BerryDunn

# Maryland Health Care Commission

## Maryland Medical Assistance Program and Health Insurance – Required Coverage for Menopause-Related Treatment, Care, and Training of Clinicians

MARYLAND Health Care Commission

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# Highlights

The Maryland General Assembly, via letter on July 17, 2025, requested the Maryland Health Care Commission (MHCC) to study the cost of requiring health insurers, nonprofit health insurance plans, and health maintenance organizations to cover the cost of menopause-related treatment and care and menopause-specific training for clinicians.[1] This study is not associated with legislation. MHCC tasked BerryDunn with evaluating:

1. Requiring comprehensive insurance coverage for menopause-related treatment and care
2. The market impact of requiring clinicians to receive menopause-specific training

### Social Evaluation

- Menopause is the biological transition marking the end of menstruation and reproductive capacity for individuals with ovaries. It also represents a key stage in the aging process.
- Women spend nearly one third of their lives in postmenopause, linking early-life and midlife exposures, nutrition, stress, socioeconomic status (SES), and access to care with later life health outcomes.
- Most women experience at least one menopause-related symptom. Vasomotor symptoms (VMS) are the most common menopause-related symptoms and can persist into postmenopause.
- Untreated menopause symptoms contribute to chronic disease risk (e.g., cardiovascular disease, osteoporosis) and workforce disruptions.
- Black and Hispanic women experience earlier and more severe symptoms of menopause yet are less likely to receive systemic hormone therapy (HT), reflecting systemic inequities in access, education, coverage, and outcomes.
- Several states have enacted menopause legislation addressing insurance coverage, provider training, and awareness, signaling a growing national focus on menopause care.

### Medical Evaluation

- HT remains the most effective treatment for eligible individuals, reducing VMS and other symptoms; however, nationally, usage has declined over the last 20 years.
- Nonhormonal, behavioral, and lifestyle options are available, but usage varies depending on symptoms and/or insurance coverage.
- Provider knowledge and menopause training vary widely and there is no standardized medical school training requirement.

### Financial Evaluation

Unlike mandate benefit reviews, this study was not guided by legislative language. In the absence of a proposed mandate, precise cost estimates cannot be established. Accordingly, this analysis concentrated on potential cost implications related to the inclusion of acupuncture services, changes in cost sharing, removal of utilization management (UM), and provider training in the current environment. It is important to note the considerable uncertainty due to the introduction of new FDA-approved nonhormonal drugs Veozah (2023)[2] and Lynkuet (2025)[3] as well as the recent removal of boxed warnings for HT. [4]

# 1.0 Executive Summary

## 1.1 Background

Menopause Overview

Menopause marks a key biological and social transition affecting all individuals with ovaries,[i] shaping long-term health, quality of life, and well-being.[5,6] Medically, menopause reflects the gradual decline in ovarian hormone production and the end of menstruation. During perimenopause, the menopausal transition, the ovaries decrease production of estrogen and progesterone. Perimenopause typically occurs between ages 45 and 55.[7] This transition can last several years,[ii,8] and symptoms often persist well into postmenopause.[9]

Menopause can also occur prematurely, either spontaneously or because of surgery (e.g., hysterectomy) or medical treatments such as chemotherapy.[9] Genetics[7] and early-life and midlife factors such as nutrition, chronic stress, SES, and access to preventive healthcare can shape the timing, severity, and health impacts of the menopausal transition.[7,10,11]

Study Background and Scope

This study originated from a request by Chair Peña-Melnyk of the Maryland General Assembly to evaluate the potential market impact of two related policy concepts currently under consideration:

1. Mandating comprehensive insurance coverage for menopause-related treatment and care
2. Requiring menopause-specific training for clinicians

At the time of writing this report, no legislation has been introduced. The study was conducted to assess possible implications for coverage, utilization, provider capacity, and cost, to inform potential future legislation. The study included individuals ages 45 – 55 experiencing menopause symptoms that could be treated with prescription hormonal treatments, nonhormonal treatments, and/or acupuncture. BerryDunn considered "menopause-related" to reflect treatments pertaining to menopause symptoms rather than menopause-related conditions (e.g., osteoporosis, cardiovascular disease).

Note on language: The medical and social evaluations of this report refer to individuals experiencing perimenopause or menopause based on physiological characteristics rather than gender to promote both inclusivity and medical accuracy. For example, treatment approaches may vary depending on whether an individual has a uterus or has undergone hysterectomy. Accordingly, the report uses terms such as "people with ovaries," "people with a uterus," "women," and/or "female" as appropriate, to reflect current medical literature and inclusive policy language. Terminology pertaining to menopause, its presentation, symptoms, and treatments can be found in Appendix A.

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[i] This analysis does not include specific treatment considerations or needs for individuals who had their ovaries removed (surgical menopause) or individuals who experience early menopause (before age 45), including primary ovarian insufficiency (POI).

[ii] The Seattle Midlife Women's Health study found that women began perimenopause ages 43 – 49.8 (average age 46.4), experienced perimenopause (beginning of irregular periods) for 1.3 – 4.3 years (average 2.8), and entered into menopause ages 49.2 – 55 (average 52.1).

## 1.2 Social Evaluation

Each year, approximately two million people in the United States enter perimenopause[12] and more than one million reach menopause.[9] About 80% of menopausal individuals report experiencing symptoms that range in duration, severity, and impact.[9] Most women who seek care for menopausal symptoms report multiple concerns, with an average of over four symptoms.[13] Common symptoms include VMS genitourinary changes (e.g., vaginal dryness, urinary symptoms), pelvic floor relaxation, cardiac and metabolic changes, migraines, and mental health effects such as mood changes, anxiety, depression, and cognitive difficulties also referred to as "brain fog."[14] Many postmenopausal women also experience bone density loss or osteoporosis, increasing risk for fractures and related complications.[15,16] As life expectancy increases, a growing proportion of the population spend nearly a third of their lives in postmenopause,[17] increasing the prevalence of chronic conditions such as cardiovascular disease, osteoporosis, depression, and sleep disorders that intersect with menopausal changes.[18]

While HT remains the most effective treatment for VMS and genitourinary syndrome of menopause (GSM),[19] its use has declined sharply in recent decades.[20] Underutilization of treatment across hormonal, nonhormonal, and behavioral therapies stems from concerns about safety, lack of provider training, inconsistent insurance coverage, and limited patient awareness.[21] Newer options, such as the Food and Drug Administration (FDA)-approved nonhormonal medications for VMS, fezolinetant (Veozah) and elinzanetant (Lynkuet), expand treatment choice but remain underused.[22,23]

Socially, menopause occurs within the broader context of lifelong structural determinants of health, shaped by the combined effects of social and systemic factors. Racial and ethnic disparities persist: Black and Hispanic women experience earlier onset, more severe symptoms, and lower treatment utilization compared to white women, reflecting cumulative inequities in access to care, socioeconomic stress, and chronic disease burden.[9,24] LGBTQ+ individuals face additional barriers due to limited research, lack of provider familiarity, and stigma within healthcare settings.[25] These disparities contribute to inequitable health outcomes and reinforce gendered economic impacts, including workforce participation losses linked to unmanaged menopausal symptoms.[26]

The Affordable Care Act (ACA) requires coverage of many preventive services but does not require coverage for treating menopause symptoms.[27] Insurers responding to the MHCC and BerryDunn survey reported that menopause-related care coverage depends on the type of service, medical necessity, and prior authorization requirements rather than being menopause-specific. Preventive services were generally covered, while certain services, such as bone density scans or medications for bone loss, might be subject to prior authorization. Self-insured employer plans usually cover medically necessary services under broader categories. Insurers did not anticipate that a mandated coverage requirement would substantially impact utilization, costs, or provider capacity, though effects could vary depending on specific legislative provisions.

## 1.3 Medical Evaluation

In November 2025, the FDA removed boxed warnings for HT.[4] Providers and professional societies recognize HT as the most effective treatment option for menopause symptoms.[28,29,30,31] Individuals with histories of certain estrogen-dependent cancers, high blood pressure, or other contraindications might be unable to safely use HT.[32] For individuals who cannot or choose not to use HT, other nonhormonal treatments are available to treat menopause symptoms. These options include local HT for GSM and

selective serotonin reuptake inhibitors (SSRIs), selective norepinephrine inhibitors (SNRIs), Veozah, Lynkuet, gabapentin, or oxybutynin for VMS. Many menopausal individuals use alternative treatments such as cognitive behavioral therapy (CBT), lifestyle changes, acupuncture, and herbs in conjunction with or in place of pharmaceutical interventions.

