PREPARED TESTIMONY AND STATEMENT FOR THE RECORD OF
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Half the Country, Zero Hearings:

Meeting the Moment to End the Menopause Care Gap in America

Before the

U.S. SENATE COMMITTEE ON AGING

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Thank you Chair Scott, Ranking Member Gillibrand, and Members of the Committee for convening this historic hearing. My name is Jennifer Weiss-Wolf and I am an attorney, advocate, and author whose primary professional focus is menstruation, menopause, and the law – an unusual sphere of expertise, I know. These are universal experiences for every girl and woman that too often go neglected, and are deeply deserving of public policy attention and intervention.

My work entails analyzing laws and regulatory systems to see where gaps and inequities may exist – ranging from tax codes and public benefits, to scientific research and medical education – and then proposing policies to remedy that. My new book, *When in Menopause: A User's Manual & Citizen's Guide*, out next month, is intended to help everyday people likewise engage. So too does my role as Board member of Let's Talk Menopause, a nonprofit that provides information, community, and resources.

Over the past decade, policymakers at all levels of government, state and federal, and of all political affiliations, have begun to advance related reforms. Among these:

- Menstrual policy: Nearly every Member of this Committee hails from a state that has eliminated the "tampon tax" (signed into law in Florida by Chair Scott in 2017 when he served as Governor). The only two federal laws in our nation's history that address menstrual product access and affordability, *The First Step Act of 2018* and *The CARES Act of 2020,* were signed by President Trump in his first term.

- Menopause policy: Since 2024, more than 60 bills to improve menopause care, education, and access to treatment have been introduced in 28 states. The Food and Drug Administration (FDA) recently removed an outdated, inaccurate labeling requirement on certain menopause hormone treatments; the agency is holding public panels this week, one on female-dosed testosterone and another to address the dearth of availability of estradiol patches.

The goal of my testimony is to set the stage for this Committee to: (1) become more aware of the challenges women in the United States experience throughout menopause ("Menopause 101"); (2) offer clarity on policies that would address women's midlife health and longevity, and in particular the role of Congress to meet the urgent need to fuel modern research, improve medical education, increase public information, and ensure access to quality care and evidence-based treatment ("Policy Opportunities"); and (3) demonstrate what we all stand to gain by committing to these reforms ("A Better Future").

(1) Menopause 101

I trust the expert medical witnesses will educate the Committee on the science of menopause. Below I provide some basic definitions that have guided my own legal and policy work:

- *Perimenopause* is the time leading up to menopause when key reproductive hormones, especially estrogen and progesterone, fluctuate and become increasingly erratic before ultimately declining; it typically begins in a women's mid-40s.
- *Menopause* refers to 12 consecutive months without a period, ushering in the end of hormone production by the ovaries. The average age of menopause for women in the United States is 51; Black and Hispanic women in the U.S. generally reach menopause earlier, on average at age 49.
- Associated *symptoms* can last anywhere from four to ten years and may include hot flashes, night sweats, brain fog, insomnia, and anxiety, as well as less commonly-recognized indicators like frozen shoulder, joint pain, heart palpitations, and about three dozen others. These may start in perimenopause, and can go on to have long-term impact on bone, brain, and heart health, as well as longevity.
- Around 1 percent of all women will experience *premature menopause* (before age 40) and 5 percent go through *early menopause* (before age 45). Induced *medical* or *surgical menopause* occurs when both ovaries are surgically removed or permanently damaged (often by cancer interventions like radiation and chemotherapy), and is marked by its sudden, immediate onset.
- Modern *pharmaceutical menopause treatments* can offer relief from certain symptoms. The primary form of systemic hormone therapy prescribed for menopause utilizes estradiol, a form of estrogen, plus progesterone (the latter for women who haven't undergone hysterectomy, and still have a uterus, to protect from endometrial cancer).
- Every professional menopause society, as well as leading endocrine and OB-GYN specialists and medical associations, is in alignment that systemic hormone therapy is the *most effective treatment* for hot flashes and night sweats, as well as for premature or early menopause; another primary usage is for the prevention of bone loss. Localized vaginal estrogen therapy is the *most effective treatment* for genitourinary symptoms of menopause (GSM), a position supported by the same experts as well as the American Urological Association. The FDA has approved all of the above uses.
- Patients for whom the *risks* of systemic hormone treatment are generally deemed to outweigh the benefits include women with a personal history of breast or estrogen dependent cancer, of heart attack or stroke, and/or blood clots in the legs or lungs, as well as women with undiagnosed vaginal bleeding or active liver disease. There are FDA-approved non-hormonal options for those who can't or don't want to use hormones.
- All told, menopause is a whole-body transition affecting women's *immediate and long-term* physical, cognitive, mental, and metabolic health. Too often, women navigate these changes without the support they need.

