A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Analysis of California Assembly Bill 432: Menopause

APRIL 22, 2025

CHBRP

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

chbrp.org

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.

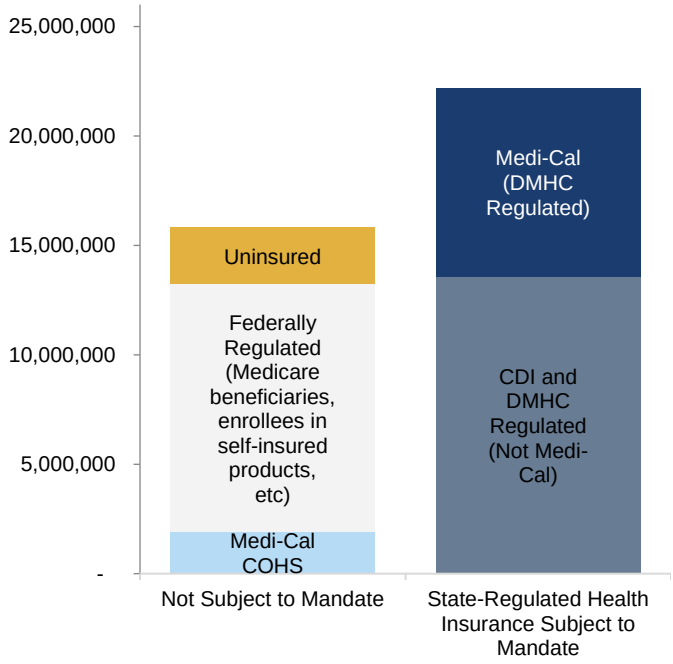
Additionally, plans and policies would be required to annually provide current clinical care recommendations for hormone therapy from the Menopause Society or other nationally recognized professional associations to all contracted primary care clinicians who treat enrollees with perimenopause and menopause,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

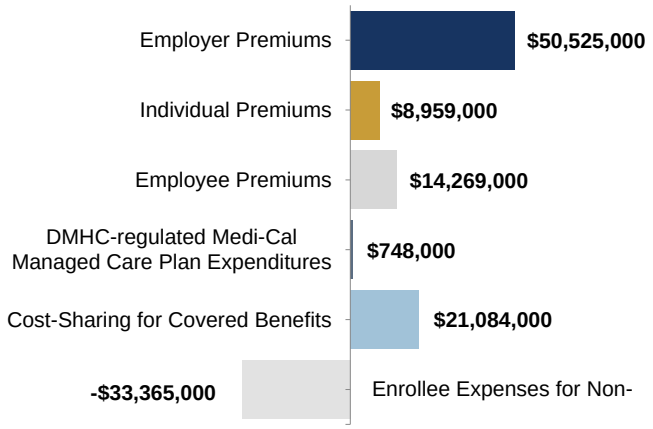
(0.05%). Cost sharing for covered benefits for enrollees would increase by $21,083,000, and enrollee out-of-pocket expenses for noncovered benefits would decrease overall by $33,365,000. As a result, total net expenditures would increase by $62,220,000 (0.04%) (Figure B).

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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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. An 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 Assembly Bill 432: Menopause.* Berkeley, CA.

Table of Contents

Lists of Tables and Figures

Acronyms and Abbreviations

AB – Assembly Bill
ACA – Affordable Care Act
ACOG – American College of Obstetricians and Gynecologists
ACP – American College of Physicians
CA – California
CalPERS – California Public Employees' Retirement System
CEE – conjugated equine estrogens
CDI – California Department of Insurance
CHBRP – California Health Benefits Review Program
COHS – County Organized Health System
DHCS – Department of Health Care Services
DHEA – dehydroepiandrosterone
DMHC – Department of Managed Health Care
DSM - Diagnostic and Statistical Manual of Mental Disorders
EHB – Essential Health Benefits
FDA – U.S. Food and Drug Administration
FSH – follicular stimulating hormone
GABA – gamma-aminobutyric acid
GSM – genitourinary syndrome of menopause
HSDD – hypoactive sexual desire disorder
LH – luteinizing hormone
NAMS – North American Menopause Society
NK3 – neurokinin 3
PMPM – per member per month
RCT – randomized controlled trial
SERM – selective estrogen receptor modulator
SNRI – serotonin-norepinephrine reuptake inhibitors
SSRI – selective serotonin reuptake inhibitors
SWAN – Study of Women's Health Across the Nation
TEAE – treatment-ending adverse event
UTI – urinary tract infection
VMS – vasomotor symptoms
WHI – Women's Health Initiative

Introduction

The California Assembly Committee on Health requested that the California Health Benefits Review Program (CHBRP)[8] conduct an evidence-based assessment of the medical, financial, and public health impacts of Assembly Bill (AB) 432, which would require coverage for evaluation and treatment options for perimenopause and menopause.

AB 432, Menopause Bill Language

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 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 U.S. Food and Drug Administration (FDA)-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.
    - At least one from each class of medications approved to prevent and treat osteoporosis.
- Clinicians would have the authority adjust the dose of a drug consistent with clinical care recommendations.
- 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.
- Coverage for the evaluation and treatment options for perimenopause and menopause shall be provided without discrimination on the basis of gender expression or identity.
- Nothing in this section shall be construed to limit coverage for medically necessary outpatient prescription drugs pursuant to Section 1342.71 or any other provision under this chapter.

See the full text of AB 432 in Appendix A.

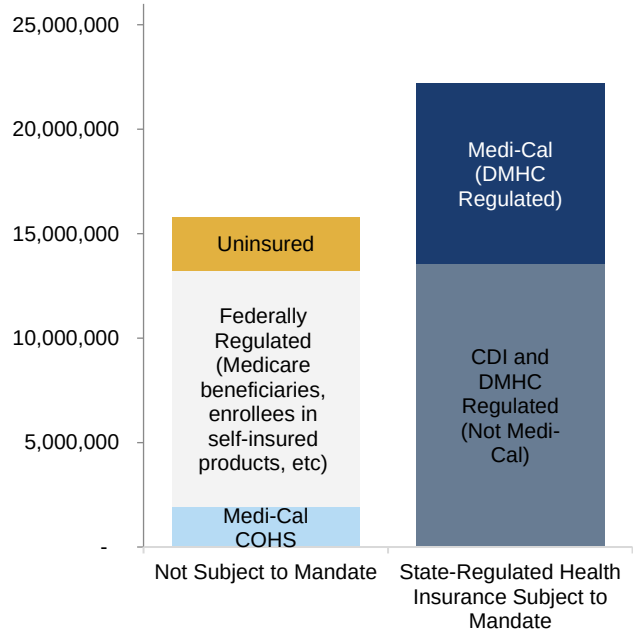
[8] See CHBRP's authorizing statute.

If enacted, AB 432 would apply to the health insurance of approximately 22,207,000 enrollees (58.8% 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), 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 AB 432.[9]

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

Figure 1. 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.

What Is 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[10] 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). Some women experience bothersome symptoms prompting requests for treatment.

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 (Delamater and Santoro, 2018). 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 (Avis et al., 2015; CHIS, 2022; NIA, 2021).

Terminology

AB 432 provides the following definitions:

[9] 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.
[10] CHBRP refers to women in the discussion of menopause, but recognizes that individuals with female reproductive organs who identify as male or nonbinary also experience menopause.

- **Formulation** – means all of the following:
  - A tablet or capsule.
  - A transdermal patch.
  - A topical spray.
  - A cream, gel, or lotion.
  - A vaginal suppository, cream, or silicone ring.
  - CHBRP notes there are additional formulations including vaginal tablets, liquid and lyophilized powder.
- **Method (or route) of administration** – means administering a formulation via an oral, topical, vaginal, subcutaneous, injectable, or intravenous route of administration.

Types of Menopause

- **Natural:** median age 51 years.
- **Clinically induced:** May occur at any age due to some prescription drug treatments (e.g., chemotherapy or hormone therapy used to treat breast cancer) or surgical removal of the ovaries (oophorectomy).

Other definitions relevant to this analysis include:

- **Systemic** – means the medication is absorbed into the blood stream and spreads through the entire body to have medication effects throughout the body. This is in contrast to **local** where the medication stays and works locally with minimal absorption into the blood stream.

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[11] – 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 with each other 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

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

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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Analytic Approach and Assumptions

CHBRP previously analyzed similar bill language, AB 2467 Menopause, in 2024. Where applicable, this analysis builds off that previous analysis.

AB 432 would impact services and medications covered under the medical benefit as well as the pharmacy benefit. Drugs that are physician-ordered and administered under the supervision of a physician (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 prescriptions that are generally filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy.

Pharmacy Benefits Assumptions

As mentioned above, medications covered under the medical benefit would not be required to be covered under the pharmacy benefit, and vice versa.

Almost all (96.2%) commercial/California Public Employees' Retirement System (CalPERS) enrollees in plans and policies regulated by the Department of Health Care Services (DMHC) or California Department of Insurance (CDI) have an outpatient pharmacy benefit regulated by DMHC or CDI that covers both generic and brand-name outpatient prescription drugs; there is no pharmacy benefit for 1.2% of enrollees, and 2.6% of commercial/CalPERS enrollees have a pharmacy benefit that is not regulated by DMHC or CDI. For this analysis, CHBRP has assumed that plans and policies that **would not** have covered both generic and brand-name outpatient prescription drugs[12] would not be required to do so for drugs prescribed as treatment for menopause symptoms.

As of January 1, 2022, outpatient prescription drugs are covered on a fee-for-service basis by the Department of Health Care Services (DHCS) for all Medi-Cal beneficiaries through the Medi-Cal Rx program.[13] Their pharmacy benefit is "carved out" of the coverage provided by Medi-Cal Managed Care plans, and so AB 432 would not be expected to impact their pharmacy benefit coverage. Medi-Cal Managed Care plans would still be required to provide services mandated by AB 432 that would fall under the medical benefit. Table 1 provides an overview of how AB 432 would impact the medical benefit and pharmacy benefit of state-regulated health insurance.

Table 1. State-Regulated Health Insurance Subject to AB 432, by Medical Benefit and Pharmacy Benefit

	Medical Benefit	Pharmacy Benefit
Commercial/CalPERS	Yes	Yes (for pharmacy benefits regulated by DMHC or CDI)
Medi-Cal Managed Care Plans	Yes	No (pharmacy benefit is administered by DHCS)

Source: California Health Benefits Review Program, 2025.
Key: CDI = California Department of Insurance; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

Bill-Specific Assumptions

The language of AB 432 that amends the Business and Professions Code does not place requirements on health plans or policies. Therefore, these changes in requirements for continuing medical education are outside the scope of this analysis.

[12] See CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[13] 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.*

Additionally, CHBRP assumes the requirement for health plans and policies to provide clinicians with current clinical care recommendations for hormone therapy from the Menopause Society or other professional associations would be included in the administrative costs of a plan or policy.

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 (systemic hormonal therapy, nonhormonal medications, treatments for genitourinary syndrome of menopause, and osteoporosis), as well as each hormone type within that formulation and route of administration (see Appendix C for categories and examples of medications within each category). 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, as well.

The bill language of AB 432 uses "FDA-regulated." New drugs and biological products for people must be FDA approved before they are marketed. "[C]ompanies must demonstrate that its drug or biological product is safe and effective for the intended use, and that it can manufacture the product to federal quality standards. If the FDA grants an approval, it means the agency has determined that the benefits of the product outweigh the risks for the intended use" (FDA, 2022). Therefore, CHBRP uses "FDA-approved" throughout this analysis. Medications are FDA-approved for a specific purpose but can also be used "off-label" for other purposes. As discussed in the *Policy Context* section below, plans and policies cannot deny coverage for off-label use of prescription drugs in accordance with existing law.

CHBRP assumes AB 432 would not require coverage of non–FDA-approved medications, such as non–FDA-approved compounded bioidentical hormones (see the *Background* section for more information on these medications). However, should the bill be interpreted to require such coverage, impacts would be greater.

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Policy Context

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

California law and regulations

All Department of Managed Health Care (DMHC)-regulated health plans are required to cover medical necessary "Basic Health Care Services".[14] Large-group health policies regulated by the California Department of Insurance (CDI) have similar requirements.[15] Basic health care services include physician services including consultation and referral, hospital inpatient services and ambulatory care services, and diagnostic laboratory services. AB 432's requirements to cover evaluation of perimenopause and menopause, as well as the requirement to cover medications under the medical benefit, fall under the purview of basic health care services and are therefore already required to be covered.

Plans and policies cannot deny coverage for off-label use of prescription drugs in accordance with existing law.[16] Existing law prohibits health plans and policies that cover prescription drugs from limiting or excluding coverage drugs on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA, 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.

The California health insurance benefit mandate requiring coverage of contraception[17] prohibits denial of contraception when the contraception is a treatment for menopause symptoms.

DMHC Independent Medical Review

If a plan or policy denies, changes or delays an enrollee's request for medical services, denies payment for emergency treatment or refuses to cover experimental or investigational treatment for a serious medical condition, enrollees with state-regulated health insurance can apply for an Independent Medical Review through DMHC and CDI. CHBRP searched DMHC's Independent Medical Review database for menopause-related complaints during the last 5 years (DMHC, 2025). Of the 17 complaints identified related to treatments for menopause, the decision of the health plan was overturned for 9 complaints. Of the 8 that were upheld, 2 health plan decisions were upheld because an enrollee had not tried other medications or forms of medications prior to filing the complaint, 4 decisions were upheld because enrollees were requesting coverage for non–FDA-approved medications such as bioidentical hormone pellets or compounded medications, and 2 were upheld because enrollees had experienced or were likely to experience adverse reactions to the requested medications.

There were three complaints related to osteoporosis. Two complaints were requesting coverage of imaging services, with one decision being upheld and one being overturned. The third complaint was requesting coverage of an osteoporosis medication, and this health plan decision was overturned.

Previous California Legislation

CHBRP analyzed similar legislation in 2024, AB 2467 Menopause. AB 2467 was amended as it moved through the Legislative process and the final language sent to Governor Newsom was near identical to the coverage requirement

[14] HSC 1367 and Section 1300.67 of Title 28 of the California Code of Regulations.
[15] INS 10112.281.
[16] HSC 1367.21 and INS 10123.195.
[17] HSC 1367.25 and INS 10123.196.

language included in AB 432. Governor Newsome vetoed AB 2467, stating in his veto message that the "bill's expansive coverage mandate in conjunction with a prohibition on utilization management is too far-reaching….A mandate to cover non-FDA approved treatments, without utilization management, is unprecedented. These factors, in conjunction with ambiguities in the bill for undefined terms, raise concerns for cost containment and bill implementation."

Similar Legislation in Other States

Nevada requires that health insurance that covers prescription drugs or devices include coverage for any type of hormone replacement therapy that is approved by the FDA and is lawfully prescribed or ordered in Nevada.[18]

Illinois requires coverage for "medically necessary hormone therapy treatment to treat menopause that has been induced by a hysterectomy."[19] Louisiana passed a law in 2024 that requires coverage for any medically necessary care or treatment for menopause and perimenopause and prohibits use of prior authorization or step-therapy for hormone replacement therapy.[20]

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 AB 432 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).[21,22]

Essential health benefits

In California, nongrandfathered[23] individual and small-group health insurance is generally required to cover EHBs.[24] In 2026, approximately 11% of all Californians will be enrolled in a plan or policy that must cover EHBs.[25]

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

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[18] NRS 689A.0415.
[19] Sec. 356z.53 – source: P.A. 102-804, eff. 1-1-23.
[20] Louisiana Act Number 784.
[21] 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.
[22] 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.
[23] 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."
[24] For more detail, see CHBRP's issue brief, *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*.
[25] See CHBRP's resource, *Sources of Health Insurance in California*.

Background on Menopause

This section provides contextual information defining menopause, the symptoms that may accompany the menopause stages, the percent of people potentially affected by symptoms, and pharmacologic treatments for symptoms. It also summarizes disparities among women experiencing menopause, barriers to treating the symptoms, and estimates of societal burden associated with menopause.