Despite broad medical consensus and emerging policy momentum, gaps remain in provider education, clinical capacity, and access to treatments for menopause.[33,34] According to a 2019 study, less than 10% of providers feel prepared to effectively treat menopause symptoms.[33] Expanding provider training, insurance coverage, and culturally competent care could reduce treatment inequities and support healthier aging for individuals experiencing menopause.[35]

## 1.4 Financial and Cost Evaluation

This analysis uses the Maryland Claims Database (MCDB), Maryland's All Payer Claims Database (APCD). The MCDB includes enrollment, provider, and claims data for Maryland residents across private insurance (excluding self-insured plans governed by the Employee Retirement Income Security Act of 1974 [ERISA] since 2015), Medicaid fee-for-service (FFS), and Medicaid managed care organizations (MCOs).[36] Data from the MCDB was supplemented by:

- Insurer responses to the survey administered by MHCC in conjunction with BerryDunn
- Input from medical experts, including OB/GYNs
- Data points from reviewed published literature to contextualize and support the analysis
- Maryland State Employee Health Plan information
- Maryland Medicaid financial monitoring reports

Unlike mandate benefit reviews, this study was not guided by legislative language. In the absence of a proposed mandate, precise cost estimates cannot be established. Accordingly, this analysis concentrated on potential cost implications related to the inclusion of acupuncture services, changes in cost sharing, removal of UM, and provider training in the current environment. It is important to note the considerable uncertainty due to the introduction of new FDA-approved nonhormonal drugs Veozah (2023)[2] and Lynkuet (2025)[3] as well as the recent removal of boxed warnings for HT.[4]

# 2.0 Social Evaluation

## 2.1 Prevalence

Maryland Perimenopause and Menopause Prevalence

In 2025, the Prince George's County Health Department estimated that 390,898 women, or 12.3% of Maryland's female population, were between ages 45 and 54.[37] Because this age group typically encompasses when an individual begins perimenopause, this data suggests that a meaningful share of Maryland women might be experiencing menopause or related symptoms. Using national estimates that up to 80% of women experience menopause-related symptoms, approximately 310,000 Maryland women are potentially affected.[9]

VMS Prevalence

VMS are the most commonly reported menopause-related symptoms with an estimated 75% – 80% of menopausal women reporting experiencing VMS.[13] Individuals typically experience these symptoms for one to six years, but 10% – 15% of women experience symptoms for up to 15 years.[9] VMS is also a risk factor for cardiovascular disease and hypertension.[38]

Prevalence of Other Common Menopause-Related Symptoms and Conditions

*GSM*

In addition to VMS, individuals experience other common perimenopause and menopause-related symptoms. Between 27% and 84% of women experience GSM, though this condition is likely underreported.[39] GSM, caused by decreased estrogen levels, is characterized by vaginal dryness, increased urinary tract infections (UTIs), weak pelvic floor, and decreased elasticity of the vagina. These symptoms can lead to general discomfort as well as discomfort during sex,[9] especially among Chinese, Japanese, and Black women.[40] GSM, as well as perimenopause broadly, affects up to 75% of individuals' sexual desire and function.[40,41]

*Sleep Disruptions*

Individuals experiencing perimenopause report greater difficulties falling and staying asleep compared to individuals who have not yet begun perimenopause.[9] A 2017 study found that women between the ages of 40 and 59 who were peri- and postmenopausal reported experiencing greater difficulties with sleep compared to premenopausal women.[iii,42] Hot flashes are correlated with difficulties falling asleep, staying asleep through the night, and waking up earlier than intended.[8] Perimenopausal individuals can also experience sleep disruptions without hot flashes.[9]

*Migraines and Cognitive Changes*

Researchers estimate between 16% and 29% of perimenopausal women experience migraines. Additionally, 8% – 13% of women report experiencing migraines for the first time during perimenopause.[38] Migraines can increase the risk of hypertension and cardiovascular disease.[38] More

[iii] Of perimenopausal women, 56% reported sleeping less than seven hours, compared to 40.5% of postmenopausal and 32.5% of premenopausal women.

severe VMS are also correlated with migraines.[38] Nearly 70% of women experience mood changes, anxiety and/or depression, changes in memory and concentration, and lower confidence as a result of perimenopause.[9]

Growing evidence shows that a molecule called calcitonin gene-related peptide (CGRP) plays an important role in both hot flashes and hormonally related migraines. CGRP widens blood vessels and affects body temperature regulation. These effects become stronger when estrogen levels drop. Studies have found that postmenopausal women with hot flashes have higher levels of CGRP, and low estrogen might make the body more sensitive to CGRP's effects.[43]

CGRP also contributes to menstrual and perimenopausal migraines. Women with episodic migraine have higher CGRP levels during menstruation, when estrogen is lowest, compared with women who do not have migraines. CGRP levels are more stable and lower in women who take hormonal contraception or who are postmenopausal, suggesting that stable estrogen levels reduce CGRP activity.[44]

## 2.2 Coverage of Services

Federally Required Preventive Services

The ACA requires non-legacy plans to cover services recommended by the United States Preventive Services Task Force (USPSTF) as well as additional preventive services recommended by the Health Resources and Services Administration (HRSA) without cost sharing.[45] Applicable services relevant to this study include anxiety screening, cervical cancer screening, mammography screening for breast cancer starting at age 40, obesity prevention counseling, contraception, well-woman preventive visits, and screening for urinary incontinence.[46] Applicable USPSTF recommendations include: screening for anxiety disorders, biennial mammograms, cervical cancer screening, sexually transmitted infection screening, colorectal cancer screenings, behavioral counseling interventions for individuals with risk of cardiovascular disease, hypertension screening, and behavioral interventions for individuals with obesity.[iv,47,48]

Coverage in Maryland

In response to the survey administered by MHCC in conjunction with BerryDunn, Maryland insurers reported that menopause-related care is not governed by a dedicated coverage policy. Coverage varies by service, drug, and medical necessity criteria, and one insurer has no utilization controls. Most standard treatments are covered, with some drugs such as vaginal antibiotics, vaginal estrogens, ospemifene, and Veozah subject to prior authorization or quantity limits. Two insurers cover HT without restrictions, and one covers CBT and clinical hypnosis as part of general behavioral health benefits.

Insurers noted that self-insured employer plans typically cover menopause-related services within broader benefit categories, with significant variation across plans. Common covered services include bone density screenings, HT, and treatment for related symptoms, though many plans do not track menopause-specific claims.

[iv] The USPSTF also recommends bone density screening for postmenopausal women under age 65 with at least one risk factor for osteoporosis. This recommendation was not included in the main list based on direction from the Chair.

Insurers indicated that they do not anticipate an increase in utilization of menopause-related services if coverage were to be required. Most insurers indicated that mainline menopause treatments are already covered because they are deemed medically necessary. However, none of the insurers reported tracking claims or utilization for menopause or menopause-related treatment. Accordingly, they also did not expect any significant change in costs or any challenges related to provider capacity to deliver the services should they be required in a proposed bill. Insurers noted that their estimates could change with more detailed information about specific coverage requirements; however, based on current survey responses, insurers expect no material impact on utilization, provider capacity, or overall cost.

## 2.3 Current Treatment Utilization

While insurers anticipate minimal impact on utilization or costs under a potential coverage requirement, these expectations contrast with evidence indicating significant gaps in care. Menopause remains broadly undertreated, suggesting gaps in both awareness and access to care.[22] These findings suggest that while pharmacologic and nonpharmacologic therapies are commonly discussed, evidence-based medical treatments remain underutilized.[13] HT usage has declined from 26.9% of menopausal women in 1999 to 4.7% in 2020.[20] In a 2023 survey, individuals cited not using HT due to fear of breast cancer, heart attack/stroke, not having "severe enough symptoms," and cost.[21] Vaginal estrogen therapy, a first-line treatment for GSM, is also underused; despite high prevalence, about half of women do not utilize any treatment for GSM.[39]

A 2022 retrospective electronic health record (EHR) study found that among predominantly white and privately insured women, 60.1% used a prescription medication (e.g., HT, SSRIs/SNRIs, or gabapentin) to manage VMS.[13] About 21.1% of women in the study used SSRIs/SNRIs.[13] A 2025 study found that among individuals treated for symptomatic menopause or VMS, 29.7% (n = 32,618 of 109,931) used SSRIs or SNRIs.[49] Estimates for alternative and nonprescription treatments vary widely due to underreporting of utilization to providers and/or use at different times throughout perimenopause and menopause.[50] The 2022 EHR study reports that 62.4% of women used nonprescription treatments, including a variety of herbal supplements and vitamins (54.7%), CBT (4.9%), exercise (41.6%), acupuncture (6%), or hypnosis (0.3%).[50] A 2019 review reported across studies that an estimated 10% – 30%[51] of menopausal individuals use alternative treatments such as herbal supplements, vitamins, yoga, mindfulness, and acupuncture to treat perimenopause or menopause symptoms.[52] A 2023 study using Study of Women's Health Across the Nation (SWAN) data found that 0.5% of women utilized acupuncture to treat menopausal symptoms.[v,50]

Gaps in Care

A 2021 study using Patient-Reported Outcomes Measurement Information System (PROMIS) Sleep-Related Impairment and Sleep Disturbance measures in women with moderate to severe VMS aged 40 – 64 found that 75% identified sleep disturbance as their most bothersome symptom, and many described significant effects on work, relationships, and daily functioning. Despite this burden, a substantial share of women did not use HT, the most effective treatment for hot flashes, due to medical contraindications or personal preference. These findings underscore persistent gaps in access to