Who and how many. According to the National Institutes of Health (NIH) and leading affinity organizations like the Menopause Society, there are now a billion women around the globe who have reached or are already in menopause.

- In the United States, approximately 66 million women are age 50 and over – about 19% of the total national population – and entering or in menopause or are postmenopausal. (U.S. Census Bureau).
- About 1.3 million women enter menopause each year in the U.S. – roughly 6,000 per day. (StatPearls).
- With an average female life expectancy of 81, U.S. women spend more than one-third of their lives in perimenopause, menopause, and post-menopause. (Journal of Primary Care and Community Health).
- Black women in the U.S. experience more severe symptoms for a longer duration, yet are 26% less likely (and Hispanic women 32% less likely) to be prescribed hormone therapy. (Menopause).
- An estimated 27 million U.S. women, or about 20% of the workforce, are in the menopause transition. (Mayo Clinic).
- There are currently only around 4,000 clinicians across the entire U.S. who are certified Menopause Practitioners; menopause care deserts are common everywhere, though more concentrated in rural areas and across the South and Midwest. (Johns Hopkins Center for Global Women's Health).

The Women's Health Initiative (WHI). Commissioned by the NIH in 1991, the WHI to this day remains not only the largest and most expensive undertaking ever to investigate health outcomes for menopausal women, but also the largest randomized clinical trial in history to involve only women. (Women's Health Initiative).

- The WHI set out to study health outcomes for 160,000 postmenopausal women over the course of up to 15 years – in particular, whether the cardiovascular benefits of hormone therapy seen in observational studies were applicable to older women at substantial risk.

- In July 2002, one arm of the study (using conjugated equine estrogen plus progestin) was shut down suddenly by way of a National Press Club announcement that the treatment was tied to elevated risks of breast cancer, heart disease, and stroke.

- We now know that the announcement was both statistically insignificant and an overgeneralization (Climacteric). But the panic that ensued led a generation of doctors and patients to abandon any form of menopause hormone treatment. The proportion of eligible women prescribed them declined from about 27 percent in 1999 to two percent in 2023. (Mayo Clinic).

In 2026, among the persistent, ongoing systemic gaps in menopause information, care, and treatment that are directly and/or indirectly tied to the legacy of the WHI announcement:

- **Retrenchment in research:** Menopause is woefully under-studied, and receives around 1% of federal research funding (Nature Aging); less than 1% of published studies focus on menopause (Harvard Medical School). NIH allocated just $56 million to menopause studies (FY2023), $59 million (FY2024), and $78 million (FY2025) against a total NIH budget of roughly $48 billion (NIH Report). NIH funding for all aspects of women's health represented just 8.8% of total NIH spending from 2013–2023. (National Academies of Sciences).

- **Inadequate medical training:** Only 31.3% of U.S. residency programs offer a formal menopause curriculum. Nearly 80% of medical residents report they are "barely comfortable" discussing or treating menopause. (Menopause).
- **Lack of awareness:** Most women enter perimenopause without knowing what it is, what to expect, or that effective treatments exist. A quarter of women aged 50-65 say their doctor never informed them they were in perimenopause or menopause, despite the vast majority reporting symptoms. (Menopause). As a result, more than 80% of midlife women never seek medical care, and only about one in four receive any treatment. (Mayo Clinic).
- **Substandard insurance coverage:** Only one in four (26%) of women have full insurance coverage for menopause-related prescriptions, and nearly half (45%) have had a prescription denied. (GoodRx Research). Prior authorization and formulary restrictions can also inhibit access to FDA-approved hormone therapy.
- **Lack of Medicaid and Medicare mandates:** Neither program requires menopause coverage, though adult women are 37% of the overall Medicaid population and the majority of adults in the program (Kaiser Family Foundation); women make up more than half of all Medicare beneficiaries (more than 38 million in total) (Centers for Medicaid and Medicare Services).
- **Costly neglect:** Untreated menopause symptoms increase long-term health risks – including due to osteoporosis, cardiovascular disease, diabetes, and cognitive decline – driving avoidable costs for women, employers, Medicare, Medicaid, and taxpayers. Menopause symptoms cost the U.S. economy $1.8 billion annually in lost work time and $26.6 billion when healthcare costs are included. (Mayo Clinic Proceedings).
- **Rise in opportunities for misinformation:** Social media, online, and commercial marketing now dominate the conversation. Two-thirds (67%) of posts are deemed to be misleading, the vast majority (93%) have conflicts of interest (two-thirds of which go undisclosed). (BMJ Open).