What is 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[26] 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). 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 (Delamater and Santoro, 2018). 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.

Physiologically, during the menopause transition (whether natural or induced), hormone levels fluctuate and then decline as the ovaries begin to produce less estrogen and progesterone as they stop releasing eggs. Once a woman achieves menopause, she can no longer become pregnant without significant medical intervention (Casper, 2023). The decrease in the hormonal levels may lead to bothersome symptoms prompting requests for treatment.

Most women typically notice symptoms of menopause without a formal diagnosis. Although the diagnosis of menopause does require hormone level testing, there may be instances where healthcare providers may need to run blood or urine tests to support a diagnosis of menopause to rule out other possible causes of symptoms. Lab tests to evaluate hormone levels may include testing for anti-müllerian hormone (AMH), luteinizing hormone (LH), follicular stimulating hormone (FSH), estradiol, and testosterone (Caspar et al., 2024).

Symptoms and Evaluation of Menopause

Fluctuating estrogen and progesterone production can produce a wide variety of symptoms across all stages of menopause (NIA, 2021). Symptoms can affect women differently by type, intensity, and duration during any menopause stage. 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 (Avis et al., 2015; CHIS, 2022; NIA, 2021). See the "Disparities in Menopause Symptoms and Treatment" section for discussion of differences in symptoms by race/ethnicity.

The longitudinal Study of Women's Health Across the Nation (SWAN) released findings that differentiated between symptoms attributable to menopause and those attributable to the general aging process. Table 2 describes common menopause symptoms and their estimated prevalence (when available). Genitourinary (vaginal atrophy and/or dryness) and vasomotor symptoms (night sweats, hot flushes [colloquially called hot flashes]) are the two most commonly reported symptoms 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) (SWAN, 2023). For those who experience moderate-to-severe vasomotor symptoms (VMS), sleep

[26] 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).

disruption and insomnia can occur which, in turn, may affect memory, cognition, and mood (irritability or depression). Additionally, frequent or persistent VMS is associated with an elevated risk of cardiovascular disease (such as heart attacks, heart failure, and stroke) and cognitive decline (such as Alzheimer's diseases and related dementias later in life) (SWAN, 2025). 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 also related to other menopause symptoms such as GSM or depression. There is mixed evidence as to whether menopause reduces physical functioning or changes to skin and hair. Urinary incontinence and urinary tract infections may be related to the general aging process or to changes during menopause transition (Casper, 2023; SWAN, 2023).

Some nonpharmacologic treatments such as cognitive behavioral therapy, hypnosis, and mindfulness-based stress reduction may have beneficial effects on menopause symptoms (SWAN, 2023).

Table 2. Common Symptoms Related to Menopause

Symptom	Description/Duration	Estimated National Prevalence
Genitourinary syndrome of menopause (GSM)*	Vaginal dryness and/or vulvovaginal atrophy can result in vaginal discomfort, burning, stinging, and itching during urination; frequent urination; recurrent urinary tract infections; and/or painful intercourse.	Prevalence of vaginal dryness ranges between 30% and 50% of menopausal women. Symptoms persist in more than 25% of women in later stages of menopause.
Vasomotor symptoms (VMS) Hot flushes/flashes/night sweats	Hot flashes/night sweats are due to sudden body temperature dysregulation. They last for 2 to 4 minutes and may be associated with sweating and palpitations, sometimes followed by chills and/or a sensation of anxiety. Hot flashes that occur during sleep are called night sweats. Frequency varies from 1 to 2 per day to 1 to 2 per hour and may last a few months to many years. Frequent severe hot flashes may impact sleep, concentration, mood, energy, and sexual activity, and may last longer for those experiencing stress, anxiety, or depression.	80% of women experience some hot flashes/night sweats. Can last 7+ years for about 50% of women. Prevalence of moderate-to-severe hot flashes in the United States is 35%. An estimated 20%-30% of women seek medical attention.
Memory and cognition	Menopausal memory concerns, which generally occur in earlier menopausal stages, can reverse in later stages of menopause. Sleep disruption and depression, also menopause symptoms, can affect memory and cognition.	An estimated 65% women reported memory complaints during menopause transition.
Mood disturbance	Includes depression and anxiety. Feelings of sadness, feeling down, tired, and helpless or hopeless, as well as irritability and panic, are not uncommon, especially during transition to menopause as production of progesterone ends. Sleep disturbance from vasomotor symptoms may also affect mood.	Unknown. Significant increased risk of new-onset depression/anxiety in women during the menopausal transition with risk decreasing in into later menopause stage. The menopause transition may also exacerbate pre-existing mood disorders.
Low libido	Decreased sexual desire. A subset of menopausal women with low libido may also 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.	An estimated 50% of menopausal women may experience low sexual desire. An estimated 12% of menopausal women may experience HSDD.

Symptom	Description/Duration	Estimated National Prevalence
Sleep disturbance	Difficulty staying asleep and waking too early; symptoms are most frequent in the early menopause stage and may stabilize or improve later. Night sweats caused by vasomotor symptoms can disrupt sleep. Sleep disorders such as restless legs syndrome and sleep apnea may develop during the menopause transition.	An estimated 50% of women reported sleep problems during early menopause compared to 30% before menopause. In the perimenopause stage, estimated prevalence of sleep disorders is 42%, which rises up to 60% throughout the menopause transition.
Bone loss	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.	About 13% of women aged 50-64 years have bone loss (osteoporosis) and increases to 27% for those 65 years and older; some may be age-related rather than menopause-specific.

Source: California Health Benefits Review Program, 2025, based on 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.
Note: * Urinary incontinence is not a symptom of menopause; it is aging related.

Treatments for Menopause Symptoms

AB 432 lists overlapping categories of drugs for the treatment of menopause symptoms (see the *Introduction* section). Table 3 lists the drug treatments included in the analysis, with the routes of administration and the symptoms the drugs treat. See Appendix C for the comprehensive list of drug treatments in each of the bill-specified categories.

Drug treatments for menopause symptoms include hormonal drug therapy, nonhormonal drug therapy, and drugs to treat or prevent osteoporosis. Women may also seek compounded, non–FDA-approved systemic and local hormonal drug therapies including oral tablets, creams, and pellets (examples include intravaginal testosterone, and testosterone or estradiol pellets), which are not covered by this bill. There are concerns regarding the use of such non–FDA-approved drug therapies due to the lack of FDA oversight, lack of standardization of compounded formulations, and uncertainty regarding the safety and efficacy of these drugs (ACOG, 2023; Bell et al., 2018; Bhavnani et al., 2012; Constantine et al., 2016; Pinkerton, 2022).

Table 3. Description of Drug Categories in AB 432 and Menopause Symptoms Treated

Therapeutic Categories	Routes of Administration & Dosage Form	Menopause Symptoms Treated
Hormonal drug therapy		
Oral systemic • Estrogen only (a) • Progesterone only (b) • Combination estrogen-progesterone • Combination estrogen-SERM (c) • Combination estrogen and androgens	Oral tablet or capsule	VMS, GSM
Topical systemic • Estrogen only • Progesterone only • Testosterone only (d)	Spray, cream/gel/ lotion	VMS, GSM HSDD (testosterone only) (e)
Transdermal systemic • Estrogen only	Transdermal patch	VMS, GSM

Therapeutic Categories	Routes of Administration & Dosage Form	Menopause Symptoms Treated
• Combination estrogen-progesterone		
Vaginal high-dose systemic • Estrogen only	Vaginal silicone ring only	VMS, GSM
Vaginal low-dose local • Estrogen only	Vaginal silicone ring, suppository, or cream	GSM
DHEA local • Prasterone	Vaginal suppository	GSM
Nonhormonal drug therapy		
Neurokinin 3 (NK3) receptor antagonist (f) • Fezolinetant	Oral tablet	VMS
SERM • Ospemifene	Oral tablet	GSM
Antidepressants (f) • SSRIs • SNRIs	Oral tablet/capsule	VMS, mood disturbance
Anticonvulsants (f) • GABA analog	Oral tablet/capsule	VMS, mood disturbance
Drugs to prevent or treat osteoporosis		
Bisphosphonates (g)	Oral tablet/capsule, injection, or intravenous	Bone loss (osteopenia and osteoporosis)
SERM	Oral tablet or capsule	Bone loss (osteopenia and osteoporosis)
Combination estrogen and SERM (c)	Oral tablet	Bone loss (osteopenia and osteoporosis)
Synthetic parathyroid hormone	Injection	Bone loss (osteopenia and osteoporosis)
Monoclonal antibodies	Nasal spray, injection	Bone loss (osteopenia and osteoporosis)
Calcitonin	Nasal spray, injection	Bone loss (osteopenia and osteoporosis)

Source: California Health Benefits Review Program, 2025, based on Ayers et al., 2023; Martin and Barbieri, 2023; Qaseem et al., 2023; Stanczyk et al., 2019.
Notes: (a) Recommended only for women who have had a hysterectomy because of the marked increased risk of uterine cancer when estrogen is taken alone.
(b) Co-prescribed with estrogen-only drugs to reduce risk of uterine cancer.
(c) Conjugated/equine estrogen and bazedoxifene (Duavee).
(d) Although testosterone is available in other routes and formulations, some are not FDA-approved and others are not indicated for use in menopausal women by clinical guidelines.
(e) Flibanserin and bremelanotide are also used to treat HSDD in premenopausal women but are not indicated for use in menopausal women; therefore they are not included in this analysis.

(f) Appropriate for women wanting treatment for VMS who have contraindication to hormone therapy due to high risk of or have/had hormone-sensitive cancers.
(g) First line therapy, except for patients with osteoporosis at very high risk of fracture who can use a monoclonal antibody or synthetic parathyroid hormone as first line.
Key: DHEA = dehydroepiandrosterone; GABA = gamma-aminobutyric acid; GSM = genitourinary syndrome of menopause; HSDD = hypoactive sexual desire disorder; SERM = selective estrogen receptor modulator; SNRI = serotonin-norepinephrine reuptake inhibitors; SSRI = selective serotonin reuptake inhibitors; VMS = vasomotor symptoms.

Disparities[27] in Menopause Symptoms and Treatment

Disparities are noticeable and preventable or modifiable differences between groups of people. Health insurance benefit mandates or related legislation may impact disparities.

Race or Ethnicity

There is considerable variation in the prevalence and treatment of menopause symptoms among racial/ethnic groups. Fact sheets produced by SWAN (based on its longitudinal study and other literature) state that Native American and Black women report the most frequent and most bothersome hot flashes of all groups studied with 66.7% of Native American women and 61.4% of Black women who reported having hot flashes (Reed et al., 2014; SWAN, 2023). Another study found that Black women were 50% more likely to report hot flashes than White women (Hispanic women reported similar rates to White women, and Asian women reported the lowest rates) (Harlow, et al., 2022; SWAN, 2023). The fact sheets also reported that Black women were more likely to experience depressive symptoms than White women. Despite the disparate symptom burdens, Black women were about half as likely as 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).

Other studies produced similar evidence of disparities in symptoms among different races and ethnicities. For example, Green and Santoro (2009) found that Black (46.5%) and Hispanic (49.4%) women report vaginal symptoms more often than White, Japanese, and Chinese women (28.9%, 34.3%, and 36.6% respectively). Similar findings were reported for VMS with Black women reporting the longest duration, and Chinese and Japanese women reporting the shortest duration (Avis et al., 2015). A review of literature about Black women's experience with menopause found that Black women reported most GSM symptoms less often than White women, but reported vaginal dryness more often (Williams et al., 2022). Hispanic women reported more genitourinary symptoms overall. No evidence was found regarding disparities in treatment for VMS.

Sleep disruption also differs among women with different racial/ethnic heritage. For instance, Harlow and colleagues (2022) found that Black, Chinese, Japanese, and Hispanic/Latinx women experience more interrupted sleep and poorer sleep quality relative to White women, and Black women are less likely to be treated for depression. No evidence of disparities in treatment for sleep disturbance was found. Race/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).

Treatment Preferences and Barriers

Patient Preferences

As noted, the types, severity, and duration of menopause symptoms varies among women as they advance through the menopause stages. One study examining health care seeking behaviors found that more than half (59.4%) of women reported consulting a health care provider for menopausal symptoms (Williams et al., 2007). Some women who experience symptoms do not seek prescription drug therapy because their symptoms are mild enough without any treatment or symptoms may be attenuated by over-the-counter products (e.g., vaginal lubricants for vaginal dryness,

[27] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population (Wyatt et al., 2016).

sleep aids for sleeplessness, supplements such as black cohosh for VMS), or because negative side effects from drug treatments (e.g., nausea, bloating, irregular uterine bleeding) outweigh reductions in the menopause symptom(s).

Potential Hormone Therapy Side Effects

Some women may experience side effects from systemic hormone therapy, prefer not to take hormone therapy, or have other conditions (such as high risk for or a history of breast cancer) that preclude use of hormone therapy. There are a number of documented side effects from systemic hormone therapy that may affect patients (e.g., breast tenderness, headache, heavy nonmenstrual vaginal bleeding, upset stomach, vomiting, fluid retention, and swelling) (Martin and Barbieri, 2023; NLM, 2024). Potential side effects from low-dose hormone therapy include those for high-dose systemic therapy as well as weight gain, fatigue, cold-/flu-like symptoms, hair loss, vaginal discharge, etc. (NLM, 2022, 2025). Estrogen plus progestin treatments are known to increase the risk of blood clots, heart attack, and stroke in older women, and may increase the risk of breast cancer with increased duration of hormone therapy use. Estrogen alone without progesterone increases the risk of uterine cancer, so women with an intact uterus who take systemic estrogen must also take systemic progesterone. See the *Medical Effectiveness* section for additional information about effectiveness and harms.

Barriers: Patient and Clinician Perspectives

In addition to patient preferences affecting uptake of treatment for symptoms, research shows other potential barriers to treating symptoms. A 2023 qualitative study identified several barriers preventing menopausal women from seeking help for symptoms including lack of knowledge about menopause (including the range of symptoms related to menopause and the length of time symptoms may last) or misattribution of symptoms to another cause. Additional barriers included stigma or embarrassment, as well as normalization of symptoms or cultural norms around menopause (Barber and Charles, 2023). Barriers to accessing or accepting hormone therapy treatment included perceptions of hormone therapy and beliefs about the risk of breast cancer, as well as having received limited or no information to support the decision to use hormone therapy (including how long to take it, long-term safety, long-term benefits, or that their concerns were not addressed) (Barber and Charles, 2023). A study by DePree et al. (2023) of clinician-perceived barriers to patients initiating care focused on concerns about the risks of treatment and financial considerations. The clinicians also noted that most patients waited several months before notifying their clinicians about their symptoms.

Additionally, the 2002 Women's Health Initiative (WHI) study had an impact on hormone therapy use among menopausal women both for patients and clinicians. The large clinical trial reported that postmenopausal women taking combination hormone therapy had an increased risk for breast cancer, heart disease, stroke, blood clots, and urinary incontinence (Office on Women's Health, 2020). The WHI produced a significant and longstanding decrease in the use of hormone therapy in the United States (Cagnacci and Venier, 2019). Crawford et al. (2018) analyzed SWAN data and found a significant decrease in hormone therapy initiation (from 8.6% pre-WHI to 2.8% post-WHI) and in hormone therapy continuation (from 84.0% to 62.0%) after 2002. These studies reported reasons for women declining initiation or discontinuing hormone therapy largely reflected concerns highlighted by the WHI results (such as concerns about risks of heart disease, cancer, and side effects), as well as media reports and provider advice. Similarly, clinicians were redirected away from hormone replacement therapy for a period of years based on the WHI results (Cagnacci and Venier, 2019). With the use of bioidentical estrogen and progesterone therapies, and subsequent research showing a favorable risk profile for hormone therapy use in younger patients closer to the time of their final menstrual period, changes in clinical practice guidelines have reversed prescribing trends over the last 15 years (Cho et al., 2023).