[v] Within the study, utilization varied by race. Japanese women reported the highest acupuncture use (0.8%), followed by white (0.7%), Chinese (0.5%), Black (0.3%), and Hispanic women (0.0%).

effective, acceptable menopause care and the need for validated, inclusive tools to better assess outcomes and support nonhormonal treatment options.[53]

Survey findings highlight persistent gaps in treatment satisfaction and access among women managing VMS due to menopause. Although most participants reported using hormonal, nonhormonal, or over-the-counter therapies, many remained dissatisfied, most often citing limited effectiveness and side effects, while physicians primarily emphasized long-term safety concerns. More than 75% of respondents expressed a willingness to try new nonhormonal options, underscoring significant unmet needs despite available treatments.[54]

## 2.4 Access and Disparities

Factors Influencing Menopause Timing and Severity

The timing of menopause and related symptom presentation varies greatly; experiences are influenced by genetics, racial and ethnic identity, SES,[24] lifestyle factors (e.g., smoking),[55] and disparities in healthcare access.[56] Stress, lower SES,[57] and discrimination are correlated with earlier menopause, increased VMS,[58] and other menopause symptoms.[24] Compared to white women, Black and Hispanic women are more likely to experience menopause at an earlier age.[9] Menopause before age 45 can increase the risk of osteoporosis, cardiovascular disease (including strokes), other chronic conditions, and early death.[57] Black women experience more severe and prolonged VMS than other racial groups,[vi,9] and such symptom severity is correlated with decreased quality of life and cognitive functioning.[57]

Disparities in Menopause Experiences and Care

Perimenopause and menopause are associated with an increased risk for weight gain, which can increase cardiometabolic risk, including developing cardiovascular disease and type 2 diabetes. Prior to perimenopause, Black women tend to have higher weight and abdominal fat compared to white women; in perimenopause, white women tend to gain more weight and abdominal fat. These differences impact different menopause hormones (estradiol and FSH), resulting in a delayed onset (but potentially increased risk) of developing cardiovascular disease among Black women. These findings suggest that treatments and associated risks might need to be monitored differently across the stages of perimenopause and menopause and tailored to the needs of different population groups.[59]

Treatments prescribed for menopause symptoms vary across races.[58] Data collected during the SWAN demonstrated that white women use HT at higher rates compared to Black women,[58] and some studies estimate that white women are twice as likely to use HT.[50] Two studies (2022 and 2024) found that non-white, especially Black and Hispanic/Latina women, were less likely to be prescribed HT even if they did not have contraindications and reported symptoms.[60,61] Non-white women use alternative medicine at higher rates without HT due to individual attitudes about the treatment and/or varying access to HT.[50]

Evidence on Indigenous women's experiences of menopause reveals persistent inequities in access to care and knowledge. Across studies, Indigenous women reported more severe vasomotor and metabolic symptoms, yet few had access to culturally appropriate information or menopause

[vi] An estimated 80% of Black women report experiencing VMS for a median of 10.1 years, compared to 65% of white women who report experiencing VMS for a median of 6.5 years.

management. Barriers included limited healthcare availability in rural and tribal areas, lack of culturally grounded education, and ongoing mistrust of medical systems.[62]

Research on menopause in nonbinary and transgender individuals is limited, especially in the United States. Perimenopause and menopause presentation varies among LGBTQ+ individuals compared to cisgender women.[25] Additional research is needed to better understand the menopause-related needs of this population, especially given use of medications and therapies (e.g., gender-affirming hormone therapy/surgery), discrimination, and increased risks for chronic conditions in this population.[26]

Workforce Impact

Recent evidence also highlights the broader economic and workforce implications of untreated menopausal symptoms. A 2023 Mayo Clinic study of more than 4,400 employed women aged 45 – 60 found that 13% experienced at least one adverse work outcome related to menopause symptoms, and women with the most severe symptoms were over 15 times more likely to report missed work or reduced productivity.[63]

One study found that menopause symptoms are associated with increased healthcare utilization, particularly more physician visits, and reduced work productivity, including higher presenteeism and overall work impairment. These findings indicate a substantial economic burden, underscoring the potential value of improved management and treatment strategies.[64]

## 2.5 State Comparisons

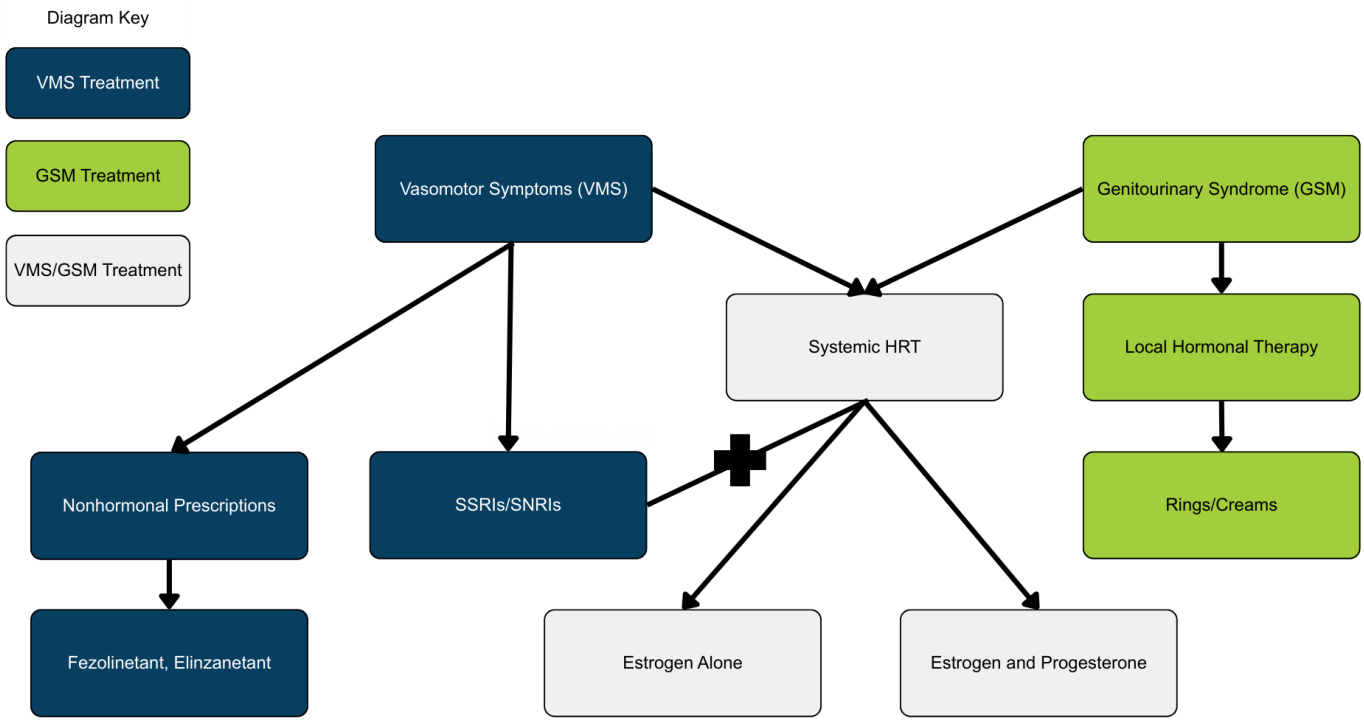
As of the writing of this report, 13 states have introduced menopause-related legislation, including declaration of menopause awareness weeks/months, workplace protections, development of menopause educational resources, expanded insurance benefit coverage, and continuing medical education (CME) requirements. As of July 2025, Illinois, Louisiana, Oregon, and Washington have passed menopause-related legislation similar to this study.[65] Other states have menopause legislation in progress that could be enacted in the near future. While menopause-focused legislation has increased in recent years and will likely continue to increase as more legislation is passed, specific provisions and coverage vary greatly from state to state, and overall guidelines for menopause care requirements are lacking. Table 19 in Appendix B summarizes and compares applicable state legislation.

# 3.0 Medical Evaluation

Management strategies for menopause are diverse and should be individualized based on symptom severity, health risks, and patient preference. Evidence-based approaches include HT (estrogen for individuals without a uterus or combined estrogen-progestogen[vii] for individuals with a uterus), nonhormonal pharmacologic options (e.g., SSRIs/SNRIs), and behavioral interventions such as CBT, lifestyle modification, and stress reduction (see Figure 1). Education and shared decision-making are critical to ensuring that treatment aligns with patient goals and safety considerations.[8,14]

[vii] Progestogens are a category of synthetic (chemical synthesis) progestins and bioidentical (made using living cells) progesterone. For simplicity, this report uses progestogens, unless specified otherwise.