Women's Testimonies. As much as statistics matter, so do real women's stories. Among the hundreds recounted to me in my advocacy work, these four are published in my book (pseudonyms are used):

- *Beth (Age 58)* – whose internist misdiagnosed vaginal dryness and pain to the tune that she found herself rushed to the ER with an excruciating urinary tract infection that kept her home for three weeks to recover – and the menopause specialist who cleared it up immediately with a vaginal estrogen prescription.

- *Ana (Age 48)* – whose general practitioner failed to connect the dots among her symptoms of heart palpitations, debilitating anxiety, and insomnia. Shuttled from specialist to specialist – and written prescription after prescription for everything under the sun, from antidepressants to sleep meds – only by sheer luck did she land at a university clinic that became an effective one-stop-shop for care.

- *Kim (Age 52)* – who went to an OB-GYN practice that would not even entertain her questions about hormone treatment for her frequent hot flashes and night sweats, despite that she had no contraindications – and the telemedicine practice she found thereafter whose staff probed her history accordingly and quickly let her know her options.

- *Kira (Age 46)* – who had zero interest in sex with her longtime partner and barely slept a wink for months, only to be dismissed at her annual check-up when she queried about the possible connection to perimenopause, chided that she was "clearly watching too many TikTok videos" and recommended to "just relax and have a glass of wine."

Dr. Rachel Rubin, Georgetown University Hospital Board-certified urologist and menopause expert, shared this at the FDA's July 2025 public panel on menopause hormone treatment warning labels:

- When her comatose, immunocompromised elderly mother was in immediate danger of going into urosepsis, the emergency medical team denied Dr. Rubin's request to prescribe vaginal estrogen, incorrectly claiming it would cause her mother to form blood clots. After Dr. Rubin eventually secured a prescription, the hospital pharmacist then refused to dispense it, citing the mere existence of its warning label (which, as noted above, the FDA has now removed). If this is how hard an expert had to fight to get an urgent prescription filled, with life and death consequences, that speaks volumes about what is at stake for everyday people.

I wrote about some of my own workplace experiences in my book:

- "Hindsight on my own working-through-menopause chapter is more telling than I necessarily appreciated at the time. I've since thought back to the times when my periods were so unbearably heavy that I had to max out on maxi pads – doubled up overnight-sized pads didn't even do the trick – and still could not sit at my desk for more than 30 minutes without having to dash out to change. The embarrassment of bleeding through my clothes and onto my chair (both happened more than once). The times I lost my temper, lost my train of thought, lost painstaking documents that I literally forgot to click save on. It never occurred to me that not only was this in the range of normal, but that it would have been infinitely more manageable if openness and information were the baseline. Not just a lifesaver for me, mind you, but an asset for my colleagues and all who relied on me."

Spouses are impacted by menopause too. Consider the experience of Octogenarian rock star Sir Rod Stewart, whose wife Penny Lancaster's symptoms went untreated and misdiagnosed as depression:

- Explaining that he "hadn't seen the menopause before, because my [previous] marriages didn't last that long" – his first wife was 39 when the couple divorced, his second wife left him when she was 29 – the experience led Stewart and Lancaster to become active campaigners for improved education and public policy. Stewart told *Forbes*: "I googled and googled and googled. I googled menopause so much when she was going through it. She was in a fragile situation. I just had to listen and learn and get ready for saucepans being thrown through the kitchen. It was frightening because this really wasn't the person I married. We talked about it, which I think is the most important thing a couple can do, and she explained to me – through the tears, as Penny likes a cry – and talked it through, and that's what couples do." (Forbes).

(2) Policy Opportunities

What these vignettes tell us is that, yes, menopause is an individual and collective health story. But it also is a marriage and family story. A career and economic story. An aging and longevity story. And most certainly a public policy story. While there is no singular reform that will respond to every scenario, or address every challenge facing every woman in midlife, there is a collection of proposals ***already on the table in Congress***, being discussed and ***acted upon in federal agencies***, and ***advancing in statehouses*** that are a meaningful start.

Policy priority #1: Invest in a modern research agenda

In the words of neuroscientist Dr. Lisa Mosconi, "Menopause remains one of the most under-diagnosed, under-researched, under-treated, and under-funded fields in medicine. We owe women centuries of research."