Gaps in clinician knowledge and education on menopause symptoms and treatment can also be a barrier in providing menopause care to women. A scoping review by Macpherson and Quinton (2022) examined how menopause is taught within health professions' education. The review found that there are significant knowledge gaps in training for menopause management and that clinician's reported feelings of inadequacy in discussing menopause and treatment approaches, particularly regarding hormone therapy treatment. One study on primary care and obstetrics and gynecology resident knowledge found that 7% of residents felt adequately prepared to manage menopause symptoms (Kling et al., 2019).

Several organizations, such as the Menopause Society, the American College of Obstetricians and Gynecologists (ACOG), and the Endocrine Society, provide continuing medical education courses and credits to increase and update knowledge on menopause symptoms and treatment (ACOG, 2025; Endocrine Society, 2025; Menopause Society, 2025). However, there is a lack of evidence that continuing education increases knowledge of menopause in the long term.

Societal Impact of Menopause

Menopause occurs during a significant portion of a woman's work life. Evidence of the effect of menopause on direct and indirect economic and societal costs varies. CHBRP found several studies that estimated financial impacts of menopause symptoms on productivity ranging between $1.8 billion and $2.2 billion annually. For example, a 2016 review of 75 studies on experiences of menopausal women in the workplace identified studies that indicate VMS have a negative impact on productivity, capacity to work, and work experience, although this was not a uniform finding (Jack et al., 2016). The review also found that physical and psychosocial factors in the workplace can also affect the relationship between symptoms and work. A 2013 study of 3,000 women found that moderate and severe VMS were associated with lower work productivity compared to mild symptoms (Whiteley et al., 2013).

A more recent study (2021) study of 4,000 women attending Mayo Clinic sites found that menopause symptoms resulted in an average of three missed workdays in the previous 12 months among 11% of women, a cutback in hours worked among 5% of women, quitting/retiring among 1% of women, and layoffs or firings among 0.3% of women (Faubion et al., 2023). The authors estimated menopause-related productivity losses of about $1.8 billion annually assuming 11% of women aged 40 to 60 years missed 3 workdays/year. This estimate excludes reduced work hours, loss of employment, or changing jobs (Faubion et al., 2023).

Finally, a 2021 study using SWAN survey data examined the impact of sleep disturbances among women of menopausal age on employment and work productivity. The study found that risk of unemployment was 31% higher for women with new-onset sleep disturbances. Although the study did not find significant associations between sleep disturbances and reduction in work time, the authors estimated that sleep problems could be associated with a reduction in 0.44 hours of work per week. Based on this finding, the authors estimate around $2.2 billion in lost productivity among women aged 42 to 64 in the United States (Kagan et al., 2021). (Please note, the societal impact discussed here is relevant to a broader population than those covered by AB 432; see the *Benefit Coverage, Utilization, and Cost Impacts* section for estimates of direct cost impacts for the specific population impacted by AB 432.)

The societal impact of menopause is beginning to be publicly acknowledged by employers as well. CHBRP found reports by several large companies surveying their workforce about the effect of menopause in the workplace and suggested employer-based supports (Bank of America, 2024; Carrot Fertility, 2022).

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Medical Effectiveness

As discussed in the *Introduction* section, AB 432 would require coverage (without utilization management) of four categories of treatment for perimenopause and menopause:

1. FDA-approved systemic hormone therapy
2. Nonhormonal medications for each menopause symptom
3. Genitourinary syndrome of menopause (GSM) treatment
4. Medications to prevent and treat osteoporosis

Coverage must include at least one medication within each formulation and hormone type or medication class. Additional information on menopause and the treatments included in AB 432 are summarized in the *Background* section and Appendix C.

As discussed in the *Benefit Coverage, Utilization, and Cost Impacts* section, there is already broad benefit coverage without utilization management for many of the treatments endorsed by existing clinical practice guidelines and AB 432 is not expected to change benefit coverage for those medications. As such, the medical effectiveness review summarizes findings from evidence[28] on the effectiveness of treatments that may not be commonly covered by insurance or that have utilization management in place. Some of these treatments may be more appropriate for patients who have significant risk factors, such as high risk or history of breast cancer that makes systemic hormone therapy inadvisable.

Research Approach and Methods

As described above, 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 (see the *Benefit Coverage, Utilization, and Cost Impacts* section) (see Table 4). Some medications fall into multiple bill-identified categories and are therefore listed more than once in the below table.

Key Questions

1. In menopausal women, what is the effect of systemic hormonal drug therapy on reduction in menopause symptoms compared with no intervention?
2. In menopausal women, what is the effect of nonhormonal drug therapy on reduction in menopause symptoms compared with no intervention?
3. In menopausal women, what is the effect genitourinary syndrome of menopause (GSM) treatment on reduction in menopause symptoms compared with no intervention?
4. In menopausal women, what is the effect of osteoporosis medications on reduction in postmenopausal osteoporosis outcomes compared with no intervention?

[28] Much of the discussion in this section is focused on reviews of available literature. However, as noted in the section on Implementing the Hierarchy of Evidence in the Medical Effectiveness Analysis and Research Approach document, in the absence of fully applicable to the analysis peer-reviewed literature on well-designed randomized controlled trials (RCTs), CHBRP's hierarchy of evidence allows for the inclusion of other evidence.

Table 4. Treatment Categories included in AB 432 and Inclusion in the Medical Effectiveness Review

Treatment Category	Treatments Included in the Medical Effectiveness Review	Treatments Not Included in the Medical Effectiveness Review due to Clinical Practice Guideline Endorsement *and* Existing Insurance Coverage Without Utilization Management (per the *Benefit Coverage, Utilization, and Cost Impacts* Section)

Systemic hormonal drug therapy	• Testosterone therapy (topical, oral, intramuscular, subcutaneous)
	• Vaginal high-dose systemic (ring)
	  ○ Estrogen only
		• Oral systemic
		  ○ Estrogen only
		  ○ Progesterone only
		  ○ Combination estrogen-progesterone
		  ○ Combination estrogen-SERM (a)
		  ○ Combination estrogen-androgen
		• Topical systemic
		  ○ Topical estrogen
		• Transdermal systemic
		  ○ Estrogen only
		  ○ Combination estrogen-progesterone

Nonhormonal drug therapy	• Neurokinin 3 (NK3) receptor antagonist
	  ○ Fezolinetant
	• Selective estrogen receptor modulator (SERM) (b)
	  ○ Ospemifene
		• Antidepressants
		  ○ Selective serotonin reuptake inhibitors (SSRIs)
		  ○ Serotonin-norepinephrine reuptake inhibitors (SNRIs)
		• Anticonvulsants
		  ○ GABA analog

Genitourinary syndrome of menopause (GSM) treatment	• Vaginal low-dose local (cream, tablet, insert, ring)
	  ○ Estrogen only
	• Selective estrogen receptor modulator (SERM) (b)
	  ○ Ospemifene
	• Dehydroepiandrosterone (DHEA)
	  ○ Prasterone (vaginal insert)	

Osteoporosis drug therapy	• Bisphosphonates • Selective estrogen receptor modulators (SERM) • Synthetic parathyroid hormone • Monoclonal antibodies	• Calcitonin

Source: California Health Benefits Review Program, 2025.
Note: Some medications fall into more than one bill-identified category.
(a) As presented in the *Benefit Coverage, Utilization and Cost* section, combination estrogen-SERM has low baseline benefit coverage but is FDA-approved to treat VMS and is included in The Menopause Society position statement on hormonal therapy; therefore, CHBRP did not review the evidence on the effectiveness of this treatment.
(b) Nonhormonal GSM treatment.

For vaginal estrogen, fezolinetant, and ospemifene, the search was limited to studies published from 2024 to the present because CHBRP had previously conducted thorough literature searches on these topics in April 2024 for the analysis of AB 2467.[29] For prasterone and systemic testosterone therapy, the search was limited to studies published from 2015 to present, bridging forward from a 2014 Endocrine Society Statement (Wierman et al., 2014).

A total of 17 studies were included in the medical effectiveness review for this report. The other articles were eliminated because they did not focus on menopausal women, include the treatments of interest, or report relevant outcomes. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to

[29] Studies of the effects of vaginal estrogen, testosterone, fezolinetant, ospemifene, and prasterone were identified through searches of PubMed (MEDLINE) and the Cochrane Library. The search was limited to abstracts of studies published in English.

grade the evidence for each outcome measure is presented in CHBRP's Medical Effectiveness Analysis and Research Approach document.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.[30] Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Outcomes Assessed

The outcomes of interest for the medical effectiveness review include vasomotor symptoms (VMS) associated with menopause, including hot flashes or flushes and night sweats, and genitourinary syndrome of menopause (GSM), which includes symptoms of sexual dysfunction, sexual well-being, dyspareunia, and urinary symptoms (including dysuria, urgency and frequency of urination, recurrent urinary tract infections [UTIs], and urinary incontinence). CHBRP also reviewed the evidence of the effectiveness of osteoporosis medications on fracture risk.

CHBRP also reviewed evidence on the harms of treatment for menopause symptoms, which include elevated risks of endometrial hyperplasia and endometrial cancer when systemic estrogen is given without progesterone to women with a uterus, cardiovascular events, and risk of breast cancer. Additional harms assessed include changes of total cholesterol, triglycerides, low-density lipoprotein or high-density lipoprotein, fasting glucose, insulin, or insulin resistance, and liver enzyme elevations with use of compounded bioidentical hormones.

Study Findings

This following section summarizes CHBRP's findings regarding the strength of evidence for the effectiveness of treatments addressed by AB 432. Each section is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms are included in the box below.

The following terms are used to characterize the body of evidence regarding an outcome:

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.

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.

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.

Conflicting evidence indicates that a similar number of studies of equal quality suggest the treatment is effective as suggest the treatment is not effective.

[30] Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. See CHBRP's website for more information.

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.

Effectiveness of Systemic Hormonal Drug Therapy

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 vasomotor symptoms (VMS) and the genitourinary syndrome of menopause (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).

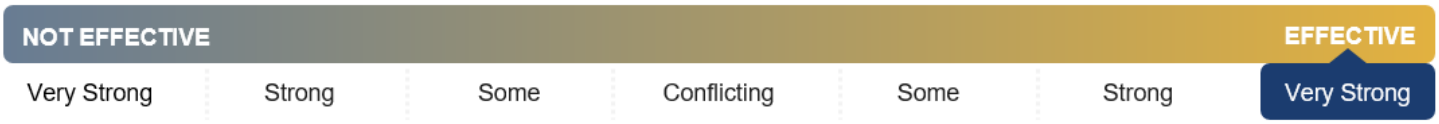
Systemic testosterone therapy

The American College of Obstetricians and Gynecologists (ACOG), the Endocrine Society, and the American Society for Reproductive Medicine currently support the use of testosterone therapy for the treatment of hypoactive sexual desire disorder (HSDD) only (ACOG, 2019; Davis et al., 2019; Wierman et al., 2014). HSDD was defined in the 4th edition of Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) as "a deficiency of sexual thoughts, feelings or receptiveness to sexual stimulation that has been present for at least 6 months, causes personal distress, and is not due to another medical condition (Adebisi and Carlson, 2024)." The DSM-V combined HSDD with female sexual arousal disorder (defined as "reduced sensation, pleasure, or excitement during sexual activity") under the umbrella term "female sexual interest/arousal disorder" (Adebisi and Carlson, 2024).

A 2019 systematic review including 36 randomized trials (46 total publications; N = 8,480 patients) compared the benefits of systemic testosterone (oral and non-oral) versus placebo or usual treatment (e.g., estrogen with or without progesterone). The included studies examined oral testosterone (15 studies) and non-oral administration including a patch (13 studies), gel (2 studies), cream (2 studies), sublingual (1 study), intramuscular injection (1 study), implant (1 study), and spray (1 study); however, findings were not stratified by route of administration. Meta-analyses indicate that testosterone significantly improved several outcomes among menopausal women, including increased frequency sexually satisfying events (8 studies, 3,238 patients; $p = 0.014$), higher sexual desire (15 studies, 3,762 patients; $p < 0.0001$), and reduced personal sexual distress (4 studies, 1,898 patients; $p < 0.0001$) (Islam et al., 2019).

Summary of findings regarding the effectiveness of systemic testosterone therapy on the treatment of hypoactive sexual dysfunction disorder (HSDD): There is *very strong evidence* that systemic testosterone therapy for the treatment of HSDD is effective, based on a systematic review and meta-analysis including 36 studies.

Figure 2. Findings Regarding the Effectiveness of Systemic Testosterone Therapy on the Treatment of Hypoactive Sexual Desire Disorder



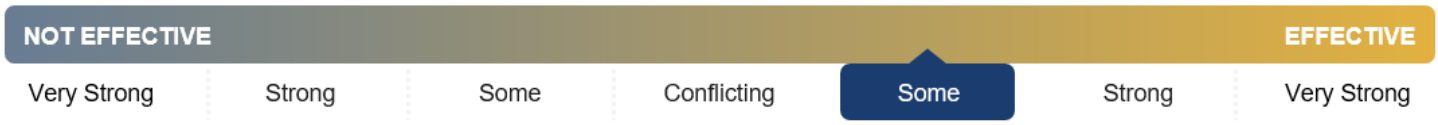
High-dose vaginal systemic estrogen

High-dose vaginal estrogen, which has been FDA approved for the relief of moderate-to-severe VMS and GSM in menopausal women since 2003, is available via a prescription vaginal ring that contains estradiol (an estrogen hormone) with the goal of systemic distribution.

One older RCT (N = 225 subjects) reported that 50 or 100 µg per day of vaginally administered estradiol, significantly reduced moderate-to-severe VMS and improved urogenital symptoms in menopausal women, compared with placebo, at 13 weeks follow-up (Speroff, 2003).

Summary of findings regarding the effectiveness of high-dose vaginal estrogen on the treatment of perimenopausal and menopausal symptoms: There is *some evidence* that high-dose vaginally administered estrogen for the treatment of menopausal VMS is effective, based on one RCT.

Figure 3. Findings Regarding the Effectiveness of High-Dose Vaginal Estrogen on Treatment of Menopause Symptoms



Effectiveness of Nonhormonal Drug Therapy

While systemic hormone therapy remains the most effective treatment for vasomotor symptoms and should be considered in menopausal women within 10 years of their menopause onset, a 2023 NAMS position statement also recommended nonhormone medications including fezolinetant, antidepressants, and anticonvulsants for women who want drugs to manage moderate-to-severe VMS, but do not want to take hormone therapy or have significant risk factors such as high risk or history of breast cancer that make hormone therapy inadvisable (NAMS, 2023).

Ospemifene and prasterone (vaginal DHEA) nonhormonal medications also treat genitourinary symptoms of menopause; the effectiveness of these medications are discussed in the next section.

Fezolinetant

Fezolinetant is a nonhormone neurokinin 3 receptor antagonist that was approved in 2023 by the FDA for treatment of moderate-to-severe VMS due to menopause. This drug is indicated for women with a high risk or history of breast cancer or other hormonal dependent cancer in whom hormone therapy is strongly recommended against due to its associated increased risk of breast cancer. Although there are other nonhormonal treatments for VMS, fezolinetant fills a gap for women in this group with moderate-to-severe VMS whose symptoms are not alleviated by other nonhormonal treatments.

In a systematic review and meta-analysis, Bonga et al. (2024) included RCTs that compared fezolinetant to placebo for the treatment of menopause-associated VMS lasting for 12 weeks or longer (five RCTs; N = 2,168). This meta-analysis reported that fezolinetant significantly reduced VMS frequency[31] (four studies, n = 860) and was significantly more likely to show a reduction of at least 75% in frequency of moderate-to-severe VMS compared with placebo (three studies;167/388

[31] VMS frequency was defined as the number of VMS, such as night sweats and hot flushes, experienced by postmenopausal women in a day.

