Department of Managed Health Care and Department of Health Care Services
Proposed Trailer Bill Language
2026-27 May Revision

Menopause Coverage

Section 1451.3 is added to the Business and Professions Code, to read: 1451.3.

(a) For purposes of this section, "qualifying nurse practitioner" means a holder of a nurse practitioner certificate, who is certified by national certifying body recognized by the Board of Registered Nursing, in a specialty of family practice, women's health, adult-gerontology primary care, or a substantially equivalent specialty, and whose patient population is composed of 25 percent or more of adult women under 65 years of age.
(b) Beginning July 1, 2027, a qualifying nurse practitioner who completes continuing education courses in perimenopause, menopause, and postmenopausal care shall receive two hours of credit for each hour completed of that coursework, for a total earned credit that does not exceed eight course hours, toward the requirement set forth in Section 1451 of Title 16 of the California Code of Regulations.

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

(a) Beginning July 1, 2027, a qualifying physician and surgeon who completes continuing medical education courses in perimenopause, menopause, and postmenopausal care shall receive two hours of credit for each hour completed of that coursework, for a total earned credit that does not exceed eight course hours, toward the requirement set forth in Section 1336 of Title 16 of the California Code of Regulations.
(b) For purposes of this section, “qualifying physician and surgeon” means a holder of a physician’s and surgeon’s certificate from the board who is certified by a member board of the American Board of Medical Specialties in internal medicine, family medicine, obstetrics and gynecology, neurology, neurological surgery, or psychiatry and whose patient population includes adult women under 65 years of age.

SectionSection 2454.7 is added to the Business and Professions Code, to read: 2454.7.

Beginning July 1, 2027, an osteopathic physician and surgeon who completes continuing medical education courses in perimenopause, menopause, and postmenopausal care shall receive two hours of credit for each hour completed of that coursework, for a total earned credit that does not exceed eight course hours, toward the requirement set forth in Section 1635 of Title 16 of the California Code of Regulations.

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

(a) A health care service plan contract that provides outpatient prescription drug benefits and is issued, amended, or renewed on or after the operative date of this section shall include coverage for United States Food and Drug

Administration-approved treatments used to treat menopausal symptoms, as medically necessary, including, but not limited to, all of the following:
(1) Hormone therapy, including combination estrogen and hormone medicines, combination estrogen and progestin medicines, estrogen-only and progestin-only medicines, vaginal estrogen, and topical hormone therapy. This does not include glucagon-like peptide-1 or glucagon-like peptide-1 receptor agonists used solely for weight loss.
(2) Low-dose antidepressants.
(3) Anticonvulsants.
(4) Medications to prevent or treat osteoporosis.
(5) Nonhormonal medications for vasomotor-related symptoms.
(b) A health care service plan contract that is issued, amended, or renewed on or after January 1, 2027, shall include a program to ensure enrollees have access to current menopause information and covered items and services.
(c) For the program to satisfy subdivision (b), the plan shall do all of the following:
(1) Provide, no later than July 1, 2027, and biannually thereafter, all contracted providers delivering primary care with information about current clinical care recommendations for menopause care, including hormone therapy, from the Menopause Society or other nationally recognized professional association. The plan shall encourage providers delivering primary care to review the information.
(2) Establish and maintain a policy to reimburse providers for provision of services related to menopause care, including services integrated with primary care and obstetrician-gynecologist services. The policy shall identify the Current Procedural Terminology (CPT) codes for services commonly used to evaluate, diagnose, and treat symptoms resulting from menopause.
(3) Establish and maintain a policy to provide enrollees who may experience menopause and who are 40 years of age and older with an annual menopause assessment during primary care and obstetrician-gynecologist appointments. Enrollees may opt out of receiving the assessments. The policy shall include a copy of the assessment tool and information on how it was developed or chosen.
(4) Provide enrollees who may experience menopause and who are age 40 years of age and older with a notice that includes a definition of menopause and that lists the covered items and services used to evaluate and treat symptoms resulting from menopause. The first notice shall be sent within 60 days of the enrollee's 40th birthday and shall be sent biannually thereafter. Enrollees may opt out of receiving the notices. The notice shall include a description of at least all of the following types of federal Food and Drug Administration-approved items and services:
(A) Hormone therapy in the full range of formulations and methods of administration.
(B) Low-dose antidepressants.
(C) Anticonvulsants.
(D) Medications to prevent or treat osteoporosis.
(E) Nonhormonal medications for vasomotor-related symptoms.
(5) Establish and maintain a policy to contract with providers delivering primary care, including Advanced Practice Providers such as licensed Nurse Practitioners and Certified Nurse-Midwives, who hold a certification or credential in menopause care from a nationally recognized organization, such as the Menopause Society or other similar organization. The policy shall state what steps the plan will take to incentivize providers to receive and maintain the certification or credential.
(d) The plan shall file with the director within six months of the operative date of this statute the policies and notices specified in subdivision (c). The plan shall also disclose the policies to network providers, provider groups, and delegated entities that may be impacted by the policies and notices and shall attest to that disclosure to the director.

