPM.

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 AB 432.

Medical Effectiveness

CHBRP's review of literature does not include treatments for menopause that are endorsed by clinical practice guidelines (see below) *and* already widely covered by insurance without utilization management.

Some medications, such as fezolinetant, ospemifene, and prasterone, may be appropriate for patients with significant risk factors including high risk or history of breast cancer or other estrogen-dependent cancers that make hormone therapy inadvisable; therefore, alternate drugs are needed.

Systemic Hormonal Drug Therapy

According to the Menopause Society, "[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."

There is *some evidence*[4] that high-dose vaginal estrogen is effective at treating vasomotor symptoms (VMS). CHBRP did not find any studies that reported harms or adverse effects of high-dose vaginal estrogen.

There is *very strong evidence*[5] that systemic testosterone therapy (oral and non-oral) can improve symptoms of hypoactive sexual desire disorder (HSDD). CHBRP did not find any studies that reported significant harms or adverse effects of systemic testosterone therapy for menopause symptoms.

Nonhormonal Drug Therapies

There is *strong evidence*[6] that fezolinetant is effective for treatment of VMS due to menopause. There were no reported significant differences in all adverse events or study dropouts due to treatment-ending adverse reactions.

Genitourinary Syndrome of Menopause Treatment

There is *very strong evidence* that low-dose vaginal estrogen is an effective treatment for GSM (including dysuria, urgency and frequency of urination, recurrent urinary tract infections, and urinary incontinence). Additionally, systematic reviews of the literature found no evidence of increased risk of endometrial hyperplasia or endometrial cancer, or breast cancer recurrence or mortality in breast cancer survivors, with low-dose vaginal estrogen alone. There is uncertain evidence on the effect of low-dose vaginal estrogen on adverse events.

There is *strong evidence* that ospemifene improved symptoms of dryness and dyspareunia (painful intercourse) in menopausal women compared to placebo. Evidence also suggests that the effects of ospemifene on dyspareunia (painful intercourse) and vaginal dryness are similar to the effects of other treatments. There were no reported statistically significant differences between ospemifene 60 mg and other tested therapies for most safety outcomes.

There is *strong evidence* that prasterone (vaginal DHEA) improved symptoms of vaginal dryness and dyspareunia (painful intercourse) in menopausal women compared to placebo, although vaginal DHEA may result in more adverse events compared with placebo.

Drugs to Prevent and Treat Osteoporosis

There is *very strong evidence* that bisphosphonates as first-line treatment for osteoporosis can effectively reduce fracture risk among postmenopausal women. There is *strong evidence* that monoclonal antibodies, and *some evidence* that synthetic parathyroid hormone, are effective as second-line treatments for postmenopausal women with contraindications to bisphosphonates or at very high risk of fracture. However, these medications carry additional harm compared to bisphosphonates. There is *not enough research*[7] to establish whether SERMs are effective in reducing fracture risk among postmenopausal women.

Public Health

Within the first year postmandate, CHBRP estimates that AB 432 would improve the health of ~22,274 women who may receive new prescriptions for menopause symptoms under new coverage and removal of utilization management.

Health impacts include improved quality of life through reduction in GSM 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.

[4] *Some evidence* indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.
[5] *Very strong evidence* indicates that there are multiple studies of a treatment, and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.

[6] *Strong evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.
[7] *Not enough research* indicates that there are no studies of the treatment, or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

VMS can cause or exacerbate sleep problems and memory/cognitive function. Furthermore, some women experiencing moderate-to-severe VMS may experience reduced productivity, reduced 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 presenteeism as their VMS subside (and sleep improves). Note that these women may also experience drug side effects, which may or may not influence decisions to continue the drug therapy.

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).

Long-Term Impacts

The long-term public health impacts (including disparities) of AB 432 are expected to be similar to those described in the short-term impact section. Management of VMS may also prevent or reduce the risk of cardiovascular disease and cognitive decline in the long-term.

Most drugs across the bill-specified categories are already covered at baseline. Therefore, CHBRP anticipates that a limited number of women (especially those with high risk for or history of hormone-sensitive cancers) will access the newly covered medications or may access different treatments due to the removal of utilization management. These women would be expected to experience reductions in or abatement of moderate-to-severe VMS and GSM over the course of their treatment, which might last 4 to 12 years after they start menopause. These treatments rarely have negative long-term effects, so no population-level harms are expected in the long-term.

The bill requirement for the completion of a menopause continuing medical education course may potentially impact physician knowledge on menopause, comfort in treating menopause symptoms, and drug prescribing patterns over time. Non–bill-related factors that influence treatment uptake would remain unaffected by AB 432 including patient knowledge of menopause and treatment options, and comfort or confidence in discussing bothersome symptoms with clinicians.

Essential Health Benefits and the Affordable Care Act

As AB 432 would not require coverage for a new state benefit, it appears not to exceed the definition of essential health benefits (EHBs) in California.

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