Certainly decades. Among the fallout of the 2002 WHI press conference, the announcement *chilled* public discourse about hormone therapy usage – and worse, *killed* commitments to future research about midlife women's health. Consider these examples:

- Dr. Philip Sarrel of Yale School of Medicine has estimated that in the decade after the WHI was halted, the decrease in usage of hormone therapy led between 18,000 and 90,000 women to lose their lives prematurely. (American Journal of Public Health)

- Even at the time of the WHI release, the data showed potential avoidance of osteoporosis and fewer bone fractures. Today, nearly one in five women age 50 and older (19.6%) has osteoporosis, half of whom will break a bone because of osteoporosis in her lifetime. (National Center for Health Statistics, U.S. Department of Health and Human Services (HHS)). The annual cost of osteoporotic fractures among U.S. women age 65 and older, including indirect costs, was estimated at $57 billion in 2018 and is projected to exceed $95 billion by 2040 if current trends continue. (Journal of Bone and Mineral Research).

- Women have half the risk of cardiovascular disease as men but only until menopause, at which time the risks equalize. After women reach 65, cardiovascular disease jumps to the number one cause of death. According to Dr. Howard Hodis of USC's Keck School of Medicine, unrecognized heart disease in women has deadly consequences: more women than men die of sudden cardiac arrests often with no previous history; even when diagnosed, women are still more likely to die within the first five years than their male counterparts. (Keck Medicine of USC). Yet we still lack definitive knowledge of whether cardiovascular disease is affected by hormone treatment, despite observational studies that suggest benefits.

- Women in the U.S. are two-thirds of all Alzheimer's cases, a phenomenon not simply explained by having a longer lifespan than men. Yet only 12 percent of NIH funding for Alzheimer's and related dementia research is focused on women. (Alzheimer's Association). Might estrogen support cognitive function in perimenopausal women? Many experts surmise it could, as have recent observational studies, but it is impossible to know since there has never been a randomized trial among that age group. [Quick note that a series of studies of Viagra show a linkage to lower risk of Alzheimer's. How is it

possible we do not dedicate even a fraction of our attention and research dollars to the effects of menopause and hormone treatment on this disease?]

The nation's scientific research engines have an affirmative obligation to reset the record and reboot the research.

On the reset. The WHI itself has since issued a slow trickle of piecemeal updates and more affirmative clarifying statements, though many are in academic articles that live behind paywalls and do not get much attention. What would be better? A full court press conference and long-term public education plan. Something as headline-grabbing and declarative as the National Press Club event in 2002. Cultivating more journalists and medical professionals willing to speak up and out – and, for our collective part, whether as Members of Congress and everyday citizens, standing by our doctors and colleagues when they do so – is also an important strategy.

On the reboot. It is high time for a redesigned comprehensive women's health initiative in this country – a next generation of federally-funded research and government commitments that leverage modern data collection and new ideas. Here are some of the broad questions I believe we must commit to answering:

- What, if any, are the preventive, pre-emptive, and/or proactive benefits of menopausal hormone therapy to chronic brain, bone, and heart health? Is there a certain window in which taking hormone treatments might maximize the benefit? To date, there have been no clinical trials that follow healthy women who start taking it in perimenopause, or who stay on it continuously from their 50s through their 60s.

- Do newer formulations or methods of delivery of hormone therapy lessen certain risks, for example, for women with a history of breast cancer? If so, to what extent are those risks lowered? What are other ways to best manage perimenopause and menopause for those living with or who have survived breast cancer?

- How can we ensure further study of racial disparities in the timing and severity of menopause symptoms? And how can this information be used to inform better, unbiased, and more thoughtfully calibrated care and treatment and decrease the related risks for long-term health issues?

- What cost benefit and fiscal analyses would help calculate the vast financial and societal impact of menopause – from billions of dollars associated with geriatric care issues, to the costs associated with medical education reforms, to the toll of lost wages and worker productivity on the global economy?

- Because time is of the essence – we have already lost 20-plus years and counting – how can researchers simultaneously combine and leverage current observational data that already exists from previously under-funded and smaller-scale studies? And how can they do this in a way that produces real-time recommendations that do not take decades to enact?

- Potential new study: The National Menopause Advocacy Working Group, led by the nonprofit organization Let's Talk Menopause and composed of leading physicians, researchers, and women's healthcare and menopause advocates, is poised to propose a

new, modern version of the Study of Women's Health Across the Nation. (SWAN). SWAN is the longest longitudinal, multi-racial/ethnic study of women going through menopause, launched in 1994 and co-sponsored by NIH's Office of Research on Women's Health, the National Institute on Aging, the National Institute of Nursing Research, and the National Center for Complementary and Alternative Medicine. SWAN researchers followed a deliberately diverse cohort of 3,000 women between the ages of 42 and 52 over 25 years as they transitioned through menopause: Chinese, Japanese, Latina, Black and white women hailing from Northern and Southern California, Michigan, and cities including Pittsburgh, Boston, Chicago, and Jersey City. Preliminary ideas for expansion for a SWAN 2.0 would include: new cohorts, including Millennials and Gen X women; more equitable racial, ethnic and socioeconomic representation; inclusion of Veterans and women in military service; expanded geographical representation; and more comprehensive symptom tracking using modern technology.