**Figure 1: Menopause Symptom Treatments**




## 3.1 Medical Efficacy of Treatments

Menopause treatments are tailored to the patient's specific conditions and symptom severity. Treatment efficacy can be shaped by cumulative biological, behavioral, and social exposures over time, such as preexisting conditions, contraindications, prior hormone use, nutritional status, chronic stress, and access to preventive healthcare, which influence both the timing and severity of menopause symptoms and the individual's response to therapy.[10,11]

Beyond the physical transition, menopause often brings mixed emotions and social adjustments, influencing self-perception, identity, and well-being. Understanding menopause as both a biological and social process can inform more comprehensive clinical and policy approaches that support healthy aging for women and others with ovaries.[8,14]

Systemic HT

For individuals with moderate to severe symptoms under age 60, HT is considered the most effective first-line option by many professional organizations, provided there are no contraindications such as estrogen-dependent cancers,[viii] blood clots, heart disease, stroke, and liver disease. Estrogen and

[viii] Estrogen-dependent cancers include breast cancer, endometrial (uterus) cancer, ovarian cancer, and cervical cancer.

progestogens[ix] are prescribed for individuals with a uterus, and estrogen alone is prescribed for individuals without a uterus. Physicians are encouraged to use the lowest effective dose, with periodic check-ups to monitor treatment response.[28,29,30,31]

HT can be administered through an oral tablet, transdermal patch, or vaginal ring.[28] Oral estrogen is convenient and provides consistent absorption but carries risks such as blood clots, gallstones, and thyroid effects.[19] Transdermal estrogen bypasses liver metabolism, minimizing some systemic side effects, but can cause skin irritation in some users. Vaginal ring devices, such as Femring, offer a newer alternative that avoids patch replacement and uneven absorption.[32] HT also helps prevent bone loss and fractures and has been shown to reduce VMS by up to 85% in perimenopausal women.[19] Expert interviews with clinical providers conducted for this study substantiate the literature, affirming broad consensus that HT is an effective first-line treatment for menopause.

As of November 2025, the FDA announced it will remove the boxed warning from many commonly used HT medications. The warning advised users of increased risks of cardiovascular disease, breast cancer, dementia, and blood clots. After reviewing newer evidence, particularly for women who begin HT within 10 years of menopause onset or before age 60, regulators determined that a universal warning was no longer supported.[4]

*Compounded HT*

While a combination of estrogen and progestogens is a standard treatment for menopausal individuals with a uterus, custom compound HT medications can be a risky and ineffective treatment. Compound HT medications can be unevenly concentrated between estrogen and progestogens, and total dose amounts can be uncertain. At the time of this report, compounded HT is not FDA approved, and these medications are not recommended by research or expert opinions.[66]

Local Hormone Therapy

Local vaginal therapy uses low-dose estrogen, prasterone, or ospemifene applied topically to the vaginal area to treat GSM symptoms.[67] This localized approach minimizes systemic hormone absorption while effectively relieving vaginal dryness, pain, and discomfort. A longitudinal large-scale 2019 study found no statistically significant increase in adverse health outcomes among users, confirming that vaginal estrogen is a safe and effective therapy for GSM.[68]

Testosterone

Testosterone therapy may be considered for postmenopausal women experiencing female sexual interest and arousal disorder (FSIAD) when other causes have been excluded and conventional HT is insufficient. Although studies show transdermal testosterone can improve sexual desire and satisfaction, there are currently no FDA-approved testosterone products for women, and long-term safety data remains limited.[19]

[ix] Progestogens are synthetic medications that mimic the natural hormone progesterone, used in the treatment of menopause for individuals with a uterus in combination with estrogen.

Nonhormonal Medications

*SSRIs/SNRIs*

A variety of nonhormonal prescription medications can alleviate menopausal symptoms, particularly for individuals who cannot or prefer not to use HT. Although paroxetine mesylate (Brisdelle) is the only FDA-approved SSRI to treat hot flashes, many SSRIs/SNRIs are an effective treatment for hot flashes.[29] A 2011 study on the efficacy of SSRIs in the treatment of VMS found a significant improvement in symptomatic remission among individuals who were prescribed SSRIs versus individuals given a placebo.[69] SSRIs/SNRIs have been shown to improve hot flash severity and frequency between 25% and 69%.[29] While less effective than HT, SSRIs and SNRIs are a safe and effective alternative that can alleviate menopausal symptoms.[29,70,71,72]

*Migraine Medications*

Non-steroidal anti-inflammatory drugs (NSAIDs) are the most effective and commonly used drugs to treat migraines. Triptans are prescribed if NSAID treatments have failed. Antiemetics (anti-nausea) can be used in combination with NSAIDs or triptans or used alone if migraines are accompanied by nausea or vomiting. Preventive therapies approved by the FDA include certain beta-blockers, anticonvulsants, onabotulinumtoxinA (generic name for Botox), and CGRP monoclonal antibodies.[72]

CGRP plays a central role in vasodilation, thermoregulation, and migraine-related pain signaling. Preventive CGRP monoclonal antibodies and acute CGRP receptor antagonists reduce symptoms by blocking CGRP or its receptor. Research shows that CGRP receptor suppression prevents hot-flash-like temperature surges, which supports the biologic connection between hormonal change, VMS, and migraine. This mechanism is consistent with clinical observations that migraine activity often increases during perimenopause and declines after menopause.[73]

Findings from the American Academy of Neurology (AAN) further support the role of CGRP in hormonally influenced migraines. A 2023 study published in *Neurology* reported that women with episodic migraine had significantly higher CGRP levels during menstruation, when estrogen levels are lowest, compared with women without migraine. The AAN notes that these fluctuations might help explain why migraine is more likely during menstruation and why attacks often diminish after menopause. The study found that elevated CGRP levels were not present in women taking oral contraceptives or in postmenopausal women, suggesting that stable estrogen levels might modulate CGRP activity.[44]

The American Headache Society (AHS) has issued a position statement identifying CGRP-targeting therapies as first-line options for migraine prevention. As of March 2024, the AHS states that initiation of these medications should not require prior trial and failure of traditional preventive therapies. The updated recommendations include monoclonal antibodies targeting CGRP or its receptor and oral CGRP receptor antagonists as first-line preventive options for episodic and chronic migraine. Earlier AHS guidance had required failure or intolerance of at least two standard preventive medications; the 2024 update reflects accumulating evidence of strong efficacy, better tolerability compared with older agents, and improved adherence in clinical practice.[74]

Overall, CGRP-targeting therapies provide an effective treatment option for individuals who do not respond to or cannot take other migraine medications and could be particularly relevant for women experiencing migraine exacerbations related to hormonal changes or VMS. Ongoing research will

further clarify their role in menopausal populations, but current biologic and clinical evidence supports their use in this context.

*Neurotransmitter Agonists*

Veozah, a nonhormonal drug approved by the FDA in 2023, has demonstrated reductions in VMS ranging from 20% to 95%, depending on dosage and individual response.[75] This variation reflects differences across clinical trials, dosing regimens, and patient characteristics rather than inconsistency in efficacy. Dose-ranging studies tested Veozah at multiple levels, typically 30 mg, 45 mg, and 90 mg daily or twice daily. Higher doses were associated with greater reductions in VMS frequency and severity, with improvements of up to 95% among participants receiving higher-dose regimens, compared to 20% – 40% reduction observed at lower doses or among placebo groups. Individual variability also contributed to this range. Factors such as baseline symptom frequency, duration since menopause, and comorbid conditions influenced treatment response. Across studies, improvements were observed as early as the first week of treatment and sustained through 12 weeks or longer. While data on long-term outcomes is still emerging, early evidence suggests Veozah offers a promising alternative for individuals who are unable to use hormones.[22]

Approved by the FDA on October 24, 2025, Lynkuet is a new nonhormonal treatment for moderate to severe VMS associated with menopause. Like Veozah, Lynkuet acts on neurokinin pathways but targets both NK1 and NK3 receptors,[x,76] which could also improve sleep quality. Clinical trials found reductions in VMS severity among over 70% of patients at 12 weeks and 80% at 26 weeks.[23] Lynkuet expands treatment options for individuals experiencing VMS who cannot or choose not to use HT, including cancer survivors and those using older nonhormonal agents such as gabapentin or antidepressants. However, early trials noted sleepiness as a common side effect. Experts expect Lynkuet to complement rather than replace existing therapies. Uptake will depend largely on insurance coverage and affordability, as patients currently using HT or Veozah are unlikely to switch unless cost or access improves and might have concerns about sleepiness side effects. Bayer has indicated proactive efforts to address pricing and coverage issues experienced with prior nonhormonal therapies.[77]

*Other Nonhormonal Medications*

Other nonhormonal prescription medications used by some individuals to treat VMS include gabapentin and oxybutynin. Gabapentin, an anticonvulsant (antiepileptic) medication, is FDA approved to treat conditions like nerve pain and seizures but has also been shown to reduce the frequency and severity of hot flashes at doses between 900 mg and 2,400 mg per day. Side effects such as dizziness, drowsiness, and unsteadiness are common early in treatment but often improve over time. Because it can cause sleepiness, bedtime dosing can be helpful for individuals whose hot flashes disrupt sleep. Oxybutynin, an antimuscarinic (anticholinergic) medication, typically used for overactive bladder and urinary urge incontinence, has also been shown in clinical studies to reduce moderate to severe hot