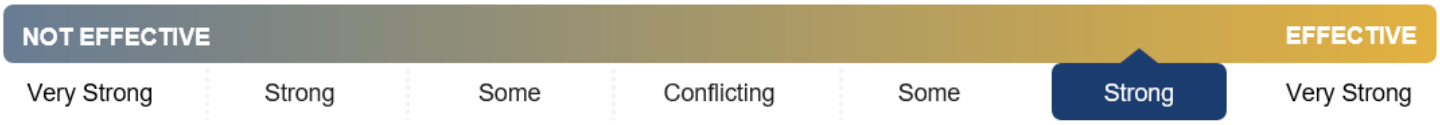
versus 81/385 participants). The Bonga et al. (2024) meta-analysis also found that women taking fezolinetant reported significantly higher menopause quality-of-life scores relative to placebo (three studies; n = 773) as well as improved self-reported perceptions of sleep[32] (two studies; 267/343 vs. 204/342).

This Medical Effectiveness review identified three additional systematic reviews of the effectiveness of fezolinetant; each of these reviews included the same five RCTs as the Bonga et al. (2024) review and reached the same conclusions (Akhtar et al., 2024; Chavez et al., 2024; Elnaga et al., 2024).

An RCT by Schaudig et al. (2024) examined the efficacy and safety of fezolinetant in women considered unsuitable candidates for hormone therapy, who had previously discontinued hormone therapy, or were adverse to hormone therapy (N = 452). The authors found that fezolinetant (versus placebo) significantly reduced the frequency and severity of VMS, and reduced sleep disturbance, at 24 weeks' follow-up (Schaudig et al., 2024).

Summary of findings regarding the effectiveness of fezolinetant on treatment of menopause symptoms: There is *strong evidence* that fezolinetant is effective for treatment of VMS due to menopause based on four systematic reviews (of the same five RCTs) and one additional RCT that compared it to placebo.

Figure 4. Findings Regarding the Effectiveness of Fezolinetant on Treatment of Vasomotor Menopause Symptoms



Effectiveness of Genitourinary Syndrome of Menopause Treatment

Low-dose vaginal local estrogen

A systematic review of 30 randomized controlled trials (RCTs) (N = 32,204) examining the effect of hormone therapy on urinary symptoms (including dysuria, urgency and frequency of urination, recurrent urinary tract infections [UTIs], and urinary incontinence) in menopause included five RCTs examining vaginal low-dose local estrogen compared to placebo (Christmas et al., 2023). The authors reported significant improvements in dysuria, incontinence, frequency of UTIs, and decreased UTI in patients that were treated with vaginal low-dose estrogen compared to placebo. One included trial reported that vaginal low-dose estrogen showed significant improvement in dysuria, incontinence, urinary frequency, and decreased UTI. Another included trial reported a significant decrease incidence of stress urinary incontinence and UTI in patients treated with vaginal estrogen. Another included trial showed a significant reduction in urinary urgency with 25 µg vaginal estradiol but no improvement in urinary frequency or incontinence. An included trial of postmenopausal women with history of recurrent UTIs comparing 2 mg vaginal estradiol ring to placebo reported significant improvement in urge urinary incontinence, stress urinary incontinence, and higher incidence of being UTI-free, but no significant difference in dysuria, frequency, or urgency. Two included trials of postmenopausal women with recurrent UTIs reported a significant lower incidence of UTIs in the treatment group (over 6 to 8 months), and an 8-month-long RCT reported significantly lower days of antibiotic use in the vaginal low-dose estrogen treatment group than placebo (6.9 ± 1.1 versus 32.0 ± 7.8 days).

A systematic review including 53 RCTs[33] (N = 32,204) evaluated the effect of hormone therapy on urinary symptoms in menopause and included 24 trials that compared vaginal low-dose estrogen therapy to placebo (Biehl et al., 2019). The authors reported that vaginal low-dose estrogen significantly reduced urinary frequency, urgency, urge and stress incontinence, and recurrent urinary tract infections. All included studies showed superiority of vaginal low-dose estrogen products when compared with placebo in outcomes including maturation of the vaginal epithelium, reduction of vaginal

[32] Patients were asked to rate how well they were sleeping at that timepoint compared with the start of the study by using a scale ranging from 1 (much better) to 7 (much worse).
[33] Cardozo, 2021, and Simunić et al., 2003, are in both Christmas et al., 2023, and Biehl et al., 2019, systematic reviews.

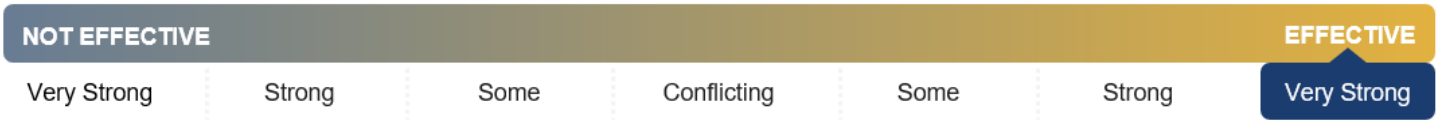
pH, and symptoms of dyspareunia (6 studies), vaginal dryness (7 studies), and alleviation of urogenital symptoms (2 studies) including reduced urinary urgency and decreased incidence of cystitis.

A systematic review including 26 RCTs evaluated the effect of vaginal estrogen on GSM symptoms compared to placebo or no treatment (Danan et al., 2024). The authors concluded that vaginal estrogen may improve dryness, dyspareunia, and treatment satisfaction (low certainty of evidence).

In a 2022 small, participant-masked RCT (N = 39) comparing the effect of estrogen-containing vaginal ring to a placebo vaginal ring on vaginal or urinary *Lactobacillus* relative abundance, researchers reported no significant difference or changes in vaginal or urinary *Lactobacillus* relative abundance, vulvovaginal dryness, urinary frequency, painful intercourse, and urinary urgency at 12-week follow-up (Lillemon et al., 2022).

Summary of findings regarding the effectiveness of low-dose vaginal estrogen on the treatment of genitourinary menopause symptoms: There is *very strong evidence* that low-dose vaginal estrogen for the treatment of GSM symptoms (including dysuria, urgency and frequency of urination, recurrent UTIs, and urinary incontinence) is effective, based on three systematic reviews (including 26 to 53 trials) and one smaller RCT.

Figure 5. Findings Regarding the Effectiveness of Low-Dose Vaginal Estrogen on the Treatment of GSM Symptoms



Ospemifene

Ospemifene is a selective estrogen receptor modulator (SERM) that was approved in 2013 by the FDA for the treatment of vulvar and vaginal atrophy due to menopause, including moderate-to-severe symptoms of dyspareunia and/or vaginal dryness and physiological changes (parabasal cells, superficial cells, and pH).

In a systematic review and network meta-analysis, Simon et al. (2023) (44 RCTS; N = 12,637) reported that ospemifene (6 RCTs) showed significant improvements in vaginal dryness compared to placebo and vaginal estradiol inserts, and similar symptom relief compared to conjugated equine estrogens (CEE) vaginal cream (high and low doses[34]), prasterone vaginal ovule (DHEA), and vaginal estrogen cream. The effects of ospemifene on dyspareunia (painful intercourse), ospemifene were similar to those of other active treatments — including CEE vaginal cream (high and low doses[35]), DHEA, vaginal estradiol inserts, and vaginal estrogen cream — and compared to placebo. The network meta-analysis also reported that ospemifene (60 mg) was associated with an increase in the risk of hot flashes versus placebo and DHEA 6.5 mg. There was no statistically significant difference in the risk of hot flashes associated with ospemifene 60 mg and other treatments.

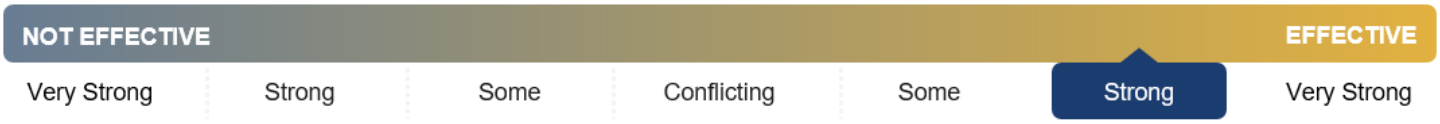
A systematic review by Danan et al. (2024) found that ospemifene may improve vulvovaginal dryness (three RCTs, N = 1,1771). All of the included trials demonstrated an improvement in severity of vulvovaginal dryness after 12 weeks, but only two trials reported a statistically significant difference in change in severity between the treatment and placebo arms. The review identified three trials (N = 2,062) reporting a statistically significant improvement in dyspareunia compared with placebo (Danan et al., 2024).

[34] CEE vaginal cream dosages were separated as low (twice weekly, 0.3–0.625 mg) and high doses (daily for 21 d, 7 d off, 0.3–1.25 mg).
[35] CEE vaginal cream dosages were separated as low (twice weekly, 0.3–0.625 mg) and high doses (daily for 21 d, 7 d off, 0.3–1.25 mg).

In one RCT, Goldstein et al. (2019) (N = 63) reported that ospemifene significantly improved total scores for severe vaginal dryness from baseline to week 12, with significant improvement reported by 4 weeks.

Summary of findings regarding the effectiveness of ospemifene on treatment of genitourinary menopause symptoms: There is *strong evidence* that ospemifene improved symptoms of vaginal dryness and dyspareunia (painful intercourse) in menopausal women compared to placebo. Evidence suggests that the effects of ospemifene on dyspareunia (painful intercourse) and vaginal dryness are similar to those of other treatments.

Figure 6. Findings Regarding the Effectiveness of Ospemifene on Treatment of Menopause Symptoms

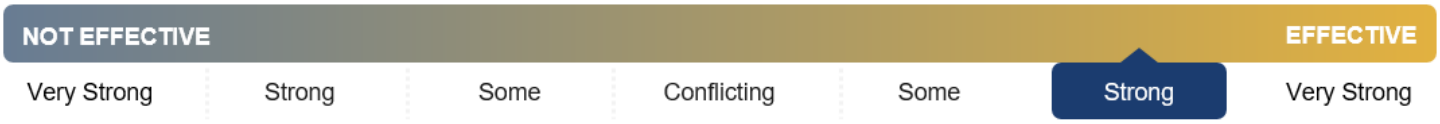


Prasterone (vaginal DHEA)

A systematic review by Danan et al. (2024) (four RCTs, N = 1,472 patients) examined the effect of vaginal DHEA on GSM symptoms. All of the included trials demonstrated an improvement in severity of vulvovaginal dryness after 12 weeks, but only three trials reported a statistically significant difference in change in severity between the treatment and placebo arms. All of the included trials demonstrated an improvement in dyspareunia after 12 weeks. The review did not identify any studies assessing the effect of DHEA on dysuria or satisfaction with treatment (Danan et al., 2024).

Summary of findings regarding the effectiveness of prasterone (vaginal DHEA) on treatment of genitourinary menopause symptoms: There is *strong evidence* that prasterone (vaginal DHEA) improved symptoms of vaginal dryness and dyspareunia (painful intercourse) in menopausal women compared to placebo.

Figure 7. Findings Regarding the Effectiveness of Prasterone on Treatment of Genitourinary Menopause Symptoms



Effectiveness of Osteoporosis Medications

Bisphosphonates

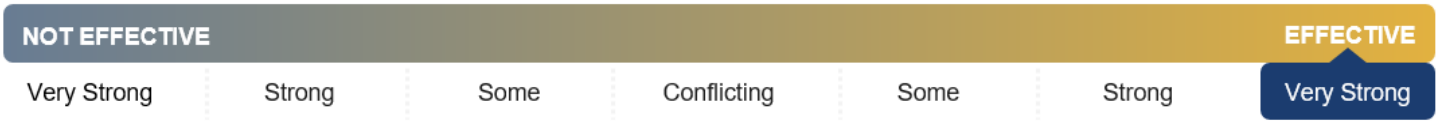
Recommendations from the American College of Physicians (ACP) and the Menopause Society state that bisphosphonates are an appropriate first-line treatment to reduce fracture risk for women with postmenopausal osteoporosis (NAMS, 2021; Qaseem et al., 2023).

The systematic review and network meta-analysis accompanying the ACP recommendations found high-certainty evidence that bisphosphonates reduce risk for hip fracture, vertebral fractures, and other clinical fractures compared to placebo and no greater benefit from other drug classes compared with bisphosphonates (Ayers et al., 2023).

A recent RCT following 1,054 postmenopausal women for 10 years found that zoledronate (a bisphosphonate) infusions 5 years apart was effective in prevention vertebral fractures compared to a placebo (Bolland et al., 2025).

Summary of findings regarding the effectiveness of bisphosphonates to prevent and treat osteoporosis: There is *very strong evidence* that bisphosphonates as a first-line treatment for osteoporosis can effectively reduce fracture risk among postmenopausal women, based on one systematic review including 19 RCTs and 1 additional RCT.

Figure 8. Findings Regarding the Effectiveness of Bisphosphonates for Preventing and Treating Osteoporosis



Monoclonal antibodies

The ACP recommends that denosumab (a monoclonal antibody) be used as a second-line treatment to reduce fracture risk in women with postmenopausal osteoporosis who have contraindications to bisphosphonates (Qaseem et al., 2023). The systematic review accompanying the ACP recommendations concluded that denosumab (four RCTs) reduces vertebral fractures and probably reduces the risk of hip fractures at least years after treatment initiation compared to placebo (Ayers et al., 2023).

ACP recommendations state that romosozumab (another monoclonal antibody), followed by bisphosphonates, can be used as a second-line treatment in women with postmenopausal osteoporosis who are at very high risk of fracture (Qaseem et al., 2023). The authors also note that the benefits of romosozumab may outweigh the harms only in women with postmenopausal osteoporosis at very high risk for fracture (Qaseem et al., 2023). The Menopause Society also notes that denosumab can be used in women with a high risk of fracture (NAMS, 2021). The systematic review accompanying the ACP recommendations found that romosozumab (two RCTs) may reduce risk of vertebral fractures compared to placebo but found no studies assessing its effect on hip fracture risk; there was also no difference in vertebral fractures in studies comparing romosozumab versus bisphosphonates (Ayers et al., 2023).

Summary of findings regarding the effectiveness of monoclonal antibodies to prevent and treat osteoporosis: There is *strong evidence* that monoclonal antibodies as a second-line treatment for osteoporosis can effectively reduce fracture risk among postmenopausal women, based on one systematic review including six RCTs.

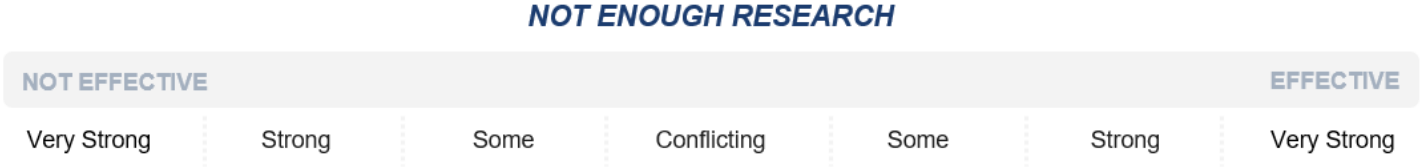
Figure 9. Findings Regarding the Effectiveness of Monoclonal Antibodies for Preventing and Treating Osteoporosis

Selective estrogen receptor modulators

The Menopause Society position statement recommends that raloxifene (a selective estrogen receptor modulator [SERM]) be used for women with postmenopausal osteoporosis with a low risk of hip fracture who have an elevated risk of breast cancer (NAMS, 2021). The ACP recommendations conclude that there is inconclusive evidence of the benefits and harms of raloxifene to recommend for or against its use (Qaseem et al., 2023).

Summary of findings regarding the effectiveness of SERMs to prevent and treat osteoporosis: There is *not enough research* to establish whether SERMs for osteoporosis can effectively reduce fracture risk among postmenopausal women.