(e) Coverage for the treatment options pursuant to this section shall be provided without discrimination on the basis of gender expression or identity.
(f) This section does not apply to a Medi-Cal managed care plan contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. This section also does not apply to a Medicare supplement health care service plan contract. This section only applies to a specialized health care service plan to the extent it provides coverage for the treatment of symptoms resulting from menopause.
(g) For purposes of this section, "menopause" includes perimenopause, menopause, and postmenopause.

Section 1367.253 is added to the Health and Safety Code, to read:
1367.253.

(a) A health care service plan shall base a medical necessity determination or the utilization review criteria that the plan, and an entity acting on the plan's behalf, applies to determine the medical necessity of health care services and benefits for the treatment of symptoms resulting from menopause on current generally accepted standards of menopause care.
(b) Beginning January 1, 2027, when conducting utilization review of all covered health care services and benefits for the treatment of symptoms resulting from menopause, a health care service plan shall apply criteria and guidelines developed by the Menopause Society or another nationally recognized professional association, as specified by the department.
(c) In conducting utilization review involving patient care decisions that are within the scope of the sources specified in subdivision (b), a health care service plan shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit a plan from applying utilization review criteria to health care services and benefits for menopause care that meet either of the following criteria:
(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), if the utilization review criteria were developed in accordance with subdivision (a).
(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), if the utilization review criteria were developed in accordance with subdivision (a).
(d) If a health care service plan purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the plan shall verify and document before use that the criteria were developed in accordance with subdivision (a).
(e) A health care service plan shall not adopt, impose, or enforce terms in its contracts or provider agreements, in writing or in operation, that undermine, alter, or conflict with this section.
(f) For purposes of this section:
(1) "Generally accepted standards of menopause care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties, including gynecology, endocrinology, and family practice. Valid, evidence-based sources establishing generally accepted standards of menopause care include peer reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies, and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.
(2) "Menopause" includes perimenopause, menopause, and postmenopause.
(3) "Utilization review" means either of the following:

(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, enrollees, or their authorized representatives for coverage of health care services prior to, retrospectively, or concurrent with the provision of health care services to enrollees.
(B) Evaluating the medical necessity, appropriateness, or efficacy of health care services, benefits, or procedures, under any circumstances, to determine if a health care service or benefit subject to a medical necessity coverage requirement in a health care service plan contract is covered as medically necessary for an enrollee.
(4) "Utilization review criteria" means criteria, standards, protocols, or guidelines used by a health care service plan to conduct utilization review.
(g)(1) This section applies to all health care services and benefits for the treatment of symptoms resulting from menopause covered by a health care service plan contract, including prescription drugs.
(2) This section applies to a health care service plan that conducts utilization review and an entity or contracting provider that performs utilization review or utilization management functions on a plan's behalf.
(3) This section does not apply to a Medi-Cal managed care plan contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code. This section also does not apply to a Medicare supplement health care service plan contract. This section only applies to a specialized health care service plan to the extent it provides coverage for the treatment of symptoms resulting from menopause.
(h) The director may assess administrative penalties for violations of this section as provided for in Section 1368.04, in addition to any other remedies permitted by law.
(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section and Section 1367.252 by means of all-plan letters or similar instructions, without taking regulatory action, until the department adopts regulations pursuant to the Administrative Procedure Act. The department shall consult with the Department of Insurance and interested stakeholders in developing guidance.

Section 10123.861 is added to the Insurance Code, to read:
10123.861.