[x] Neurokinins are brain-signaling molecules involved in regulating body temperature. NK1 and NK3 are types of neurokinin receptors that influence hot flashes and related symptoms during menopause. Medications such as Veozah (NK3 antagonist) and Lynkuet (dual NK1/NK3 antagonist) work by blocking these receptors to reduce nerve activity linked to VMS.

flashes in postmenopausal women. Both medications are considered nonhormonal options for managing menopause symptoms, particularly for individuals who cannot or prefer not to use HT.[29]

Non-Pharmacologic Treatments

*Behavior and Lifestyle*

Behavioral and lifestyle interventions, including menopause-specific CBT, exercise, sleep hygiene, and stress reduction, can alleviate symptoms of menopause and complement medical treatment.[78] A 2023 survey found that 75% of providers recommend behavioral or lifestyle interventions generally for the menopausal population, as well as to help treat menopause symptoms.[51] Some providers suggest behavioral and lifestyle interventions before prescribing drugs.[51] While U.S.-based studies are limited, one small study suggests CBT can decrease severity of insomnia and VMS.[79] Overall, menopause-specific CBT has mixed efficacy.[52]

*Alternative Medicine*

Some individuals experiencing menopause use alternative medicine in addition to, or in lieu of, pharmacologic interventions. Common treatments include hypnosis, meditation, acupuncture, herbs, supplements, and/or vitamins. While these remedies are used widely, especially among non-white women, existing research, efficacy, and safety vary.[52] Currently, hypnosis is the only alternative treatment option recommended by the Menopause Society.[29]

Researchers note mixed evidence on acupuncture for VMS, insomnia, and mood concerns. Some studies report improvement, while others show no meaningful difference from placebo.[52] Experts are similarly divided, with some viewing acupuncture as a potentially useful supportive therapy and others emphasizing the lack of consistent trial results. Variability in study design, including treatment frequency and acupuncture protocols, contributes to inconsistent findings. Evidence is also limited by the small number of U.S. studies and the use of small samples, which makes it difficult to draw firm conclusions.[80]

*Pelvic Floor Physical Therapy*

Some individuals use pelvic floor physical therapy (PFPT) to address urinary and sexual health symptoms that arise during menopause, either alone or alongside medication. PFPT involves exercises to strengthen the pelvic muscles and can include techniques such as biofeedback, electrical stimulation, or guided muscle training. These therapies can improve bladder control, reduce urinary leakage, and enhance sexual comfort. Evidence supports PFPT as an effective, noninvasive treatment for stress and mixed urinary incontinence, with research suggesting that about half of participants experience meaningful improvement in symptoms.[81,82] The Menopause Society recommends PFPT and other nonhormonal options as first-line treatments for mild GSM, according to its 2020 position statement. For moderate to severe GSM, the Menopause Society notes that low-dose vaginal estrogen, vaginal dehydroepiandrosterone, or oral ospemifene might be more effective.[39]

## 3.2 Medical Community Recognition and Provider Training

Systemic HT Guidelines

Clinical practice guidelines from the American College of Obstetricians and Gynecologists ([ACOG], 2014), the Menopause Society (2023), and the Endocrine Society (2015) identify HT (estrogen alone or

combined with progestogens) as the most effective treatment for VMS.[xi,28,30,31] All three professional organizations recommend clinicians individualize treatment based on each woman's medical history, risk factors, and preferences. Additionally, before starting HT, clinicians should assess cardiovascular and breast cancer risk and select the most appropriate regimen accordingly.

ACOG released separate guidance (2023) cautioning against routine use of compounded "bioidentical" HT, emphasizing that FDA-approved formulations, many of which are also bioidentical, are preferred due to their proven safety, quality, and efficacy. The guidance notes that compounded preparations lack FDA oversight, standardized dosing, and quality control and could vary in potency and purity. Clinicians are encouraged to educate patients about these risks and use a shared decision-making approach. ACOG highlights the need for high-quality research comparing compounded and FDA-approved hormone therapies, particularly for testosterone formulations and long-term safety outcomes.[83]

Nonhormonal Treatment Guidelines

For individuals who cannot or prefer not to use hormones, several nonhormonal treatments are recommended to help relieve symptoms. ACOG and the Menopause Society recommend nonhormonal options such as SSRIs/SNRIs, clonidine, and gabapentin as effective HT alternatives.[xii,29,31] In addition, the Menopause Society approves of the use of Veozah and oxybutynin for VMS.[29] For vaginal symptoms, ACOG recommends local estrogen therapy[31]; the Endocrine Society promotes low-dose vaginal estrogen, ospemifene, or vaginal moisturizers and lubricants as effective options to treat GSM.[30]

ACOG concludes that evidence does not support progestogens-only therapy, testosterone, herbal supplements, or lifestyle modifications as effective treatments.[31] However, the Endocrine Society and Menopause Society encourage postmenopausal women to adopt healthy lifestyle measures such as weight loss,[29] balanced nutrition, regular physical activity, and smoking cessation.[30] The Menopause Society also recommends CBT, hypnosis, and local anesthetic neck injections that can block nerves as effective nonhormonal treatments for menopause symptoms.[29]

In 2022, the USPSTF found that HT has no net benefit for preventing chronic conditions in asymptomatic individuals who have reached menopause.[84] The Endocrine Society also concluded that HT should not be used to prevent heart disease, breast cancer, or dementia.[30]

Preventive Services Guidelines

Current guidelines regarding preventive services for individuals with menopause are generally broad, age related, and not specific to menopause. HRSA recommends annual well-woman visits; however, no specific mention of menopause is included.[46]

Provider Attitudes, Awareness, and Current Training

While many perimenopausal individuals seek care to alleviate symptoms and monitor related conditions, provider knowledge and preparedness vary widely. PCPs and OB/GYNs most often treat

[xi] The Menopause Society and the Endocrine Society report less risk associated with using HT for individuals under age 60 within 10 years of starting menopause and who do not have preexisting conditions.
[xii] ACOG notes paroxetine remains the only FDA-approved nonhormonal therapy for hot flashes.

menopause,[33] yet many report limited education and preparedness in this area.[85,86] A 2019 study found that 20% of residents received no menopause-related education, and although about 60% had at least one lecture on the topic, fewer than 7% felt prepared to manage menopause symptoms effectively.[33] Another study found that only about 31% of OB/GYN residency programs offer menopause curricula, with notable variation across programs.[34] Provider type also appears to influence treatment patterns. Patients cared for by gynecologists were more likely to receive prescription menopause therapies, whereas those treated by primary care providers (PCPs) more often used or had documentation of nonprescription treatments.[13]

Researchers have emphasized the need for standardized menopause education to reduce stigma, improve symptom management, and promote overall well-being.[35,87] In Maryland, physicians must complete 50 CME hours every two years, including at least 25 Category 1 hours,[xiii] but menopause-specific content is not required.[88,89]

Several professional organizations offer menopause-focused training. The ACOG provides a self-directed CME course, *Management of Menopause*, covering the health consequences of menopause, HT risk-benefit differences by age, and hormonal and nonhormonal treatment options. The course offers up to seven American Medical Association (AMA) Physicians Recognition Award (PRA) Category 1 credits™ and is available through December 2025 for $140 ($105 for ACOG members).[90] The Menopause Society offers the Menopause Society Certified Practitioner (MSCP) credential, which validates provider expertise in menopause care. However, according to a 2023 Menopause Society survey, standardized menopause curricula remain limited: 71% of programs with menopause education reported two or fewer lectures annually, and 84% of respondents agreed their programs need more educational resources.[91]

Interviews with experts corroborated findings from literature indicating that menopause is undertreated and providers lack training for treating menopause. Additionally, all experts advocated for more comprehensive provider education for menopause treatment, mentioning the lack of formal guidelines, limited efficacy of education, and wide variety of differing sources as difficulties for providers to properly educate themselves.

Overall, expert interviews and professional organization data suggest that insufficient provider education contributes to persistent undertreatment of menopause. Strengthening menopause-related training requirements, whether through dedicated CME credits or inclusion in medical education curricula, could improve access to comprehensive, evidence-based care. Implementation costs will depend on the timing and frequency of training requirements; while integrating content into existing programs might minimize costs, supplemental CME or certification courses could pose financial or participation barriers for individual providers.

# 4.0 Financial Evaluation

Unlike mandate benefit reviews, this study was not guided by legislative language. Cost cannot be determined without the final wording of a mandate. There is potential for cost increases related to limits

[xiii] Category 1 Certification Programs are certification or recertification activities preapproved by the American Academy of Physician Associates (AAPA) for a set number of Category 1 CME credits, regardless of presenter or location. Credits may be applied once per calendar year and no more than twice per logging cycle.

on cost sharing, removal of UM, required provider training, and possible inclusion of acupuncture services. Considerable uncertainty also comes from recent market changes, including new FDA-approved nonhormonal therapies (Veozah in 2023[2] and Lynkuet[3] in 2025) and the recent removal of boxed warnings for HT.[4]

Given these uncertainties, the analysis focused on the incremental costs associated with broadening coverage under current conditions. The modeling examined acupuncture, cost sharing, removal of UM, and provider training based on information from carriers, experts, and available literature. It incorporated data on the population likely to use menopause-related care, current utilization patterns, and expected shifts if coverage is standardized or expanded. Premium, administrative, and retention factors were also applied to estimate potential per-member-per-month (PMPM) impacts.