Figure 10. Findings Regarding the Effectiveness of SERMs for Preventing and Treating Osteoporosis

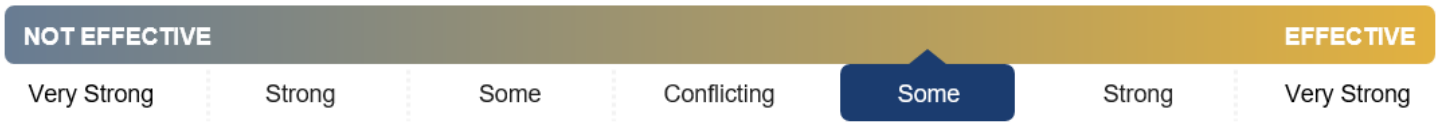


Synthetic parathyroid hormone

ACP recommendations state that teriparatide (a synthetic parathyroid hormone), followed by bisphosphonates, can be used as a second-line treatment in women with postmenopausal osteoporosis who are at very high risk of fracture (Qaseem et al., 2023). The systematic review and network meta-analysis accompanying the ACP recommendations concluded that teriparatide reduces risk for vertebral fractures, but found no difference in hip fracture risk, compared to placebo (Ayers et al., 2023). The network meta-analysis found that teriparatide may yield further fracture risk reduction compared to bisphosphonates but noted increase in potential harm (see the "Finding on the Harms of Treatments of Menopause Symptoms" section) (Ayers et al., 2023).

Summary of findings regarding the effectiveness of monoclonal antibodies to prevent and treat osteoporosis: There is *some evidence* that synthetic parathyroid hormone as a second-line treatment for osteoporosis can effectively reduce fracture risk among postmenopausal women, based on one systematic review including six RCTs.

Figure 11. Findings Regarding the Effectiveness of Synthetic Parathyroid Hormone for Preventing and Treating Osteoporosis



Findings on the Harms of Treatments of Menopause Symptoms

Systemic hormonal drug therapy

Systemic Testosterone Therapy

One systematic review did not find that systemic testosterone therapy (oral or non-oral) was associated with more frequent serious adverse events (including cardiovascular events) compared to placebo or standard treatment (e.g., estrogen with or without progesterone) (relative risk 0.97, 95% confidence interval: 0.65-1.14). The review did find that testosterone use was associated with a greater likelihood of acne and hair growth compared to placebo or standard treatment, but did not identify other androgenic effects (Islam et al., 2019).

Vaginal High-Dose Systemic Estrogen

CHBRP did not find any studies that reported harms or adverse effects of high-dose vaginal estrogen.

Nonhormonal drug therapy

Fezolinetant

The systematic review and meta-analysis by Bonga et al. (2024) reported no significant difference between fezolinetant and placebo in liver function assessments (five RCTs; 2,080 subjects). A systematic review by Rahman et al. (2023) (five studies; N = 4,064) reported no significant differences endometrial hyperplasia/tumors (four studies; n = 3,621) or uterine bleeding (four studies; n = 3,707) compared to placebo. Neither the Bonga et al. 2024 or Rahman et al. 2023 meta-analyses reported any significant difference in all adverse events or study dropouts due to treatment-ending adverse

events (TEAEs) between fezolinetant and placebo. Additionally, the RCT by Schaudig et al. (2024) did not identify differences in the incidence of adverse events between fezolinetant and placebo (Schaudig et al., 2024).

Genitourinary syndrome of menopause treatment

Vaginal Low-Dose Local Estrogen

A systematic review of low-dose vaginal estrogens using endometrial histology (20 RCTs: N = 2,983 unique women exposed to vaginal estrogen products for up to 1 year) reported no evidence of increased risk of endometrial hyperplasia or endometrial cancer with low-dose vaginal estrogen alone (Constantine et al., 2019). A 2024 systematic review (26 RCTs) found uncertain evidence on the effect of vaginal estrogen on adverse events compared to placebo due to inconsistent reporting (Danan et al., 2024). A 2025 systematic review of (eight observational studies; N = 24,060 patients) did not identify an increased risk of breast cancer recurrence, breast cancer mortality, or overall mortality with the use of vaginal estrogen in in breast cancer survivors (Beste et al., 2025).

Ospemifene

The Simon et al. 2023 network meta-analysis reported no statistically significant difference between ospemifene 60 mg and other tested therapies for most safety outcomes. There were no statistically significant differences in serious TEAEs between patients taking 60 mg ospemifene and other comparator treatments including CEE and DHEA 3.25 mg and 6.5 mg, estrogen cream, and vaginal estrogen insert. However, TEAE were significantly less likely to occur with estradiol capsules (4, 10, 25 µg) and placebo than ospemifene. There were no cases of endometrial carcinoma or hyperplasia (12 studies), nor polyps with atypical hyperplasia (7 studies) or cancer in ospemifene trials (12 studies) at up to 52 weeks of treatment.

The Danan et al. (2024) systematic review concluded that there is no difference in risk of serious adverse events for patients using ospemifene compared to placebo. However, hot flashes and vulvovaginal candidiasis (four RCTs, N = 1,767) occurred more often among patients using ospemifene compared to placebo at 12-weeks follow-up (Danan et al., 2024).

Prasterone (vaginal DHEA)

A systematic review by Danan et al. (2024) concluded that vaginal DHEA may result in more adverse events compared with placebo, but with low certainty of evidence (three RCTs, N = 1,256 patients). Two included trials reported more adverse events among patients using vaginal DHEA compared to placebo (but did not perform a test of statistical significance), and the third trial reported no statistically significant difference in adverse events but did not report the data.

Osteoporosis medications

Bisphosphonates

The systematic review and network meta-analysis accompanying the ACP guidelines concluded with high certainty that there is no difference between bisphosphonates and placebo in terms of serious adverse effects at least 3 years after treatment initiation based on randomized trial evidence (Ayers et al., 2023). However, the authors do note that some observational studies found that bisphosphonates were associated with increased risk of atypical femoral fractures and osteonecrosis of the jaw compared to placebo, but that that these events were uncommon and may be associated with longer treatment duration (Ayers et al., 2023).

Monoclonal Antibodies

The systematic review accompanying the ACP recommendations concluded with moderate certainty that there is probably no difference in serious adverse effects between denosumab versus placebo (Ayers et al., 2023). The systematic review reported no difference in adverse effects for romosozumab versus placebo but note that romosozumab may increase risk for cardiovascular events compared with bisphosphonates (Ayers et al., 2023). The systematic review also concluded with

moderate certainty that romosozumab followed by bisphosphonates reduces fractures compared with placebo, without increasing risk for serious harms (Ayers et al., 2023).

Synthetic Parathyroid Hormone

The systematic review accompanying the ACP recommendations found no evidence of increased risk of serious adverse effects among teriparatide compared with placebo, but observed increased risk for withdrawal due to adverse effects at 24 and 36 months' follow-up due to nausea/vomiting, dizziness, headache, palpitations and leg cramps (Ayers et al., 2023). Similarly, the systematic review also found increased risk for withdrawal due to adverse effects compared to bisphosphonates at 36 months' follow-up (Ayers et al., 2023).

Summary of Medical Effectiveness Findings

The medical effectiveness review 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 (Table 5). 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 and therefore, alternate drugs are needed.

Table 5. Summary of Medical Effectiveness Findings

	Very Strong Evidence – Effective	Strong Evidence – Effective	Some Evidence – Effective	Not Enough Research	Harms
Systemic Hormonal Drug Therapy (a)					
Systemic testosterone (oral and non-oral)	*Very strong evidence* for HSDD				No identified studies of harms or adverse effects
High-dose vaginal estrogen			*Some evidence* for VMS		No identified studies of harms or adverse effects
Nonhormonal Drug Therapies					
Fezolinetant		*Strong evidence* for VMS			No significant differences in harms or adverse effects.
Genitourinary Syndrome of Menopause (GSM) Treatment					
Low-dose vaginal estrogen	*Very strong evidence* for GSM				No evidence of increased risk of endometrial hyperplasia or endometrial cancer, or breast cancer recurrence or mortality in breast cancer survivors. Uncertain evidence on the effect of low-dose vaginal estrogen on adverse events

	Very Strong Evidence – Effective	Strong Evidence – Effective	Some Evidence – Effective	Not Enough Research	Harms
Ospemifene[b]		*Strong evidence* for GSM			No significant differences in harms or adverse effects.
Prasterone (vaginal DHEA)		*Strong evidence* for GSM			Some evidence that prasterone may result in more adverse events compared with placebo.
Drugs to Prevent and Treat Osteoporosis					
Bisphosphonates	*Very strong evidence* as a first-line treatment to reduce fracture risk				No significant differences in harms or adverse effects.
Monoclonal antibodies		*Strong evidence* as a second-line treatment to reduce fracture risk			No significant differences in adverse events, but may increase risk for cardiovascular events compared to bisphosphonates
Synthetic parathyroid hormone			*Some evidence* as a second-line treatment to reduce fracture risk		No significant differences in adverse events, but increased risk for withdrawal symptoms compared to bisphosphonates
SERMs				*Not enough research* to establish whether SERMs are effective in reducing fracture risk	

Source: California Health Benefits Review Program, 2025.
Note: Some medications fall into more than one bill-identified category.
(a) Oral, topical, transdermal systemic estrogen, combination estrogen-progesterone, combination estrogen-SERM are endorsed by professional guidelines for the treatment of VMS and GSM.
(b) Nonhormonal GSM treatment.
Key: GMS = genitourinary syndrome of menopause; VMS = vasomotor symptoms.

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Benefit Coverage, Utilization, and Cost Impacts

As discussed in the *Introduction* section, AB 432 would require coverage (without utilization management) for four categories of treatment for perimenopause and menopause:

1. U.S. Food and Drug Administration (FDA)-approved systemic hormone therapy
2. Nonhormonal medications for each menopause symptom
3. Genitourinary syndrome of menopause (GSM) treatment
4. Medications to prevent and treat osteoporosis

Coverage must include at least one medication within each formulation and hormone type or medication class. Additional information on menopause and the treatments included in AB 432 are summarized in the *Background* section and Appendix C.

This section reports the potential incremental impacts of AB 432 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

Medical and Pharmacy Benefit Coverage

For this analysis CHBRP considered both prescription drugs used for the treatment of menopause and osteoporosis which are relevant to pharmacy benefit coverage, and drugs for the treatment of menopause and osteoporosis that are physician-ordered and administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility), which 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. CHBRP also considered lab tests, which are covered under the medical benefit.

In addition to commercial enrollees, 74% of enrollees associated with the California Public Employees' Retirement System (CalPERS) are enrolled in DMHC-regulated plans.[36] As noted in the *Introduction* section, AB 432 would impact these CalPERS enrollees' only if there is an existing outpatient pharmacy benefit. Almost all (96.2%) commercial/CalPERS enrollees have a pharmacy benefit regulated by DMHC or CDI that covers both generic and brand-name outpatient prescription drugs.[37] Of the remaining commercial/CalPERS enrollees, 1.2% do not have a pharmacy benefit, whereas 2.6% have a pharmacy benefit that is not regulated by DMHC or CDI.

Table 7. State-Regulated Health Insurance Subject to AB 432, by Medical Benefit and Pharmacy Benefit

	Medical Benefit	Pharmacy Benefit
Commercial/CalPERS	Yes	Yes (for pharmacy benefits regulated by DMHC or CDI)
Medi-Cal Managed Care plans	Yes	No (pharmacy benefit is administered by DHCS)

Source: California Health Benefits Review Program, 2025.
Key: CDI = California Department of Insurance; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

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

For Medi-Cal beneficiaries, the pharmacy benefit is separate and administered by the Department of Health Care Services (DHCS) under the Medi-Cal Rx program; therefore, it is not subject to DMHC regulation. Table 6 highlights which state-regulated health insurance is subject to AB 432 by medical and pharmacy benefit.

Because AB 432 would not require creation of a pharmacy benefit, baseline benefit coverage for enrollees is compliant if they are either without a pharmacy benefit or the pharmacy benefit is not regulated by DMHC or CDI. Being compliant with AB 432 at baseline does not necessarily mean that these Medi-Cal plans have a pharmacy benefit that includes coverage for treatments of menopause symptoms, as CHBRP did not survey the administrator of the Medi-Cal pharmacy benefit.

CHBRP assumed that DMHC-regulated Medi-Cal Managed Care plans would cover the lab tests used for the evaluation of menopause symptoms and drug classes covered under the medical benefit (e.g., drugs which are infused at a doctor's office or infusion center). CHBRP assumes similar coverage exists for County Organized Health System (COHS) managed care plans.

In estimating the cost impacts of AB 432, CHBRP assumes that DMHC-regulated plans and CDI-regulated policies with an outpatient pharmacy benefit would continue their current cost-sharing requirements, and that compliance with AB 432 would require on-formulary coverage. CHBRP also assumed that DMHC-regulated plans and CDI-regulated policies would continue their current cost-sharing requirements under the respective medical benefits.

Additional Key Assumptions

CHBRP restricted utilization estimates to women aged 40 to 64 years as the range around the average age of menopause at 51 years (see the *Background* section).

CHBRP did not assume a shift from therapies used at baseline to newly covered therapies or therapies with newly eliminated utilization management. CHBRP assumed that the increases in utilization would be from new users of the drug therapies.

CHBRP considered the effects of benefit coverage changes due to AB 432 on utilization on: (a) increased coverage for those therapies not covered at baseline and/or (b) eliminating utilization management. Table 7 highlights which prescription drug therapies have 100% coverage at baseline and/or had utilization management at baseline, and whether increases in utilization are expected postmandate as a result of increased coverage and/or the removal of utilization management postmandate.

Table 8. Benefit Coverage or Utilization Management for Therapies for the Treatment of Menopause or the Prevention and Treatment of Bone Loss At Baseline and Expected Increases in Utilization Postmandate

	100% Coverage at Baseline	Utilization Management at Baseline	Expected Increase in Utilization Postmandate
On-formulary coverage for systemic and local hormonal drug therapies			
Oral systemic			
Estrogen only	Yes	No	No
Progesterone only	Yes	No	No
Combination estrogen-progesterone	Yes	No	No
Combination estrogen and SERM	No	No	Yes
Combination estrogen and androgens	Yes	No	No
Topical systemic			

	100% Coverage at Baseline	Utilization Management at Baseline	Expected Increase in Utilization Postmandate
Estrogen only	Yes	No	No
Progesterone only	Yes	No	No
Testosterone	No	Yes	Yes
Transdermal systemic			
Estrogen only	Yes	No	No
Combination estrogen-progesterone	Yes	No	No
Vaginal estrogen			
High-dose systemic	No	Yes	Yes
Low-dose local	No	Yes (for one formulation)	Yes
Vaginal DHEA			
Prasterone	No	Yes	Yes
On-formulary coverage for nonhormonal drug therapies:			
Fezolinetant	No	Yes	Yes
Ospemifene	No	Yes	Yes
Anti-depressants	Yes	No	No
Anticonvulsants	Yes	No	No
On-formulary coverage to prevent or treat osteoporosis:			
Covered under the medical benefit			
Bisphosphonates	Yes	Yes	Yes
Monoclonal antibodies medication	Yes	Yes	Yes
Covered under pharmacy benefit			
Bisphosphonates	Yes	Yes	Yes
SERMs	No	Yes	Yes
Synthetic parathyroid hormone	Yes	Yes	Yes

Source: California Health Benefits Review Program, 2025.
Key: SERM = Selective estrogen receptor modulator.

Assumptions for Coverage and Utilization Under the Pharmacy Benefit

CHBRP surveyed the 8 largest (by enrollment) insurers in California to assess which therapies had coverage and/or utilization management at baseline. For drug therapies under the prescription benefit which had 100% coverage at baseline, CHBRP assumed no changes in coverage. However, CHBRP identified that some prescription drugs or drug classes with 100% coverage at baseline also had prior authorization policies at baseline. CHBRP assumed increases of up to 5% in utilization for these therapies based on consultations with a content expert, prior analyses of Milliman data, and the literature on the removal of utilization management (Udall et al., 2013). For drug therapies under the prescription benefit which did not have 100% coverage at baseline, CHBRP assumed increases in utilization.