Among the current federal bills that aim to increase research: the *Advancing Menopause Care & Midlife Women's Health Act* (S. 4503/H.R. 9090) would authorize $275 million over five years to expand federal research, provider training, and public health education on menopause; the *Servicewomen & Veterans Menopause Research Act* (S. 1320/H.R. 2717) would direct the Departments of Defense and Veterans Affairs to address research gaps affecting servicewomen and veterans experiencing menopause; and the *Hormone Health Data and Research Act* (H.R. 9077) would direct NIH and HHS to study hormone variability and testing in perimenopausal women and report findings to Congress.

Policy priority #2: Improve education

There is overwhelming consensus that the medical establishment does not adequately educate the profession about menopause. For those who started residency after 2002 – statistically, that amounts to more than half of all practicing OB-GYNs in the U.S. today – the majority have not had meaningful or even any menopause training.

Dr. Mary Jane Minkin of Yale School of Medicine sums up the collateral damage of the WHI on medical education: "You have to teach a resident how to deliver a baby. You have to teach a resident how to do a hysterectomy. They figured if nobody was going to be prescribing estrogen, maybe they didn't have to teach residents about menopause, so menopause education went by the by. It was basically cut from curricula almost totally."

A series of surveys traces the demise:

- A decade after the 2002 press conference, researchers at Johns Hopkins University found that only one in five U.S. medical school OB-GYN residency programs had a formal menopause curriculum. Nearly two-thirds of residents in the study reported not feeling knowledgeable about the connection between menopause and cardiovascular disease; less than half said they felt well versed in osteoporosis treatment and prevention. (Menopause, 2013)

- Those findings were nearly identical by 2019. The Mayo Clinic reported 20.3 percent of residents surveyed never had a single formal lecture about menopause while in medical school; 58 percent had received only one lecture on menopause in their training; and a

mere 6.8 percent said they felt adequately prepared to treat menopausal patients. (Healio 2023; Mayo, 2017).

- More recently, a 2022 survey of OB-GYN residency program directors showed minimal progress. While most (92.9 percent) strongly agreed that residents should participate in a standardized menopause curriculum, less than a third (31.3 percent) reported such training in their own program. Of those who did experience a dedicated curriculum, it amounted to less than five lectures and/or assigned readings on the topic. (Menopause, 2023).

All specialties – not only OB-GYNs and internists, but also cardiologists, endocrinologists, neurologists, oncologists, orthopedists, and urologists, among others – need to be aware that hormonal changes affect every major organ system in the body. Otherwise symptoms are missed, misattributed, or treated in isolation. On average, women spend seven years seeking a diagnosis. (Mayo Clinic Proceedings, 2023).

Intervention requires a combination of public, private, and non-profit players – including medical associations responsible for updating and upgrading standards for accreditation and developing the resources used for instruction and clinical experience.[1]

- Among the levers specifically available to Congress:
    - Graduate Medical Education (GME) funding, primarily supported by Medicare, as well as the Departments of Defense and Veterans Affairs (Congress.gov). GME could link federal funding and accreditation standards to menopause education requirements.
    - A federal bill, the *Menopause Education for Medical Students Act* (H.R. 9273), would require public medical schools receiving federal grants to include menopause training in their curricula.
- State legislatures have aimed to fill the gap by encouraging and incentivizing state medical boards to include coursework in menopause for continuing professional education requirements; laws have been passed in California, Maryland, and New Jersey.
- Private sector support, including a recent multimillion contribution from philanthropist Melinda French Gates, is going in part to the Menopause Society, to be used to expand its existing curricula and competency examination, the primary source for menopause certification for practicing clinicians.

Policy priority #3: Ensure affordable, accessible care and treatments

A 2025 study found that only 26% of women have health insurance that covers FDA-approved menopause treatments and that one in five delayed or passed it up due to financial concerns.

[1] The Liaison Committee on Medical Education (LCME), sponsored in part by the American Medical Association, serves as an accrediting body for medical schools, a role recognized by the Department of Education. Residency and fellowship programs, in which medical students get hands-on clinical training, are overseen by a national nonprofit organization called the Accreditation Council for Graduate Medical Education (ACGME), which sets and monitors standards.