## 4.1 Methodology

To estimate the financial impact of potentially mandating coverage of menopause-related treatment and care as well as provider training, BerryDunn conducted a multi-step analysis. Summary statistics, as shown in Section 4.2, include the top pharmacy and medical drivers, hormonal versus nonhormonal treatments, and FDA-approved versus off-label prescriptions. Financial modeling focused on acupuncture services, cost sharing, removal of UM, and provider training in the current environment. Information from carriers, experts, and the literature was synthesized into the review. The analysis incorporated data on the study population likely to use menopause-related care, current patterns of service use, and expected changes in utilization if coverage is standardized or expanded. The assessment also considered premium, administrative, and retention factors to develop projected PMPM impacts and, where applicable, provided an evidence-based estimate of the potential cost range for commercial insurers and Medicaid if any of these requirements are adopted.

First, BerryDunn surveyed Maryland insurers. Insurer responses indicated that menopause services are generally covered with limited UM. A review of medical and pharmaceutical claims appeared to confirm the insurers' responses. Then, expert interviews were conducted and incorporated into the analysis. The impacts of including acupuncture services, cost sharing limitations, decreases in UM, and mandated provider training were considered. BerryDunn also reviewed the claims most currently available in the MCDB related to menopause and included statistics from literature to inform the analysis.

The Medicaid, individual, and fully insured, small, and large employer group populations were identified in the MCDB using market segment codes. The State Health Plan population, identified via employer identification number (EIN), was assumed to be only those that were classified as self-insured. BerryDunn assumed the State Health Plan would voluntarily adopt these mandated benefits; therefore, the same impact assumptions as the fully insured population were applied.[xiv]

BerryDunn was asked to focus on the population experiencing menopause-related symptoms aged 45 – 55. For simplicity and to best incorporate the study population with available information, BerryDunn used claims with gender classified as female in the MCDB. Eligibility and claims data for 2024 was

[xiv] This assumption is commonly used in actuarial reviews to estimate the broader cost impacts of state insurance mandates on self-insured public employee coverage.

used as a base. Current costs, potential cost increases, and corresponding potential health insurance cost[xv] increases were considered.

## 4.2 Summary Statistics

The table below shows the distribution of the Maryland female population aged 45 – 55.

**Table 1: 2024 Average Medical Membership**

| | Total | Females Aged 45 – 55 | Females Aged 45 – 55 as % of Total Population |
|---|---|---|---|
| **Individual** | 275,814 | 30,599 | 11% |
| **Small Group** | 195,997 | 18,120 | 9% |
| **Large Group** | 438,397 | 41,585 | 9% |
| **Total Fully Insured** | 910,208 | 90,305 | 10% |
| **State Health Plan** | 204,627 | 17,059 | 8% |
| **Medicaid** | 1,659,197 | 76,213 | 5% |

BerryDunn stratified the analysis by medical and pharmacy membership and claims, noting that pharmacy membership is about 1% lower than medical membership but accounts for a greater share of claim costs. In the next section, we examine prescription drug utilization related to menopause.

### 4.2.1 Pharmacy

BerryDunn focused on claims for which the associated member had at least two medical claims with a menopause diagnosis in the first three positions within 2022 – 2024.

While BerryDunn was asked to focus on those aged 45 – 55, it should be noted that there are low levels of utilization of prescription drugs associated with perimenopause and/or menopause for those aged 35 – 44. Furthermore, the utilization levels for those aged 56 – 64 are only slightly lower than those aged 45 – 55.

In 2024, the top five prescription drugs related to menopause by total paid cost and utilization per 1,000 members are shown in Tables 2 and 3, below, stratified by market segment.

[xv] The term “health insurance costs” is used to describe premiums in the fully insured market, premium equivalents in the self-insured market, and program costs for Medicaid. Health insurance cost components vary by market segment but refer to projected funding to cover any FFS claims, non-claim expenses, capitation, administrative expenses, fixed fees, assessments, taxes, contribution to reserve/profit margin, cost of capital, and risk and contingency margin. Member cost sharing (e.g., deductible, copay, and coinsurance) is not included in health insurance costs.

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**Table 2: 2024 Top Drugs by Paid Cost**

| Fully Insured | | | |
|---|---|---|---|
| **Drug Name** | **Drug Class** | **Paid Cost** | **Percent of Total Cost** |
| Estradiol | Estrogens | $459,028 | 24% |
| Nurtec | CGRP Receptor Antagonist | $295,950 | 15% |
| Emgality | CGRP Receptor Antagonist | $187,476 | 10% |
| Veozah | Menopausal Symptoms Suppressants | $136,821 | 7% |
| Ajovy | CGRP Receptor Antagonist | $121,508 | 6% |
| **State Health Plan** | | | |
| **Service Code** | **Service Description** | **Paid Cost** | **Percent of Total Cost** |
| Nurtec | CGRP Receptor Antagonist | $190,975 | 24% |
| Emgality | CGRP Receptor Antagonist | $82,540 | 10% |
| Ajovy | CGRP Receptor Antagonist | $79,413 | 10% |
| Vagifem | Vaginal Estrogens | $56,877 | 7% |
| Estradiol | Estrogens | $56,716 | 7% |
| **Medicaid** | | | |
| **Service Code** | **Service Description** | **Paid Cost** | **Percent of Total Cost** |
| Nurtec | CGRP Receptor Antagonist | $345,711 | 19% |
| Emgality | CGRP Receptor Antagonist | $202,856 | 11% |
| Ajovy | CGRP Receptor Antagonist | $172,507 | 9% |
| Estradiol | Estrogens | $151,516 | 8% |
| Prempro | Estrogen Combinations | $138,709 | 7% |

**Table 3: 2024 Top Drugs by Utilization per 1,000**

| Fully Insured | | | |
|---|---|---|---|
| **Drug Name** | **Drug Class** | **Utilization per 1,000** | **Percent of Total Cost** |
| Estradiol | Estrogens | 2.7 | 24% |
| Progesterone | Progestins | 1.9 | 4% |
| Gabapentin | Anticonvulsants - Misc. | 0.7 | 0% |
| Metronidazole | Vaginal Anti-infectives | 0.7 | 0% |
| Escitalopram Oxalate | SSRIs[xvi] | 0.6 | 0% |
| **State Health Plan** | | | |
| **Drug Name** | **Drug Class** | **Utilization per 1,000** | **Percent of Total Cost** |
| Estradiol | Estrogens | 2.5 | 7% |
| Progesterone | Progestins | 1.6 | 3% |
| Metronidazole | Vaginal Anti-infectives | 0.7 | 0% |
| Gabapentin | Anticonvulsants - Misc. | 0.7 | 0% |
| Escitalopram Oxalate | SSRIs | 0.6 | 2% |
| **Medicaid** | | | |
| **Drug Name** | **Drug Class** | **Utilization per 1,000** | **Percent of Total Cost** |
| Gabapentin | Anticonvulsants - Misc. | 0.8 | 5% |
| Estradiol | Estrogens | 0.7 | 8% |
| Metronidazole | Vaginal Anti-infectives | 0.5 | 1% |
| Diclofenac Sodium | Topical Anti-inflammatory Agents | 0.3 | 2% |
| Sertraline HCl | SSRIs | 0.3 | 3% |

The PMPM paid costs, utilization per 1,000, and costs per user for hormonal drugs, SSRIs and SNRIs, and nonhormonal drugs by market segment are presented in Tables 4, 5, and 6. These statistics are shown over the total population for each market segment, as well as by the population of females aged 45 – 55 for each market segment.

[xvi] Pharmacy claims do not include diagnosis information, and thus it is not possible to distinguish whether an SSRI prescription was written for VMS versus depression or another condition. Because of this limitation, isolating SSRI use specifically for VMS is not feasible in the pharmacy data.