Assumptions for Coverage and Utilization Under the Medical Benefit

Due to "Basic Health Care Services" (see the *Policy Context* section for more information), CHBRP assumed that drugs that are physician-ordered and administered under the supervision of a physician (generally in a hospital, a provider's office, infusion center, or similar medical facility) were covered 100% at baseline under the medical benefit. Therefore, for these drugs, CHBRP assumed no changes in coverage postmandate. However, some of these therapies may have utilization management, such as prior authorization or step therapy requirements, at baseline. CHBRP assumed increases of up to 5% in utilization for these therapies due to the removal of utilization management postmandate.

CHBRP assumed no changes in the utilization of laboratory tests for the evaluation of menopause from baseline to postmandate. CHBRP made this assumption in consultation with the content expert, as many symptoms of menopause are assessed via patient report and do not rely solely on laboratory tests.

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

Baseline and Postmandate Benefit Coverage

CHBRP estimates that at baseline, no enrollees with state-regulated insurance subject to the mandate are enrolled in plans or policies fully compliant with AB 432 because not all medications are included in benefit coverage as would be required by AB 432, and several or more medications have utilization management at baseline.

All 22,207,000 enrollees have a medical benefit subject to AB 432 and approximately 12,948,000 enrollees have DMHC-regulated or CDI-regulated outpatient pharmacy benefit.

Services for the Evaluation of Menopause Symptoms

For lab tests used for the evaluation of menopause, including lab tests for luteinizing hormone (LH), follicular stimulating hormone (FSH), estradiol, and testosterone, CHBRP estimates 100% coverage under the medical benefit at baseline, and no changes in coverage postmandate. This includes enrollees in commercial/CalPERS plans and policies and Medi-Cal beneficiaries.

Systemic and Local Hormonal Drug Therapies

For oral systemic hormonal drug therapies, CHBRP estimates 100% of enrollees in commercial/CalPERS plans and policies with a state-regulated pharmacy benefit have coverage for estrogen-only, progesterone-only, combination estrogen-progesterone, and combination estrogen and androgen formulations at baseline; therefore, there would be no changes in coverage postmandate. CHBRP estimated no utilization management for these therapies at baseline.

CHBRP estimates that 4% of enrollees have coverage for combination estrogen-SERM at baseline, and 100% of enrollees would have coverage of combination estrogen-SERM postmandate. CHBRP estimated no utilization management for combination estrogen-SERM at baseline.

For topical systemic hormonal drug therapies, CHBRP estimates 100% of enrollees in commercial/CalPERS plans and policies with a pharmacy benefit have coverage for estrogen-only and progesterone-only formulations at baseline and no changes in coverage postmandate. CHBRP estimated no utilization management for these therapies at baseline.

CHBRP estimates that 72% of enrollees have coverage for testosterone-only topical formulations at baseline, and 100% of enrollees would have coverage of testosterone-only topical formulations postmandate. CHBRP assumed some utilization management for testosterone-only topical formulations at baseline.

For transdermal systemic hormonal drug therapies, CHBRP estimates 100% of enrollees in commercial/CalPERS plans and policies with a pharmacy benefit have coverage for estrogen-only and combination estrogen-progesterone

formulations at baseline and no changes in coverage postmandate. CHBRP also estimated no utilization management for these therapies at baseline.

For vaginal estrogen therapies, CHBRP estimates that 12% of enrollees in commercial/CalPERS plans and policies with a pharmacy benefit have coverage for high-dose systemic therapy (e.g., high-dose vaginal ring) and 96% have coverage for low-dose local therapy (e.g., local low-dose creams and vaginal ring) at baseline. Postmandate, CHBRP estimates that 100% of enrollees in commercial/CalPERS plans and policies with a pharmacy benefit have coverage for high-dose systemic therapy and low-dose local therapy. CHBRP assumed some utilization management for these therapies at baseline.

For vaginal DHEA therapies, CHBRP estimates 3% of enrollees in commercial/CalPERS plans and policies with a pharmacy benefit have coverage for prasterone at baseline. Postmandate, CHBRP estimates that 100% of enrollees would have coverage for prasterone. CHBRP assumed some utilization management for these therapies at baseline.

Non-Hormonal Drug Therapies

For non-hormonal drug therapies, CHBRP estimates that 9% of enrollees in commercial/CalPERS plans and policies with a state-regulated pharmacy benefit have coverage for fezolinetant, 19% have coverage for ospemifene, and 100% have coverage for low-dose anti-depressants and anticonvulsants at baseline. Postmandate, CHBRP estimates that 100% of enrollees have coverage for fezolinetant, ospemifene, and low-dose anti-depressants and anticonvulsants. CHBRP assumed some utilization management for these therapies at baseline.

Drug Therapies to Treat or Prevent Osteoporosis

For medications to prevent or treat osteoporosis, i.e., bone loss, CHBRP estimates 100% of enrollees with health insurance subject to AB 432 have coverage for medications covered under the medical benefit (bisphosphonates and monoclonal antibodies). For enrollees with a pharmacy benefit regulated by DMHC or CDI, 100% have coverage for bisphosphonates and synthetic parathyroid hormone at baseline.

CHBRP estimates that 28% of enrollees with a state-regulated pharmacy benefit have coverage for SERMs for osteoporosis treatment and management at baseline. Postmandate, CHBRP estimates that 100% of these enrollees would have coverage for SERMs.

CHBRP estimates that bisphosphonates, SERMs, synthetic parathyroid hormone, and monoclonal antibodies have some utilization management at baseline.

The *Medical Effectiveness* section discussion of the effectiveness of osteoporosis medications notes that bisphosphonates are considered “first-line” treatment and monoclonal antibodies, SERMs, and synthetic parathyroid hormone are considered “second-line” treatments per ACP recommendations based on a larger systemic review and meta-analysis, and that there were some harms associated with “second-line” treatments. The removal of utilization management would mean that prescribers could prescribe an osteoporosis medication from any pharmacologic class without having to prescribe a bisphosphonate first, based on their professional judgment or the patient’s medical need.

Below, Table 8 provides estimates of how many Californians have health insurance that would have to comply with AB 432 in terms of benefit coverage.

Table 9. Impacts of AB 432 on Benefit Coverage, 2026

	Baseline (2026)	Postmandate Year 1 (2026)	Increase/ Decrease
Total enrollees with health insurance subject to state benefit mandates (a)	22,207,000	22,207,000	0

	Baseline (2026)	Postmandate Year 1 (2026)	Increase/ Decrease
Total enrollees with health insurance subject to AB 432	22,207,000	22,207,000	0
Total enrollees with health insurance subject to AB 432 with a pharmacy benefit regulated by DMHC or CDI (a)	12,948,000	12,948,000	0
Enrollees with coverage for evaluation of menopause symptoms **under the medical benefit**	100%	100%	0
Enrollees with coverage for treatment of menopause symptoms that includes:			
On-formulary coverage for systemic and local hormonal drug therapies:			
Oral systemic			
Estrogen only	100%	100%	0%
Progesterone only	100%	100%	0%
Combination estrogen-progesterone	100%	100%	0%
Combination estrogen and SERM	4%	100%	96%
Combination estrogen and androgens	100%	100%	0%
Topical systemic			
Estrogen only	100%	100%	0%
Progesterone only	100%	100%	0%
Testosterone	72%	100%	28%
Transdermal systemic			
Estrogen only	100%	100%	0%
Combination estrogen-progesterone	100%	100%	0%
Vaginal estrogen			
High dose systemic	12%	100%	88%
Low-dose local	96%	100%	4%
Vaginal DHEA			
Prasterone	3%	100%	97%
On-formulary coverage for nonhormonal drug therapies:			
Fezolinetant	9%	100%	91%
Ospemifene	19%	100%	81%
Anti-depressants	100%	100%	0%
Anticonvulsants	100%	100%	0%
On-formulary coverage to prevent or treat osteoporosis:			
Covered under the medical benefit			
Bisphosphonates	100%	100%	0%
Monoclonal antibodies medication	100%	100%	0%
Covered under pharmacy benefit			
Bisphosphonates	100%	100%	0%
SERMs	28%	100%	72%
Synthetic parathyroid hormone	100%	100%	0%

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 DMHC-regulated Medi-Cal Managed Care plans.
Key: CDI = California Department of Insurance; DHEA = dehydroepiandrosterone; DMHC = Department of Managed Health Care; SERM = selective estrogen receptor modulator.

Baseline and Postmandate Utilization and Unit Cost

Baseline and Postmandate Utilization

Because CHBRP estimates the marginal impact of AB 432, the utilization analyses focus on drugs and treatments for which enrollees in DMHC-regulated plans and CDI-regulated policies did not have 100% coverage at baseline, and/or for drugs and treatments for which enrollees in DMHC-regulated plans and CDI-regulated policies had utilization management, including prior authorization or step therapy.

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-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 (e.g., SSRIS and SNRIs); and
- Low-dose anticonvulsants (e.g., gabapentin).

Among **hormonal therapies** that CHBRP identified as treatments for menopause symptoms, utilization for the oral systemic combination estrogen and SERM therapy and high-dose systemic vaginal systemic therapy (e.g., Femring), utilization would increase from baseline to postmandate due to both an increase in coverage and the removal of utilization management. 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 postmandate. 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 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. For example, utilization of topical systemic testosterone increases from an estimated 276 monthly 30-day prescriptions at baseline to 385 monthly 30-day prescriptions postmandate. For vaginal DHEA therapies, utilization of prasterone would increase from an estimated 106 monthly 30-day prescriptions at baseline to 394 monthly 30-day prescriptions postmandate due to the increase in coverage and the removal of utilization management.

For **nonhormonal therapies**, CHBRP assumed utilization for fezolinetant and ospemifene will increase substantially due to both an increase in coverage and the removal of utilization management. Changes in utilization for these three therapies 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 postmandate. Additionally, a portion of baseline utilization will shift from noncovered to being covered postmandate.

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.

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.

Table 9 provides estimates of the impacts of AB 432 on utilization of lab tests and prescription drugs covered under the medical and pharmacy benefits.

Table 10. Impacts of AB 432 on Utilization, 2026

	Baseline (2026)	Postmandate Year 1 (2026)	Increase/ Decrease	Percentage Change
Total enrollees that are women aged 40-64 years with a medical benefit subject to AB 432	4,493,797	4,493,797	0	0%
Total enrollees that are women aged 40-64 years with an outpatient drug benefit subject to AB 432	2,620,107	2,620,107	0	0%
Monthly number of evaluations for menopause/perimenopause for women aged 40-64 years				
Lab test for evaluation of menopause/perimenopause	98,891	98,891	0	0%
Monthly number of 30-day menopause prescriptions for women aged 40-64 years				
On-formulary coverage for systemic and local hormonal drug therapies:				
Oral systemic				
Estrogen only	23,602	23,602	0	0%
Progesterone only	51,233	51,233	0	0%
Combination estrogen-progesterone	10,916	10,916	0	0%
Combination estrogen and SERM	14	99	85	607%
Combination estrogen and androgens	392	392	0	0%
Topical systemic				
Estrogen only	40,368	40,368	0	0%
Progesterone only	20	20	0	0%
Testosterone	276	385	109	39%
Transdermal systemic				
Estrogen only	147,035	147,035	0	0%
Combination estrogen-progesterone	2,147	2,147	0	0%
Vaginal estrogen				
High dose systemic	299	891	592	198%
Low-dose local	34,278	35,350	1,072	3%
Vaginal DHEA				
Prasterone	106	394	288	272%
On-formulary coverage for nonhormonal drug therapies:				
Fezolinetant	4,246	13,837	9,591	226%
Ospemifene	5,224	13,933	8,709	167%
Antidepressants	211,148	211,148	0	0%
Anticonvulsants	56,212	56,212	0	0%
On-formulary coverage to prevent or treat osteoporosis:				
Covered under the medical benefit*				
Bisphosphonates	19,066	19,402	336	2%
Monoclonal antibodies medication	30,749	31,291	542	2%
Covered under pharmacy benefit				
Bisphosphonates	4,911	4,998	87	2%
SERMs	450	1,304	854	190%
Synthetic parathyroid hormone	500	509	9	2%

Source: California Health Benefits Review Program, 2025.
Notes: * Utilization and unit costs for medications covered under the medical benefit reflect total annual utilization, rather than monthly utilization or costs. These medications are injections administered by physicians and may only be administered once or twice per year due to safety or other clinical considerations.
Key: DHEA = dehydroepiandrosterone; SERM = selective estrogen receptor modulator.

Baseline and Postmandate Unit Cost

CHBRP does not anticipate that the increases in utilization will affect the average per-unit cost, postmandate for most drug categories, save for low-dose local estrogen. The low-dose vaginal estrogen ring has a higher cost per month than local, low-dose estrogen in the cream formulation. As a result of the increased utilization of the low-dose vaginal estrogen ring, the average unit cost of "low-dose vaginal estrogens" would increase.

Per-unit costs for other medications range from $20 for low-dose antidepressants to $3,626 per unit for a synthetic parathyroid hormone prescription.

Below, Table 10 provides estimates of the impacts of AB 432 on unit cost of lab tests and prescription drugs covered under the medical and pharmacy benefit.

Table 11. Impacts of AB 432 on Unit Cost, 2026

	Baseline (2026)	Postmandate Year 1 (2026)	Increase/ Decrease	Percentage Change
Unit cost for menopause/perimenopause lab tests for women aged 40-64 years				
Lab test for evaluation of menopause/perimenopause	$36	$36	0	0%
Average per unit cost for a 30-day supply (a)				
On-formulary coverage for systemic and local hormonal drug therapies:				
Oral systemic				
Estrogen only	$27	$27	$0	0%
Progesterone only	$36	$36	$0	0%
Combination estrogen-progesterone	$130	$130	$0	0%
Combination estrogen and SERM	$197	$197	$0	0%
Combination estrogen and androgens	$101	$101	$0	0%
Topical systemic				
Estrogen only	$85	$85	$0	0%
Progesterone only	$616	$616	$0	0%
Testosterone	$270	$270	$0	0%
Transdermal systemic				
Estrogen only	$78	$78	$0	0%
Combination estrogen-progesterone	$249	$249	$0	0%
Vaginal estrogen				
High-dose systemic	$245	$245	$0	0%
Low-dose local	$111	$127	$16	14%
Vaginal DHEA				
Prasterone	$275	$275	$0	0%
On-formulary coverage for nonhormonal drug therapies:				
Fezolinetant	$619	$619	$0	0%
Ospemifene	$294	$294	$0	0%
Anti-depressants	$20	$20	$0	0%
Anticonvulsants	$24	$24	$0	0%
On-formulary coverage to prevent or treat bone loss:				
Covered under the medical benefit (b)				
Bisphosphonates	$252	$252	0	0%
Monoclonal antibodies medication	$3,143	$3,143	0	0%
Covered under pharmacy benefit				

Bisphosphonates	$36	$36	0	0%
SERMs	$76	$76	0	0%
Synthetic parathyroid hormone	$3,626	$3,626	0	0%

Source: California Health Benefits Review Program, 2025.
Notes: (a) The listed cost for drugs in this table do not reflect the assumed 40%/20% reduction in costs for brand/specialty drugs due to rebate payments received from pharmaceutical manufacturers. Actual rebate payments are confidential. Therefore, these average costs may not reflect the true total cost of the medications.
(b) Utilization and unit costs for medications covered under the medical benefit reflect total annual utilization, rather than monthly utilization or costs. These medications are injections administered by physicians and may only be administered once or twice per year due to safety or other clinical considerations.
Key: DHEA = dehydroepiandrosterone; SERM = selective estrogen receptor modulator.