(GoodRx Research, 2025). As menopause medication prices have risen – as much as 58% over the last decade (GoodRx Research, 2025) – a monthly supply of systemic hormone therapy now runs roughly $100 to $250 (the cost can go down to under $100 after insurance co-pays are applied). Non-hormonal treatments for hot flashes are even more expensive (up to $700 per month) and not covered by insurance. The current crisis in estradiol patch availability implicates affordability too, as women face increased co-pays, lack of guaranteed coverage for available alternatives, and potential price gouging.

Even getting menopause prescriptions filled in the first place can be frustrating and expensive. Treatments are still routinely denied due to doctors' lack of training and costs mount even further for patients who need to go to a second (or third or fourth) clinician, or even to an emergency room, to correct misdiagnoses.

As noted above, neither Medicaid nor Medicare mandate menopause coverage to the detriment of patient care and public cost. Urosepsis in women over 65 is a major driver of Medicare spending: a recent study of more than one million Medicare patients found that less than one in ten (9%) of women with recurring urinary tract infections were prescribed vaginal estrogen; researchers estimate that doing so would not only save lives but save Medicare billions of dollars each year. (Journal of the American Medical Association, Urology Practice).

- Among potential federal interventions available to Congress:
    - Urge that the U.S. Preventive Services Task Force classify menopause doctor appointments as a preventive service, automatically triggering zero-cost-sharing coverage across most private plans and Medicaid.
    - Similarly urge the FDA to consider a best practices plan for making vaginal estrogen available over-the-counter (while ensuring it stays affordable and readily available).
    - Direct the Centers for Medicare & Medicaid Services (CMS) to evaluate and adjust reimbursement models to better reflect the time and complexity of menopause care. CMS should also establish minimum coverage standards for FDA-approved treatments and eliminate restrictions that reflect outdated post-WHI assumptions about hormone therapy that the FDA has now formally corrected.
    - Fifteen years ago, Rep. Barbara Lee from California, introduced the *Menopausal Hormone Replacement Therapies and Alternative Treatments and Fairness Act of 2011*, which would have mandated coverage under Medicare and Medicaid, as well as other federal health insurance programs and private group health plans and individual health insurance coverage. The bill never got real-time attention; its resurrection is now timely.
- To date, state legislatures in Illinois, Louisiana, Maryland, New Jersey, Oregon, Utah, and Washington have enacted laws to mandate insurance coverage for all or some of the plans delivered in their respective state, including Medicaid; California passed legislation vetoed by Governor Newsom (though a limited provision was subsequently included in the state budget).

Summary of bills introduced in the 119th Session of Congress

- *Advancing Menopause Care & Midlife Women's Health Act* (S. 4503/H.R. 9090) Would authorize $275 million over five years to expand federal research, provider training, and public health education on menopause.

- *Menopause Education for Medical Students Act* (9273) Would require public institutions of higher education that receive grants under the Medical Student Education program to include training for medical students relating to menopause in their curriculums.

- *Servicewomen & Veterans Menopause Research Act* (S. 1320/H.R. 2717) Would direct the Departments of Defense and Veterans Affairs to address research gaps affecting servicewomen and veterans experiencing menopause.

- *Improving Menopause Care for Veterans Act* (H.R. 219) Would require the Government Accountability Office to study how the VA provides menopause care and create a strategic plan to fix any gaps in care, improve provider training, and boost patient access.

- *Menopausal Workers' Fairness Act* (H.R. 9671) Would expand access for workers experiencing symptoms related to menopause to reasonable accommodations.

- *Hormone Health Data and Research Act* (H.R. 9077) Would direct NIH and HHS to study hormone variability and testing in perimenopausal women and report findings to Congress.

Summary of recent regulatory action

On November 10, 2025, the FDA announced it would eliminate the 2003 requirement for a "boxed label" on menopausal estrogen products – a reform more than a decade in the making.

The stringent "black box" warning, applied to products that cause serious life-or-death reactions, had been initiated shortly after the 2002 WHI announcement. The FDA required the label placement and wording indicate increased risk of strokes, blood clots, cancer, and probable dementia. Experts overwhelmingly agreed then – and still do – that for local vaginal estrogen, in particular, those risks were not supported by data either from the WHI or observational studies that since followed. (Menopause, 2018).

Yet for two decades, countless women read the warning and promptly tossed the prescription in the trash. Doctors and pharmacists not fluent in menopause care often refused to prescribe or dispense it at all (as per Dr. Rachel Rubin's story above).