(a) A health insurance policy that provides outpatient prescription drug benefits and is issued, amended, or renewed on or after the operative date of this section shall include coverage for United States Food and Drug Administration-approved treatments used to treat menopausal symptoms, as medically necessary, including, but not limited to, all of the following:
(1) Hormone therapy, including combination estrogen and hormone medicines, combination estrogen and progestin medicines, estrogen-only and progestin-only medicines, vaginal estrogen, and topical hormone therapy. This does not include glucagon-like peptide-1 or glucagon-like peptide-1 receptor agonists used solely for weight loss.
(2) Low-dose antidepressants.
(3) Anticonvulsants.
(4) Medications to prevent or treat osteoporosis.
(5) Nonhormonal medications for vasomotor-related symptoms.
(b) A health insurance policy that is issued, amended, or renewed on or after January 1, 2027, shall include a program to ensure insured individuals have

access to current menopause information and covered items and services.
(c) For the program to satisfy subdivision (b), the insurer shall do all of the following:
(1) Provide, no later than July 1, 2027, and biannually thereafter, all contracted providers delivering primary care with a notice that contains current clinical care recommendations for menopause care, including hormone replacement therapy, from the Menopause Society or other nationally recognized professional association. The insurer shall encourage providers delivering primary care to review the notice and information.
(2) Establish and maintain a policy to reimburse providers for provision of services related to menopause care, including services integrated with primary care and obstetrician-gynecologist services. The policy shall identify the Current Procedural Terminology (CPT) codes for services commonly used to evaluate, diagnose, and treat symptoms resulting from menopause.
(3) Establish and maintain a policy to provide insured individuals who may experience menopause and who are 40 years of age and older with an annual menopause assessment during primary care and obstetrician-gynecologist appointments. Insured individuals may opt out of receiving the assessments. The policy shall include a copy of the assessment tool and information on how it was developed or chosen.
(4) Provide insured individuals who may experience menopause and who are 40 years of age and older with a notice that includes a definition of menopause and that lists the covered items and services used to evaluate and treat symptoms resulting from menopause. The first notice shall be sent within 60 days of the insured individual's 40th birthday and shall be sent biannually thereafter. Insured individuals may opt out of receiving the notices. The notice shall include a description of at least all of the following types of federal Food and Drug Administration-approved items and services:
(A) Hormone therapy in the full range of formulations and methods of administration.
(B) Low-dose antidepressants.
(C) Anticonvulsants.
(D) Medications to prevent or treat osteoporosis.
(E) Nonhormonal medications for vasomotor-related symptoms.
(5) Establish and maintain a policy to contract with providers delivering primary care, including Advanced Practice Providers such as licensed Nurse Practitioners and Certified Nurse-Midwives, who hold a certification or credential in menopause care from a nationally recognized organization, such as the Menopause Society or other similar organization. The policy shall state what steps the insurer will take to incentivize providers to receive and maintain the certification or credential.
(d) The health insurer shall file with the commissioner within six months of the operative date of this statute the policies and notices specified in subdivision (c). The insurer shall also disclose the policies to network providers, provider groups, and delegated entities that may be impacted by the policies and notices and shall attest to that disclosure to the commissioner.
(e) Coverage for the treatment options pursuant to this section shall be provided without discrimination on the basis of gender expression or identity.
(f) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies, except to the extent they provide coverage for the treatment of symptoms resulting from menopause.
(g) For purposes of this section, "menopause" includes perimenopause, menopause, and postmenopause.

Section 10123.862 is added to the Insurance Code, to read:
10123.862.