**Table 4: 2024 Pharmacy PMPMs by Drug Category**

| Total Population | | | | |
|---|---|---|---|---|
| | **Hormonal** | **SSRIs/SNRIs** | **Other Nonhormonal** | **Total** |
| **Individual** | $0.09 | $0.01 | $0.09 | $0.19 |
| **Small Group** | $0.08 | $0.00 | $0.05 | $0.14 |
| **Large Group** | $0.10 | $0.01 | $0.08 | $0.19 |
| **Total Fully Insured** | $0.09 | $0.01 | $0.08 | $0.18 |
| **State Health Plan** | $0.12 | $0.02 | $0.18 | $0.33 |
| **Medicaid** | $0.03 | $0.01 | $0.05 | $0.09 |
| **Females Aged 45 – 55** | | | | |
| | **Hormonal** | **SSRIs/SNRIs** | **Other Nonhormonal** | **Total** |
| **Individual** | $0.78 | $0.13 | $0.84 | $1.75 |
| **Small Group** | $0.86 | $0.05 | $0.57 | $1.47 |
| **Large Group** | $1.04 | $0.08 | $0.86 | $1.97 |
| **Total Fully Insured** | $0.92 | $0.09 | $0.79 | $1.80 |
| **State Health Plan** | $1.49 | $0.28 | $2.14 | $3.90 |
| **Medicaid** | $0.65 | $0.21 | $1.18 | $2.03 |

**Table 5: 2024 Pharmacy Utilization Per 1,000 by Drug Category**

| Total Population | | | | |
|---|---|---|---|---|
| | **Hormonal** | **SSRIs/SNRIs** | **Other Nonhormonal** | **Total** |
| **Individual** | 3.9 | 2.4 | 2.6 | 6.3 |
| **Small Group** | 4.0 | 2.2 | 2.1 | 5.8 |
| **Large Group** | 3.8 | 2.0 | 2.3 | 5.8 |
| **Total Fully Insured** | 3.8 | 2.2 | 2.3 | 5.9 |
| **State Health Plan** | 3.7 | 2.2 | 2.4 | 5.8 |
| **Medicaid** | 1.0 | 1.2 | 1.8 | 2.8 |
| **Females Aged 45-55** | | | | |
| | **Hormonal** | **SSRIs/SNRIs** | **Other Nonhormonal** | **Total** |
| **Individual** | 34.7 | 21.9 | 23.6 | 56.4 |
| **Small Group** | 42.7 | 23.4 | 22.7 | 62.7 |
| **Large Group** | 38.7 | 20.9 | 23.3 | 59.8 |
| **Total Fully Insured** | 38.2 | 21.7 | 23.3 | 59.3 |
| **State Health Plan** | 44.1 | 25.8 | 28.7 | 69.8 |
| **Medicaid** | 21.9 | 26.4 | 40.2 | 61.4 |

**Table 6: 2024 Pharmacy Cost Per User Per Year by Drug Category**

| | **Hormonal** | **SSRIs/SNRIs** | **Other Nonhormonal** | **Total** |
|---|---|---|---|---|
| **Individual** | $270 | $69 | $429 | $373 |
| **Small Group** | $241 | $23 | $300 | $282 |
| **Large Group** | $324 | $43 | $441 | $396 |
| **Total Fully Insured** | $289 | $48 | $409 | $364 |
| **State Health Plan** | $404 | $128 | $895 | $671 |
| **Medicaid** | $354 | $94 | $351 | $397 |

The PMPM costs, utilization per 1,000, and costs per user for FDA-approved and non-FDA-approved drugs, stratified by market segment, are presented in Tables 7, 8, and 9. These statistics are shown for the total population in each market segment and for females ages 45 to 55 within each segment.

**Table 7: 2024 PMPMs by FDA-Approved Category**

| Total Population | | | |
|---|---|---|---|
| | FDA-Approved | Non-FDA-Approved | Total |
| Individual | $0.11 | $0.08 | $0.19 |
| Small Group | $0.09 | $0.04 | $0.14 |
| Large Group | $0.13 | $0.06 | $0.19 |
| Total Fully Insured | $0.12 | $0.06 | $0.18 |
| State Health Plan | $0.17 | $0.15 | $0.33 |
| Medicaid | $0.05 | $0.04 | $0.09 |
| **Females Aged 45 – 55** | | | |
| | FDA-Approved | Non-FDA-Approved | Total |
| Individual | $1.01 | $0.74 | $1.75 |
| Small Group | $0.99 | $0.48 | $1.47 |
| Large Group | $1.33 | $0.65 | $1.97 |
| Total Fully Insured | $1.15 | $0.65 | $1.80 |
| State Health Plan | $2.05 | $1.86 | $3.90 |
| Medicaid | $1.10 | $0.93 | $2.03 |

**Table 8: 2024 Utilization Per 1,000 by FDA-Approved Category**

| Total Population | | | |
|---|---|---|---|
| | FDA-Approved | Non-FDA-Approved | Total |
| Individual | 5.6 | 2.0 | 6.3 |
| Small Group | 5.3 | 1.6 | 5.8 |
| Large Group | 5.2 | 1.7 | 5.8 |
| Total Fully Insured | 5.3 | 1.7 | 5.9 |
| State Health Plan | 5.2 | 1.8 | 5.8 |
| Medicaid | 2.3 | 1.3 | 2.8 |
| **Females Aged 45 – 55** | | | |
| | FDA-Approved | Non-FDA-Approved | Total |
| Individual | 50.1 | 17.5 | 56.4 |
| Small Group | 57.0 | 17.5 | 62.7 |
| Large Group | 53.5 | 17.1 | 59.8 |
| Total Fully Insured | 53.1 | 17.3 | 59.3 |
| State Health Plan | 62.5 | 21.9 | 69.8 |
| Medicaid | 50.4 | 28.2 | 61.4 |

**Table 9: 2024 Cost Per User Per Year by FDA-Approved Category**

| | FDA-Approved | Non-FDA-Approved | Total |
|---|---|---|---|
| **Individual** | $242 | $508 | $373 |
| **Small Group** | $208 | $331 | $282 |
| **Large Group** | $298 | $453 | $396 |
| **Total Fully Insured** | $261 | $447 | $364 |
| **State Health Plan** | $393 | $1,018 | $671 |
| **Medicaid** | $263 | $394 | $397 |

### 4.2.2 Medical

BerryDunn focused on members who had a menopause diagnosis in the first three positions to determine the relevant population.

The medical services with the highest paid cost related to menopause in 2024 are office visits, as shown in Table 10 below, stratified by market segment.

**Table 10: 2024 Top Medical Services by Paid Cost**

| **Fully Insured** | | | |
|---|---|---|---|
| **Service Code** | **Service Description** | **Paid Cost** | **Percent of Total Cost** |
| 99214 | Office Outpatient 30 Min | $369,847 | 21% |
| 99396 | Preventive Visit Estimated Age 40-64 | $364,887 | 21% |
| 99213 | Office Outpatient 20 Min | $246,355 | 14% |
| **State Health Plan** | | | |
| **Service Code** | **Service Description** | **Paid Cost** | **Percent of Total Cost** |
| 99214 | Office Outpatient 30 Min | $108,848 | 24% |
| 99396 | Preventive Visit Estimated Age 40-64 | $74,469 | 16% |
| 99213 | Office Outpatient 20 Min | $57,036 | 13% |
| **Medicaid** | | | |
| **Service Code** | **Service Description** | **Paid Cost** | **Percent of Total Cost** |
| 99214 | Office Outpatient 30 Min | $241,368 | 23% |
| 99213 | Office Outpatient 20 Min | $168,417 | 16% |
| 99396 | Preventive Visit Estimated Age 40-64 | $113,056 | 11% |

The most utilized medical services related to menopause in 2024 are office visits and assays of hormones, as shown in Table 11 below, stratified by market segment.

**Table 11: 2024 Top Medical Services by User Counts**

| Fully Insured | | |
|---|---|---|
| **Service Code** | **Service Description** | **User Count** |
| 83001 | Assay of Gonadotropin (FSH) | 2,796 |
| 82670 | Assay of Total Estradiol | 2,522 |
| 99213 | Office Outpatient 20 Min | 2,396 |
| **State Health Plan** | | |
| **Service Code** | **Service Description** | **User Count** |
| 83001 | Assay of Gonadotropin (FSH) | 599 |
| 99214 | Office Outpatient 30 Min | 598 |
| 99213 | Office Outpatient 20 Min | 535 |
| **Medicaid** | | |
| **Service Code** | **Service Description** | **User Count** |
| 99213 | Office Outpatient 20 Min | 1,417 |
| 99214 | Office Outpatient 30 Min | 1,415 |
| 83001 | Assay of Gonadotropin (FSH) | 973 |

Tables 12 and 13 below show the total paid medical PMPMs, utilization per 1,000, and cost per user per year stratified by market segment. These statistics are shown over the total population for each market segment, as well as by the population of females aged 45 – 55 for each market segment. Utilization of these services is lower for Medicaid members, potentially due to greater barriers accessing healthcare, including difficulties with transportation and lack of available appointment times.[92]

**Table 12: 2024 Medical PMPMs and Utilization Per 1,000**

| PMPMs | | |
|---|---|---|
| | **Total Population** | **Females Aged 45 – 55** |
| **Individual** | $0.19 | $1.68 |
| **Small Group** | $0.12 | $1.25 |
| **Large Group** | $0.16 | $1.69 |
| **Total Fully Insured** | $0.16 | $1.60 |
| **State Health Plan** | $0.19 | $2.22 |
| **Medicaid** | $0.10 | $1.13 |
| **Utilization Per 1,000** | | |
| | **Total Population** | **Females Aged 45 – 55** |
| **Individual** | 8.77 | 79.09 |
| **Small Group** | 7.92 | 85.70 |
| **Large Group** | 8.18 | 86.23 |
| **Total Fully Insured** | 8.30 | 83.71 |
| **State Health Plan** | 8.06 | 96.72 |
| **Medicaid** | 2.45 | 53.30 |

**Table 13: 2024 Medical Cost per User Per Year**

| | Cost per User Per Year |
|---|---|
| **Individual** | $255.58 |
| **Small Group** | $175.23 |
| **Large Group** | $234.51 |
| **Total Fully Insured** | $229.07 |
| **State Health Plan** | $275.65 |
| **Medicaid** | $254.18 |

## 4.3 Acupuncture Services

BerryDunn was asked to consider the cost of mandating coverage for acupuncture services as a treatment for menopause symptoms. The insurer survey did not specifically ask about coverage of acupuncture (beyond requesting information on any treatments not listed in Appendix C Carrier Survey, Question 5g); however, BerryDunn thoroughly reviewed current coverage in the medical claims data. Current coverage in the commercial market likely includes UM, and the paid claims for acupuncture services with a menopause diagnosis are low in this market. Based on claims data, acupuncture does not appear to be covered for Medicaid as a treatment for menopause.