Baseline and Postmandate 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%) (Table 11 and Table 13).

Of the total expenditure impact due to AB 432, 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 AB 432.

Below, Table 11 provides estimates of the impacts of AB 432 on expenditures, which include premiums, enrollee cost sharing, and enrollee expenses for noncovered benefits.

Table 12. Impacts of AB 432 on Expenditures, 2026

	Baseline (2026)	Postmandate Year 1 (2026)	Increase/ Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$68,752,638,000	$68,799,672,000	$47,034,000	0.07%
CalPERS employer (b)	$7,881,873,000	$7,885,364,000	$3,491,000	0.04%
Medi-Cal (excludes COHS) (c)	$31,818,731,000	$31,819,479,000	$748,000	0.00%
Enrollee premiums (expenditures)				
Enrollees, individually purchased insurance	$21,757,790,000	$21,766,749,000	$8,959,000	0.04%
Outside Covered California	$6,011,399,000	$6,013,792,000	$2,393,000	0.04%
Through Covered California	$15,746,391,000	$15,752,957,000	$6,566,000	0.04%
Enrollees, group insurance (d)	$21,712,866,000	$21,727,135,000	$14,269,000	0.07%
Enrollee out-of-pocket expenses				
Cost-sharing for covered benefits (deductibles, copayments, etc.)	$18,992,422,000	$19,013,506,000	$21,084,000	0.11%
Expenses for noncovered benefits (e) (f)	$33,365,000	$0	−$33,365,000	−100.00%
Total expenditures	$170,949,685,000	$171,011,905,000	$62,220,000	0.04%

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 only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. In addition, CHBRP is estimating it seems likely that there would also be a proportional increase of $170,000 for Medi-Cal beneficiaries enrolled in COHS managed care.
(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, including patient assistance programs) 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: CalPERS = California Public Employees' Retirement System; COHS = County Organized Health Systems.

Premiums

At the end of this section, Table 12 and Table 13 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 AB 432 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 8, Table 12, and Table 13), with health insurance that would be subject to AB 432

Commercial

Premiums are expected to increase among DMHC-regulated commercial plans, ranging from $0.34 PMPM for individual plans to $0.50 PMPM for large-group plans. Among CDI-regulated policies, premiums are expected to increase from $0.36 PMPM for small-group plans to $0.45 PMPM for large-group plans.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, CHBRP estimates that premiums will increase by $0.38 PMPM.

Medi-Cal

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 prior authorization 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.

Enrollee Expenses

AB 432-related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see Table 8, Table 12, and Table 13) with health insurance that would be subject to AB 432 expected to use prescription drugs and treatments for menopause symptoms during the year after enactment.

CHBRP projects no change to copayments or coinsurance rates but does project increases in utilization of some drugs (see Table 9) and therefore an increase in enrollee cost sharing. Increases in utilization of covered benefits are comprised of a combination of reductions in utilization that was paid for out of pocket at baseline that would be covered under AB 432 postmandate combined with new utilization due to increased take-up with increases in coverage.

Enrollee expenses for cost sharing for covered benefits will increase overall by $21,083,000, ranging from increases of $0.08 per member per month (PMPM) for enrollees in DMHC-regulated large-group plans to $0.28 PMPM for enrollees in CDI-regulated small-group policies. CHBRP estimates a $33,365,000 decrease in out-of-pocket costs for noncovered benefits postmandate in aggregate, with decreases ranging from $0.21 PMPM for enrollees in CDI-regulated small-group plans to $0.17 PMPM for DMHC-regulated CalPERS plans and policies. These decreases largely result from a shift in out-of-pocket costs for drug therapies such as fezolinetant, ospemifene, and prasterone that are not covered at baseline to premiums and cost sharing.

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 8, Table 9, and Table 10), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 432.

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 AB 432

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

CHBRP has found no other payers that would be affected by the enactment of AB 432.

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Table 13. 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 (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Total enrollees in plans/policies subject to AB 432	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
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	$108,453,242,000
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**	**$151,923,898,000**
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)	$0.20	$0.21	$0.21	$0.17	$0.00	$0.00	$0.20	$0.21	$0.21	$33,365,000
Total expenditures	**$767.54**	**$884.96**	**$1,091.26**	**$939.47**	**$276.79**	**$583.72**	**$956.54**	**$1,002.84**	**$951.60**	**$170,949,685,000**

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.[38] 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 only Medi-Cal beneficiaries enrolled 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.[39]
(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.

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

Table 14. Postmandate Change in 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 (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Total enrollees in plans/policies subject to AB 432	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Premiums										
Average portion of premium paid by employer (e)	$0.3971	$0.3009	$0.0000	$0.3183	$0.0072	$0.0072	$0.3299	$0.2724	$0.0000	$51,274,000
Average portion of premium paid by enrollee	$0.1037	$0.1260	$0.3352	$0.0616	$0.0000	$0.0000	$0.1215	$0.0890	$0.4335	$23,228,000
Total premium	$0.5008	$0.4269	$0.3352	$0.3799	$0.0072	$0.0072	$0.4514	$0.3614	$0.4335	**$74,501,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0827	$0.1963	$0.2426	$0.1066	$0.0000	$0.0000	$0.1266	$0.2757	$0.2002	$21,083,000
Expenses for noncovered benefits (f)	−$0.2039	−$0.2147	−$0.2144	−$0.1707	$0.0000	$0.0000	−$0.1964	−$0.2147	−$0.2052	−$33,365,000
Total expenditures	**$0.3796**	**$0.4085**	**$0.3634**	**$0.3158**	**$0.0072**	**$0.0072**	**$0.3816**	**$0.4224**	**$0.4285**	**$62,220,000**
Percent change										
Premiums	0.0712%	0.0593%	0.0409%	0.0443%	0.0026%	0.0012%	0.0542%	0.0480%	0.0558%	0.0490%
Total expenditures	**0.0495%**	**0.0462%**	**0.0333%**	**0.0336%**	**0.0026%**	**0.0012%**	**0.0399%**	**0.0421%**	**0.0450%**	**0.0364%**

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.[40] 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 only Medi-Cal beneficiaries enrolled 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.[41]
(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.

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

Public Health Impacts

As discussed in the *Introduction* section, AB 432 would require coverage for the evaluation and treatment for menopause and symptoms from menopause.

Estimated Public Health Outcomes

The public health impact analysis includes estimated impacts in the short term (within 12 months of implementation) and in the long term (beyond the first 12 months postmandate). This section estimates the short-term impact[42] of AB 432 on menopause symptoms and potential treatment harms. See the *Long-Term Impacts* section for potential changes in utilization of menopause treatment and quality of life beyond the first year postmandate.

As presented in the *Medical Effectiveness* section, there are many treatments that are endorsed by existing clinical practice guidelines and widely covered by insurance without utilization management. CHBRP found that high-dose vaginal estrogen and fezolinetant are effective at treating vasomotor symptoms (VMS) and that ospemifene, vaginal DHEA, and low-dose estrogen are effective at treating genitourinary syndrome of menopause (GSM). CHBRP also found that systemic testosterone therapy (oral and non-oral) can improve symptoms of hypoactive sexual desire disorder (HSDD). Of the drugs that prevent and treat osteoporosis, CHBRP found that bisphosphonates are effective as a first-line treatment and that monoclonal antibodies and synthetic parathyroid hormone are effective as second-line treatments.

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, there is 100% coverage at baseline for evaluation of menopause symptoms and most of the bill-specified treatment categories. While 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. CHBRP estimates no changes in utilization of lab tests for the evaluation of menopause due to no changes in coverage and no changes in utilization management.

The primary driver of CHBRP's projection of increased utilization of treatments for menopause symptoms is the increase in coverage for drugs that do not already have 100% coverage at baseline. The elimination of utilization management in some treatment categories is also a factor to a lesser degree. Many women are already receiving treatment for menopause symptoms, it is unlikely women would opt to discontinue a specific treatment and choose a different treatment due to the elimination of utilization management or new coverage for specific drugs.

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. As discussed in the *Background* section, 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 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.

Within the first year postmandate, CHBRP finds 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.

The impact of AB 432 on disparities in the treatment of symptoms is unknown among racial/ethnic groups and different socioeconomic groups in California.

[42] CHBRP defines short-term impacts as changes occurring within 12 months of bill implementation.

Potential Harms From AB 432

As described in the *Medical Effectiveness* "Findings on the Harms of Treatments of Menopause Symptoms" section, 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).

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Long-Term Impacts

In this section, CHBRP estimates the long-term impact of AB 432, 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 does not anticipate changes to utilization patterns that are markedly different beyond the first year postmandate based on the currently available treatments. However, there are new drug therapies for menopause symptoms in late-stage clinical development (Burger, 2024), which may result in updates to clinical guidelines and increases in utilization for these types of non-hormonal therapies. Additionally, greater awareness of the evaluation and treatment of menopause symptoms via the dissemination of clinical guidelines could eventually lead to greater utilization of drug therapies for menopause.

Cost Impacts

CHBRP does not anticipate any additional changes postmandate that are different from the new levels of 100% coverage established under AB 432. If a lower-cost option were to become available, Department of Managed Health Care (DMHC)-regulated plans and California Department of Insurance (CDI)-regulated policies would shift to covering those options and would potentially reduce overall costs. Additionally, if in the future DMHC-regulated Medi-Cal plans began including an outpatient pharmacy benefit, then any menopause drugs or categories not covered for this population at baseline would be required to be covered under AB 432, resulting in associated cost increases.

Long-Term Public Health 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 treatment categories (where most prescriptions are concentrated) 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 continue to access the newly covered categories 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 vasomotor symptoms (VMS) and genitourinary syndrome of menopause (GSM) over the course of their treatment, which might last 4 to 12 years after they start menopause (Avis et al., 2015). 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, although the long term impact of such courses is unknown. 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.

It is unknown whether elimination of utilization management protocols might improve the health and quality of life of women experiencing menopause symptoms. Previous CHBRP analyses found insufficient evidence regarding the direct impact of utilization management protocols on health outcomes, so it is unknown whether the removal of such protocols

would impact health outcomes (CHBRP analysis of AB 2144 in 2020). Please note that the absence of evidence is not "evidence of no effect." It is possible that an impact — desirable or undesirable — could result, but current evidence is insufficient to inform an estimate.

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Appendix A. Text of Bill Analyzed

On February 21, 2025, the California Assembly Committee on Health requested that CHBRP analyze AB 432 as introduced on February 5, 2025.

CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

ASSEMBLY BILL **NO. 432**

Introduced by Assembly Member Bauer-Kahan

February 05, 2025

An act to amend Section 2191 of, and to add Section 2190.4 to, the Business and Professions Code, to add Section 1367.252 to the Health and Safety Code, and to add Section 10123.1962 to the Insurance Code, relating to menopause.

LEGISLATIVE COUNSEL'S DIGEST

AB 432, as introduced, Bauer-Kahan. Menopause.

(1) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and requires the board to adopt and administer standards for the continuing education of those licensees. Existing law requires the board, in determining its continuing education requirements, to consider including a course in menopausal mental or physical health.

This bill would instead require the board, in determining its continuing education requirements, to include a course in menopausal mental or physical health. The bill would require physicians who have a patient population composed of 25% or more of women to complete a mandatory continuing medical education course in perimenopause, menopause, and postmenopausal care.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law sets forth specified coverage requirements for health care service plan contracts and health insurance policies.

This bill would require a health care service plan contract or health insurance policy, except as specified, that is issued, amended, or renewed on or after January 1, 2026, to include coverage for evaluation and treatment options for perimenopause and menopause. The bill would require a health care service plan or health insurer to annually provide clinical care recommendations, as specified, for hormone therapy to all contracted primary care providers who treat individuals with perimenopause and menopause. Because a willful violation of these provisions by a health care service plan would be a crime, the bill would impose a state-mandated local program.

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

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

DIGEST KEY

Vote: MAJORITY Appropriation: NO Fiscal Committee: YES Local Program: YES

BILL TEXT

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 2190.4 is added to the Business and Professions Code, to read:

2190.4. All physicians who have a patient population composed of 25 percent or more of women shall complete a mandatory continuing medical education course in perimenopause, menopause, and postmenopausal care.

SEC. 2. Section 2191 of the Business and Professions Code is amended to read:

2191. (a) In determining its continuing education requirements, the board shall consider including a course in human sexuality, defined as the study of a human being as a sexual being and how they function with respect thereto, and nutrition to be taken by those licensees whose practices may require knowledge in those areas.

(b) The board shall consider including a course in child abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected children.

(c) The board shall consider including a course in acupuncture to be taken by those licensees whose practices may require knowledge in the area of acupuncture and whose education has not included instruction in acupuncture.

(d) The board shall encourage every physician and surgeon to take nutrition as part of their continuing education, particularly a physician and surgeon involved in primary care.

(e) The board shall consider including a course in elder abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected persons 65 years of age and older.

(f) In determining its continuing education requirements, the board shall consider including a course in the early detection and treatment of substance abusing pregnant women to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these women.

(g) In determining its continuing education requirements, the board shall consider including a course in the special care needs of drug-addicted infants to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these infants.

(h) In determining its continuing education requirements, the board shall consider including a course providing training and guidelines on how to routinely screen for signs exhibited by abused women, particularly for physicians and surgeons in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. In the event the board establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(i) In determining its continuing education requirements, the board shall consider including a course in the special care needs of individuals and their families facing end-of-life issues, including, but not limited to, all of the following:

(1) Pain and symptom management.

(2) The psychosocial dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(j) In determining its continuing education requirements, the board shall give its highest priority to considering a course on pain management and the risks of addiction associated with the use of Schedule II drugs.

(k) In determining its continuing education requirements, the board shall consider including a course in geriatric care for emergency room physicians and surgeons.

(l) In determining its continuing education requirements, the board shall ~~consider including~~ *include* a course in menopausal mental or physical health.

SEC. 3. Section 1367.252 is added to the Health and Safety Code, to read:

1367.252. (a) A health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, or renewed on or after January 1, 2026, shall 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, that includes, but is not limited to, all of the following:

(1) At least one option in each formulation of, and the associated method of administration for, federal Food and Drug Administration-regulated systemic hormone therapy.

(2) At least one option in each formulation of, and the associated method of administration for, nonhormonal medications for each menopause symptom.

(3) At least one option in each formulation of, and the associated method of administration for, treatment for genitourinary syndrome of menopause.

(4) At least one from each class of medications approved to prevent and treat osteoporosis.

(b) Coverage required under this section includes authority for the treating provider to adjust the dose of a drug consistent with clinical care recommendations.

(c) A health care service plan shall 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 with perimenopause and menopause. A health care service plan shall encourage primary care providers to review those recommendations.

(d) For purposes of this section, the following terms have the following meanings:

(1) “Formulation” means all of the following:

(A) A tablet or capsule.

(B) A transdermal patch.

(C) A topical spray.

(D) A cream, gel, or lotion.

(E) A vaginal suppository, cream, or silicone ring.

(2) “Method of administration” means administering a formulation via an oral, topical, vaginal, subcutaneous, injectable, or intravenous route of administration.

(e) Coverage for the evaluation and treatment options for perimenopause and menopause shall be provided without discrimination on the basis of gender expression or identity.

(f) Nothing in this section shall be construed to limit coverage for medically necessary outpatient prescription drugs pursuant to Section 1342.71 or any other provision under this chapter.

SEC. 4. Section 10123.1962 is added to the Insurance Code, to read:

10123.1962. (a) A health insurance policy, except for a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2026, shall 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, that includes, but is not limited to, all of the following:

(1) At least one option in each formulation of, and the associated method of administration for, federal Food and Drug Administration-regulated systemic hormone therapy.

(2) At least one option in each formulation of, and the associated method of administration for, nonhormonal medications for each menopause symptom.

(3) At least one option in each formulation of, and the associated method of administration for, treatment for genitourinary syndrome of menopause.

(4) At least one from each class of medications approved to prevent and treat osteoporosis.