A group of physicians challenged the label requirement in 2014 – a claim the FDA rejected in 2018. By 2024 a modern citizen's petition was launched by Let's Talk Menopause, garnering more than 26,000 signatures and re-elevating the demand.

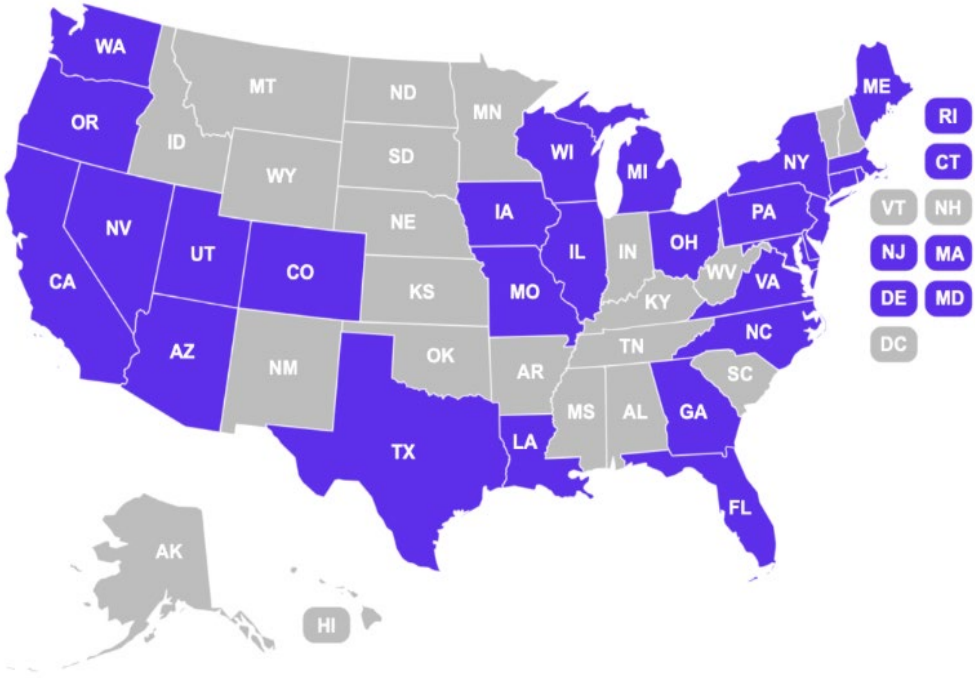
After the November announcement, replacement labelling was approved in February 2026. (FDA). The immediate next round of work entails helping the public and clinicians understand what the labeling status change does (and doesn't) mean, and ensuring accurate, nuanced engagement takes its place. Congress can help by directing HHS and the Office of Women's

Health to launch public education partnerships with medical associations to provide plain-language explainers.

Summary of state action

State legislatures have taken the lead in advancing jurisdictionally appropriate policies – primarily improving educational opportunities and mandating insurance and Medicaid coverage, as well as expanding workplace antidiscrimination protection to include menopause. Some have also declared a statewide "Menopause Awareness Day."

Reflected on the map and grid below, more than half of all states, 28 of 50, have introduced at least one piece of menopause-related legislation, with 28 bills introduced in 2026 alone.



A total of 21 laws have now been enacted across ten states:

- States with legislative insurance mandates (full or partial) include Illinois, Louisiana, Maryland, New Jersey, Oregon, Utah, Virginia, and Washington. (California, by budget.)
- Professional education opportunities for clinicians now exist by law in California, Illinois, Maryland, and New Jersey.
- Illinois, Maine, and Maryland committed to improving public resources via their respective state health departments.

- Expanded workplace accommodations and antidiscrimination protection is now the law in Illinois, Maryland, and Rhode Island, as well as the City of Philadelphia, which passed an ordinance that goes into effect in January 2027. Washington issued an executive order to examine workplace policies.

Members of Congress can follow progress in their state, examine what types of legislation are working well and why, and consider how to effectively scale nationwide.

Bills introduced 2024-2026 (*new in 2026)
Chart provided by The 'Pause Life

INSURANCE COVERAGE FOR MENOPAUSE TREATMENTS				
	Introduced or In Committee	**Partially Passed**	**Did Not Pass**	**Passed Into Law**
Colorado HB 26-1122*			Died in committee	
Delaware SB319*		X		
Georgia HB988*			Died in committee	
Illinois HB 5295				**July 2024/ Amended 2025**
Illinois SB 773				**August 2024**
Iowa SF 85*			Died in committee	
Louisiana HB392				**June 2024**
Maryland HB 1435*			Died in committee	
Massachusetts 4838	X			
Michigan HB 4814/SB0717	X			
Michigan HB 4815 /SB0718	X			
Missouri SB 1569*			Died in committee	