(a) A health insurer shall base a medical necessity determination or the utilization review criteria that the insurer, and an entity acting on the insurer's behalf, applies to determine the medical necessity of health care services and benefits for the treatment of symptoms resulting from menopause on current generally accepted standards of menopause care.
(b) Beginning January 1, 2027, when conducting utilization review of all covered health care services and benefits for the treatment of symptoms resulting from menopause, a health insurer shall apply criteria and guidelines developed by the Menopause Society or another nationally recognized professional association, as specified by the commissioner.
(c) In conducting utilization review involving patient care decisions that are within the scope of the sources specified in subdivision (b), a health insurer shall not apply different, additional, conflicting, or more restrictive utilization review criteria than the criteria and guidelines set forth in those sources. This subdivision does not prohibit an insurer from applying utilization review criteria to health care services and benefits for menopause care that meet either of the following criteria:
(1) Are outside the scope of the criteria and guidelines set forth in the sources specified in subdivision (b), if the utilization review criteria were developed in accordance with subdivision (a).
(2) Relate to advancements in technology or types of care that are not covered in the most recent versions of the sources specified in subdivision (b), if the utilization review criteria were developed in accordance with subdivision (a).
(d) If a health insurer purchases or licenses utilization review criteria pursuant to paragraph (1) or (2) of subdivision (c), the insurer shall verify and document before use that the criteria were developed in accordance with subdivision (a).
(e) A health insurer shall not adopt, impose, or enforce terms in its policies or provider agreements, in writing or in operation, that undermine, alter, or conflict with this section.
(f) For purposes of this section:
(1) "Generally accepted standards of menopause care" means standards of care and clinical practice that are generally recognized by health care providers practicing in relevant clinical specialties, including gynecology, endocrinology, and family practice. Valid, evidence-based sources establishing generally accepted standards of menopause care include peer reviewed scientific studies and medical literature, clinical practice guidelines and recommendations of nonprofit health care provider professional associations, specialty societies, and federal government agencies, and drug labeling approved by the United States Food and Drug Administration.
(2) "Menopause" includes perimenopause, menopause, and postmenopause.
(3) "Utilization review" means either of the following:
(A) Prospectively, retrospectively, or concurrently reviewing and approving, modifying, delaying, or denying, based in whole or in part on medical necessity, requests by health care providers, insured individuals, or their authorized representatives for coverage of health care services prior to, retrospectively, or concurrent with the provision of health care services to insured individuals.
(B) Evaluating the medical necessity, appropriateness, or efficacy of health care services, benefits, or procedures, under any circumstances, to determine if a health

care service or benefit subject to a medical necessity coverage requirement in a health insurance policy is covered as medically necessary for an insured individual.
(4) "Utilization review criteria" means criteria, standards, protocols, or guidelines used by a health insurer to conduct utilization review.
(g)(1) This section applies to all health care services and benefits for the treatment of symptoms resulting from menopause covered by a health insurance policy, including prescription drugs.
(2) This section applies to a health insurer that conducts utilization review and an entity or contracting provider that performs utilization review or utilization management functions on an insurer's behalf.
(3) This section does not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, dental-only, or vision-only insurance policies, except to the extent they provide coverage for the treatment of symptoms resulting from menopause.
(h) If the commissioner determines that a health insurer has violated this section, the commissioner may, after appropriate notice and opportunity for hearing in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code), by order, assess a civil penalty not to exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, a civil penalty not to exceed ten thousand dollars ($10,000) for each violation.
(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section and Section 10123.861 through guidance or similar instructions, without taking regulatory action, until the department adopts regulations pursuant to the Administrative Procedure Act. The department shall consult with the Department of Managed Health Care and interested stakeholders in developing guidance.

Section 14132.14 is added to the Welfare and Institutions Code, to read:
14132.14.

(a) Federal Food and Drug Administration-approved treatments for Menopausal symptoms are covered benefits under the Medi-Cal program, subject to medical necessity. These include all of the following:
(1) Hormone therapy, including combination estrogen and hormone medicines, combination estrogen and progestin medicines, estrogen-only and progestin-only medicines, vaginal estrogen, and topical hormone therapy. This does not include glucagon-like peptide-1 or glucagon-like peptide-1 receptor agonists used solely for weight loss.
(2) Low-dose antidepressants.
(3) Anticonvulsants.
(4) Medications to prevent or treat osteoporosis.
(5) Nonhormonal medications for vasomotor-related symptoms.
(b) The department shall establish and maintain a policy to reimburse providers for provision of services related to menopause care, including services integrated with primary care and obstetrician-gynecologist services. The policy shall consider current clinical care recommendations from the Menopause Society or other nationally recognized professional association, and shall identify billing codes for services commonly used to treat symptoms resulting from menopause.

(c) Coverage pursuant to this subdivision shall be provided without discrimination on the basis of gender expression or identity.
(d) For purposes of this section, “menopause” includes perimenopause, menopause, and postmenopause.
(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking any further regulatory action.
(f) This section shall be implemented only to the extent that any necessary federal approvals are obtained, and federal financial participation is available and not otherwise jeopardized.

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