(b) Coverage required under this section includes authority for the treating provider to adjust the dose of a drug consistent with clinical care recommendations.

(c) A health insurer shall 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 insureds with perimenopause and menopause. A health insurer shall encourage primary care providers to review those recommendations.

(d) For purposes of this section, the following terms have the following meanings:

(1) “Formulation” means all of the following:

(A) A tablet or capsule.

(B) A transdermal patch.

(C) A topical spray.

(D) A cream, gel, or lotion.

(E) A vaginal suppository, cream, or silicone ring.

(2) “Method of administration” means administering a formulation via an oral, topical, vaginal, subcutaneous, injectable, or intravenous route of administration.

(e) Coverage for the evaluation and treatment options for perimenopause and menopause shall be provided without discrimination on the basis of gender expression or identity.

(f) Nothing in this section shall be construed to limit coverage for medically necessary outpatient prescription drugs pursuant to Section 10123.193 or any other provision under this chapter.

SEC. 5. 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.

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Appendix B. 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.[43] 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.[44]

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

Analysis-Specific Data Sources

Current coverage of the evaluation and treatment of menopause and perimenopause for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represent approximately 16% of the California Department of Insurance (CDI)-regulated market and 72% of the Department of Managed Health Care (DMHC)-regulated market. Combined, responses to this survey represent 70% of enrollees in the privately funded market subject to state mandates. In addition, California Public Employees' Retirement System (CalPERS) and Medi-Cal Managed Care plans subject to the Knox-Keene Act were queried regarding related benefit coverage.

For this analysis, CHBRP relied on CPT codes to identify services related to AB 432. *CPT copyright 2025 American Medical Association (AMA). All rights reserved. Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the American Medical Association.*

Health Cost Guidelines

The Health Cost Guidelines (HCGs) are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. It is likely that these organizations use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, we believe the HCG-based values are also good estimates of the premium impact as estimated by the HMOs and insurance companies.

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.
- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing EHBs and mandated benefits, experience rating, and individual and small group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures – inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.

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

- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.
- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.
- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.
- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.

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.

Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed by CHBRP. As a result, analytic approaches may differ between topically similar previous analyses, and therefore the approach and findings may not be directly comparable.

Prior CHBRP analyses of proposed menopause and perimenopause bills were developed focusing on the utilization and unit cost for specific medications used to treat menopause that were not previously covered. The analysis of AB 432 was developed using the utilization and cost for services and medications that may increase due to the removal of utilization management on the evaluation and treatment of menopause and perimenopause. The methodology and results of AB 432 cost analysis are not comparable to results of prior menopause and perimenopause bills.

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, CalPERS, and Managed Medi-Cal plans subject to the requirements of the Knox-Keene Health Care Service Plan Act.
- CHBRP assumed that additional utilization due to the enactment of this bill will occur amongst women aged 40-64, as this is the age range where women are expected to seek treatment for naturally occurring menopause and perimenopause.
- CHBRP surveyed the carriers to determine the percentage of the population with on-formulary coverage for various treatments of menopause and perimenopause without utilization management. For carriers who did not respond to the 2025 survey, the response from the 2024 survey for AB 2467 was assumed. The types of treatments included in the survey were consistent with the treatments listed in the bill language for AB 432, with the following adjustments:
    - CHBRP included questions relating to coverage for testosterone. Though testosterone is not indicated by the federal Food and Drug Administration to treat menopause and perimenopause for women, CHBRP believes that there is sufficient ambiguity in the bill language that insurers may be required to cover testosterone without utilization management if “deemed medically by the treating health care provider.”

  - Some treatment categories listed in the bill language are already covered on-formulary without utilization management techniques. CHBRP assumes that coverage is compliant with AB 432, if at least one drug in each of the listed categories is covered on-formulary without utilization management.

- CHBRP assumed that the evaluation of menopause and perimenopause would be limited to additional laboratory tests for hormone levels.

Methodology and Assumptions for Baseline Utilization

Evaluation of menopause and perimenopause

- CHBRP assumed that the evaluation of menopause and perimenopause would be limited to diagnostic laboratory testing procedures for hormone levels. CHBRP identified these services using the following Current Procedural Terminology (CPT) [45]/Healthcare Common Procedure Coding System (HCPCS) codes: 82670, 83001, 83002, 84144, 80414, 80415, 84402, 84403, 84410. Only services provided to females ages 40-64, which did not have a diagnosis code for hormone replacement therapy (i.e., ICD-10 code F64 and Z87.980), were included in the analysis.

Coverage for the treatment of menopause and perimenopause under the medical benefit

- Osteoporosis medications administered and paid through the medical benefit were identified using CPT[46]/HCPCS. Only services provided to females ages 40-64, which did not have a diagnosis code for hormone replacement therapy (i.e., ICD-10 code F64 and Z87.980), were included in the analysis.

  - Bisphosphonates: J1740, J2430, J3489
  - Monoclonal Antibodies: J0897, J3111

- Utilization for medications administered through the medical benefit was trended to 2026 at 0% per year. This trend is based on the 2024 Milliman Health Cost Guidelines.

On-formulary prescription coverage for the treatment of menopause and perimenopause

- Enrollees with coverage for prescription drugs are those with health insurance subject to AB 432 with an outpatient prescription drug benefit regulated by DMHC or CDI.

- Baseline utilization for non-testosterone medications was estimated using Milliman's proprietary 2023 Consolidated Health Cost Guidelines Sources Database (CHSD). The data was limited to California commercial enrollees. Drugs within the bill-specified therapeutic categories were identified using the product names in the MediSpan® Master Drug Data Base v2.5 for the drugs listed in Appendix C. CHBRP made the following adjustments to the baseline utilization data for certain drugs:

  - CHBRP assumed that the utilization of ospemifene and fezolinetant would be higher than implied in Milliman's research databases by 5% of baseline hormonal therapy utilization. This is intended to reflect that utilization for these drugs in the claims data may be lower due to lack of coverage.

  - CHBRP assumed that the utilization of high dose vaginal estrogen (i.e., Femring) would be higher than implied in Milliman's research databases by roughly 2% for low dose vaginal estrogens. This is intended to reflect that utilization for this drug in the claims data may be lower due to lack of coverage. We anticipate with coverage expansion, Femring would become more widely used due to its convenience. However, given the range of alternative systemic treatment options for estrogen it would not reach the levels of other similar medications.

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  - CHBRP assumed that testosterone utilization amongst women aged 40-64 with coverage would be 5% of the utilization amongst men aged 40-64 years with coverage observed in Milliman's research databases. Utilization of testosterone by women is anticipated to be different than men for two reasons. First, the conditions treated and related prevalence varies between men and women. Second, because women typically use testosterone approved to treat men, and because women use much lower doses of testosterone as compared to men, a 30-day supply may last for a year or longer, explaining the much lower utilization rate amongst women.

- Utilization for prescription drugs was trended to 2026 at 1.6% per year.

Utilization of mandated treatments for noncovered benefits

- For most drugs, CHBRP assumed that the utilization rate amongst patients without coverage would be roughly 10% of the rate for those with full coverage. Due to the impact of copay assistance programs which reduce out-of-pocket costs, CHBRP assumed that the utilization rate for vaginal estrogens, fezolinetant, ospemifene, and prasterone would be higher, at 25% of the utilization rate amongst women with coverage.

Methodology and Assumptions for Baseline Cost

- CHBRP calculated the average cost per service using Milliman's proprietary 2023 Consolidated Health Cost Guidelines Sources Database (CHSD) for the following services:
  - The cost per service for evaluation. The average costs per evaluation of menopause and perimenopause was calculated as the average allowed costs of the amongst the CPT[47] codes: 82670, 83001, 83002, 84144, 80414, 80415, 84402, 84403, 84410. Only costs for services provided to females ages 40-64 years were included in the analysis.
  - The cost per service for osteoporosis medications administered and paid through the medical benefit.
  - The cost per script for non-testosterone medications. Only costs for medications provided to females ages 40-64 were included in the analysis.
  - The cost per script for testosterone medications. CHBRP assumed that the cost for each script would equal the average cost per script for that script amongst utilization observed from testosterone scripts filled for men aged 40-64.
- The average cost for medical and pharmacy services were trended to 2026 at 4% per year. As shifts in the mix in medications are modeled separately, the unit cost trends for prescription drugs reflect increases to the prices of the same medications.
- CHBRP assumed that 40% of the cost of brand medications would be offset by manufacturer rebates. CHBRP assumed that 20% of the cost of specialty medications would be offset by manufacturer rebates.

Methodology and Assumptions for Baseline Cost Sharing

- CHBRP assumed the cost sharing for the evaluation and treatments for menopause and perimenopause is the same as major medical cost sharing. Major medical cost sharing was estimated based on metal tier actuarial values and sample plans.
- CHBRP assumes that any enrollee who does not have on-formulary coverage for a particular product would pay 100% of the average cost at baseline.

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- CHBRP assumed that member cost sharing for prescription drugs would be assessed on the allowed costs paid to the pharmacy before rebates.

Methodology and Assumptions for Postmandate Utilization

- CHBRP assumed that the removal of prior authorization requirements would increase utilization by between 0% and 5% based upon discussions with the content expert. Drugs without barriers at baseline would see no increase, whereas drugs with prior authorization requirements at baseline that offered clinical and/or quality of life benefits for some patients as compared to alternative treatments would see increases of up to 5%.

Methodology and Assumptions for Postmandate Cost

- Postmandate, CHBRP assumed that the unit costs of low dose vaginal estrogens would increase by 14% due to the removal of prior authorization requirements which would encourage prescribers and patients to seek more convenient and higher cost brand medications.
- Otherwise, CHBRP assumed the average cost per script would not change as a result of AB 432.

Methodology and Assumptions for Postmandate Cost Sharing

- CHBRP assumed the average cost sharing per script for enrollees with coverage would be the same postmandate as baseline. Total cost sharing will increase to the extent that total utilization will increase but cost sharing per script will remain the same.

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 AB 432 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 AB 432 would be substantially the same as the impacts in the first year (see Tables 8, 9, 10, 11, and 13). 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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Appendix C. Examples of Treatments for Menopause Symptoms

Table 14, below, includes examples of medications used to treat menopause symptoms and conditions associated with menopause. These medications are grouped into categories as defined by the language of Assembly Bill (AB) 432: 1) FDA-approved systemic hormone therapy; 2) nonhormonal medications to treat menopause symptoms; 3) treatments for genitourinary syndrome of menopause (GSM); and 4) medications to prevent and treat osteoporosis. Medications are further categorized based on formulation and route of administration. Some medications fall into multiple categories and are therefore listed more than once below. Existing law requires coverage of off-label use of FDA-approved medications.

Additionally, CHBRP assumes plans and policies would be required to cover at least one medication on-formulary within each medication class. For example, within the Systemic Hormonal Drug Therapy category, plans and policies must cover oral systemic and topical systemic formulations. Within each formulation, plans and policies would be required to cover at least one medication from each class. Within oral systemic formulations, plans and policies must cover at least one Estrogen only, Progesterone only, Combination Estrogen-Progesterone, combination Estrogen and SERM, combination Estrogen and Androgens, and Testosterone medication.

Table 15. List of Medications Used for Menopause Symptoms and Conditions Associated With Menopause

Hormonal Drug Therapy
Oral systemic
Estrogen only • Estradiol* (Estrace, generics) • Conjugated estrogens (Premarin) • Esterified estrogen (Menest)
Progesterone only • Progesterone (Prometrium, generics) • Medroxyprogesterone (Provera, generics)
Combination estrogen-progesterone • Conjugated estrogens and medroxyprogesterone (Premphase and Prempro) • Estradiol and norethindrone acetate (Activella, Amabelz, Lopreeza, Mimvey, generic) • Estradiol drospirenone (Angeliq) • Estradiol and progesterone* (Bijuva)
Combination estrogen and SERM • Conjugated/equine estrogen and bazedoxifene (Duavee)
Combination estrogen and androgens • Esterified estrogen and methyltestosterone (Covaryx, Covaryx HS, EEMT, EEMT HS, Est Estrogen-Methyltest DS, Est Estrogen-Methyltest HS)
Topical systemic
Estrogen only • Estradiol gel/cream* (Divigel, Elestrin, Estrogel) • Estradiol spray* (Evamist)

Progesterone only
- Progesterone gel (Crinone)

Testosterone only
- Testosterone gel (Androgel, Natesto, Natesto Nasal, Testim, Vogelxo)

Transdermal systemic

Estrogen only
- Estradiol patch* (Alora, Estradot, Climara, Vivelle-Dot, MiniVelle, Oesclim, Menostar, Dotti, Lyllana, generics)

Combination estrogen-progesterone
- Estradiol and levonorgestrel patch (Climara Pro)
- Estradiol and norethindrone patch (CombiPatch)

Vaginal high-dose systemic

Estrogen only
- Estradiol acetate ring* (Femring)

Dehydroepiandrosterone (DHEA)

Prastrarone (Intrarosa) vaginal insert

Nonhormonal Drug Therapy

Neurokinin 3 (NK3) receptor antagonist

Fezolinetant (Veozah) oral

Selective estrogen receptor modulator (SERM)

Ospemifene (Osphena) oral

Antidepressants

Selective serotonin reuptake inhibitors (SSRIs) oral
- Paroxetine (Brisdelle, Paxil)
- Escitalopram (Lexapro)
- Citalopram (Celexa)
- Fluoxetine (Prozac)
- Sertraline (Zoloft)
- Fluvoxamine (Luvox)

Serotonin-norepinephrine reuptake inhibitors (SNRIs) oral
- Venlafaxine (Effexor)
- Desvenlafaxine (Pristiq)

Anticonvulsants

GABA analog oral
- Gabapentin (Neurontin)
- Pregabalin (Lyrica)

Drugs Used to Treat GSM

Hormonal drug therapy

Oral systemic

Estrogen only
- Estradiol* (Estrace, generics)
- Conjugated estrogens (Premarin)
- Esterified estrogen (Menest)

Combination estrogen-progesterone
- Conjugated estrogens and medroxyprogesterone (Premphase and Prempro)
- Estradiol and norethindrone acetate (Activella, Amabelz, Lopreeza, Mimvey, generic)
- Estradiol drospirenone (Angeliq)

Topical systemic

Estrogen only
- Estradiol gel/cream* (Estrogel)

Transdermal systemic

Estrogen only
- Estradiol patch* (Alora, Climara, Vivelle-Dot)

Combination estrogen-progesterone
- Estradiol and norethindrone patch (CombiPatch)

Vaginal high-dose systemic

Estrogen only
- Estradiol acetate ring* (Femring)

Vaginal low-dose local

Estrogen only
- Estradiol ring* (Estring)
- Estradiol cream* (Estrace)
- Conjugated/equine estrogen cream (Premarin)
- Estradiol vaginal insert* (Imvexxy)
- Estradiol vaginal tablets* (Vagifem, Yuvafem)

Dehydroepiandrosterone (DHEA)

Prastrarone (Intrarosa) vaginal insert

Nonhormonal drug therapy

Selective estrogen receptor modulator (SERM)

Ospemifene (Osphena) oral

Drugs to Prevent or Treat Osteoporosis

Bisphosphonates • Alendronate (Fosomax, Binosto) oral • Risedronate (Actonel, Atelvia) oral • Ibandronate (Boniva) oral and infusion • Zoledronic acid (Reclast) infusion
Selective estrogen receptor modulators (SERMs) • Raloxifene (Evista) oral
Combination estrogen and SERM • Conjugated/equine estrogen and bazedoxifene (Duavee) oral
Synthetic parathyroid hormone • Teriparatide (Forteo) oral • Abaloparatide (Tymlos) oral
Monoclonal antibodies • Denosumab (Prolia) infusion • Romosozumab (Evenity) infusion
Calcitonin (Miacalcin) oral

Source: California Health Benefits Review Program, 2025.
Notes: * Denotes manufactured FDA-approved bioidentical hormone.

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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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