New Jersey AB 5278/S4148				**January 2026**
New York AB 5444/S9230	X			
Ohio HB 767*	X			
Oregon HB 3064				**August 2025**
Pennsylvania HB 1345	X			
Pennsylvania HB 1346	X			
Pennsylvania HB 1346/SB1122	X			
Pennsylvania HB 2545	X			
Pennsylvania HB 1827	X			
Texas HB 3814			Died in committee	
Utah HCR010*				**March 2026**
Virginia SB 790*				**April 2026**
Washington HB1971				**July 2025**

MENOPAUSE EDUCATION FOR PATIENTS AND CLINICIANS				
	Introduced or In Committee	**Partially Passed**	**Did Not Pass**	**Passed Into Law**
Arizona HB 2734*			Died in committee	
California AB 2270				**September 2024**
Connecticut AB 6593			Died in committee	
Connecticut HB05389*			Died in Committee	

Florida SL 190/HB 161			Died in Committee	
Illinois SB3325*				**August 2026**
Illinois SB 3688*				**August 2026**
Maine LD 1079				**July 2025**
Michigan H4791		X		
Michigan HB 4790		X		
Michigan SB 0765*	X			
New Jersey A5309				**December 2025**
New Jersey S2827*	X			
New York A9000		X		
New York A9170	X			
New York HB9304/S8543		X		
New York S1720			Vetoed by Governor	
New York S8894/A10045*		X		
Pennsylvania HB 1411/S 1118	X			
Pennsylvania HR 292	X			
Texas HB 3961			Died in committee	
Wisconsin SB 356/AB 381			Died in Committee	

AWARENESS EVENTS FOR PERIMENOPAUSE AND MENOPAUSE				
	Introduced or In Committee	**Partially Passed**	**Did Not Pass**	**Passed into Law**
Illinois SJR0025				**May 2025**
Nevada SB 297			Vetoed by Governor	
Pennsylvania HR262				**October 2025**
WORKPLACE PROTECTIONS				
	Introduced or In Committee	**Partially Passed**	**Did Not Pass**	**Passed into Law**
Connecticut SB 353*			X	
California HB 1940*		X		
Maryland HB536*		X		
New Jersey AB 3334/SB 4197			Died in Committee	
New Jersey A4487*	X			
New York S 9247/AB 10296*	X			
New York AB 5436	X			
New York AB 01940/SB 3908			X	
New York A10270/S09244*	X			
Pennsylvania HB 2135*	X			

Pennsylvania HR 287	X			
City of Philadelphia 250849				**December 2025**
Rhode Island S 0361				**June 2025**
Virginia HB 1173*/SB 258*			Vetoed by Governor	
OMNIBUS BILLS (COMBINATION OF ABOVE TOPICS)				
	Introduced or In Committee	**Partially Passed**	**Did Not Pass**	**Passed**
Arizona HB2929			Died in Committee	
California AB 432			Vetoed by Governor	
Illinois HB 5284*				**August 2026**
Louisiana HB944*				**June 2026**
Maryland SB892/HB1121*				**May 2026**
Maryland HB 1365*				**May 2026**
Massachusetts H 5303	X			
Massachusetts 4838	X			
New York S7495/AB 8572	X			
North Carolina S522	X			
Pennsylvania Memo				
Washington SR 8657				**April 2025**

(3) A Better Future

Over the decade I have spent advocating around these issues, I have experienced a real-time transformation of my own – and I do not mean just to the other side of menopause! I began with what I presumed was a simple inquiry: what would it take to make menopause a public policy

priority? I suspected that stigma was the main barrier to progress and that the reforms might follow would look like a version of the menstruation policies I helped to envision and advance a decade prior.

Little did I know.

I quickly came to understand that forces that marginalize menopause go well beyond shame and silence and fully implicate science and policy.

I found a cadre of brilliant experts making extraordinary contributions – in medicine, in research, in organizing, in storytelling, in innovation, in media, in public and political leadership – who are driving forward a collaborative, effective, and now fully bipartisan movement.

I saw that the desire to talk about menopause was suddenly everywhere – in living rooms, on Instagram, in news headlines, on best-seller lists, the topic of celebrity fodder, on Capitol Hill – all of which can play a big role in moving the needle.

I met so many people eager not only to solve for their own health issues, but hungry to learn how to mobilize for systemic change so they could fight for their daughters and granddaughters.

Participating in this Committee hearing is now part of my own contribution to expanding what is possible at this moment and helping advocate for a better future. Thank you for your leadership.