A literature review also shows mixed results on the efficacy of acupuncture as a treatment for menopause symptoms.[52] Additionally, research suggests that a small portion of menopausal individuals use acupuncture.[13] Similar to the literature, experts had mixed views on the efficacy of acupuncture with most noting they would not recommend it as a treatment for menopause. One expert indicated that they would recommend acupuncture for those with contraindications for HT, which is 9% of individuals experiencing menopause.[93] Furthermore, some people might not choose acupuncture treatments due to fear of needles and discomfort with the practice.

Without foreknowledge of the content of provider training, it is not feasible to model the impact of mandating acupuncture coverage without UM. However, due to low provider and patient uptake rate assumptions based on the opinions of experts and a literature review, it would likely result in an immaterial cost increase for all market segments.

## 4.4 Cost Sharing Protections

States commonly use nondiscriminatory language to protect against excessive member cost sharing, such as stating that cost sharing for the mandated service will be no greater than other similar services. Another option to prevent excessive cost sharing is to remove cost sharing for services related to menopause. Eliminating cost sharing for non-preventive services for health savings account (HSA)-qualified health plans may jeopardize preferential tax treatment provided under IRS tax laws.[94,95]

The current average member cost sharing impacts for pharmacy and medical claims are shown below in Tables 14 and 15.

**Table 14: 2024 Pharmacy Cost Sharing**

| 2024 Pharmacy Cost Sharing for Females 45 – 55 | | | | |
|---|---|---|---|---|
| | Paid PMPM | Allowed PMPM | Cost Share PMPM | Cost Share Dollars Per User Per Year |
| **Individual** | $0.19 | $0.24 | $0.05 | $87 |
| **Small Group** | $0.14 | $0.21 | $0.07 | $143 |
| **Large Group** | $0.19 | $0.27 | $0.08 | $155 |
| **Total Fully Insured** | $0.18 | $0.25 | $0.07 | $131 |
| **State Health Plan** | $0.33 | $0.36 | $0.03 | $70 |
| **Medicaid** | $0.09 | $0.09 | $0.00 | $0 |

**Table 15: 2024 Medical Cost Sharing**

| 2024 Medical Cost Sharing for Females 45 – 55 | | | | |
|---|---|---|---|---|
| | Paid PMPM | Allowed PMPM | Cost Share PMPM | Cost Share Dollars Per User Per Year |
| **Individual** | $0.19 | $0.22 | $0.04 | $50 |
| **Small Group** | $0.12 | $0.17 | $0.05 | $78 |
| **Large Group** | $0.16 | $0.20 | $0.04 | $65 |
| **Total Fully Insured** | $0.16 | $0.20 | $0.04 | $63 |
| **State Health Plan** | $0.19 | $0.20 | $0.01 | $22 |
| **Medicaid** | $0.10 | $0.10 | $0.00 | $0 |

The removal of member cost sharing in its entirety, using the 2024 cost sharing amounts, would increase premiums for the commercial market $0.13 PMPM or 0.02% of premium. The increase to premium equivalents for State Health Plan would be $0.06 PMPM or 0.01% of premium equivalents. Details by market segment are shown in Table 16 below. Federal rules restrict eliminating cost sharing for members enrolled in high-deductible health plans with HSAs; however, these cost estimates are inclusive of those health plans.

**Table 16: Cost Estimate If Cost Sharing Is Removed**

| | 2024 Total Cost Share Amount Per User | Health Insurance Cost PMPM Increase | Health Insurance Cost PMPM % Increase | Health Insurance Cost Increase |
|---|---|---|---|---|
| **Individual** | $111.16 | $0.10 | 0.02% | $336,273 |
| **Small Group** | $183.23 | $0.15 | 0.02% | $355,700 |
| **Large Group** | $174.62 | $0.14 | 0.02% | $736,671 |
| **Fully Insured** | $156.07 | $0.13 | 0.02% | $1,428,643 |
| **State Health Plan** | $71.91 | $0.06 | 0.01% | $139,598 |

Retention assumptions were applied to the marginal claim costs PMPM to derive the corresponding insurance cost PMPM impacts for each market segment.[96,97]

To derive the percentage increase in insurance costs PMPM under mandated coverage, premium PMPMs for the fully insured individual, small group, and large group segments were taken from the carrier survey responses. For total fully insured, the average premium PMPM reflects a weighted

average using the carrier survey responses' reported enrollees for fully insured individual, small group, and large group. The premium equivalent PMPM for the State Health Plan was derived using the Maryland State Health Plan benefits information[98] and subscriber relationships from the MCDB. A Maryland Department of Health financial monitoring report[99] included an average program cost for Medicaid MCOs, which make up 88% of Medicaid in Maryland. For simplicity, the program cost for Medicaid FFS was assumed to be the same as for Medicaid MCOs.

## 4.5 Removal of Utilization Management

BerryDunn reviewed the carrier responses and expert interviews to determine which treatments for menopause are subject to UM. Vaginal antibiotics, vaginal estrogens, ospemifene (Osphena), and Veozah are currently subject to prior authorization or quantity limits. A review of the claims in the MCDB showed low utilization of these drugs as well as volatility across the carriers from 2022 to 2024. There is no noticeable difference between the carriers that reported they used UM and those that did not, so it is difficult to determine the impact of UM for these drugs. However, removing UM could cause an increase in utilization across all carriers.[100]

Given the information provided by experts and the higher cost of vaginal antibiotics, vaginal estrogens, Veozah, and Osphena, BerryDunn calculated the impact if UM was removed for these drugs, in the current environment. Based on literature, removing UM could cause utilization to increase by 3.6%.[100] Using claim data from 2024, this would cause an immaterial cost increase across market segments.

Given the recent introduction of Veozah and Lynkuet, which both have costs per user averaging approximately $600 PMPM, removing UM could have a meaningful impact depending on how they are treated in the provider training. It is unknown at this time how the introduction of these drugs will influence provider prescribing practices and patient demand. Furthermore, increased utilization of the drugs with UM could cause decreased utilization of other drugs, partially offsetting the cost.

Detail on claims denial rates was provided by a few carriers. The denial rates due to clinical reasons were around 1% – 2% of the total claims. These denials were likely not restricted to those aged 45 – 55 and could therefore be overstated. The way in which the carriers pulled claims related to menopause is also unknown. Using an average cost per claim, if these claims were no longer denied under the potential mandate, the impact on cost would be immaterial.

Overall, BerryDunn does not anticipate a material impact on cost from removing UM in the current environment.

## 4.6 Mandatory Provider Training

BerryDunn also considered the potential increase in utilization due to increased provider training.

The cost impact of requiring provider training is unmeasurable without knowledge of the content of the training. The calculation below uses 2024 data and assumes the same drug utilization mix and average cost per user as seen in 2024. This will likely change in the future given recent introduction of Veozah and Lynkuet and the recent FDA removal of black box warnings from menopausal hormone replacement therapy products.

BerryDunn relied on a 2025 study that found that treatment prevalence for those with education levels of "high school or lower" was 3.2%, "college" was 5.6%, and "more than college" was 7.2%.[101] BerryDunn modeled the potential utilization increase if the population that experiences menopause

utilized services at the same rate (7.2%) as those with the highest level of education. It was assumed that provider education, if symptoms are proactively raised by providers during office visits, will result in patient education. It was also assumed that provider training would mainly cause increased utilization of prescription drugs, but for every new drug user, there would be one new office visit per year. Table 17 below lays out the assumptions used in the modeling and the resulting projected cost increases. This modeling results in costs increasing by $0.08 PMPM or 0.013% of premium for fully insured, $0.02 PMPM or 0.002% of premium equivalents for State Health Plan, and $0.03 PMPM or 0.007% of program costs for Medicaid.

**Table 17: Modeling Assumptions and Cost Estimate for Impact of Mandatory Provider Training**

| | 2024 Treatment Prevalence | Projected Treatment Prevalence | 2024 User Counts | Projected New User Counts | Health Insurance Cost PMPM Increase | Health Insurance Cost PMPM % Increase |
|---|---|---|---|---|---|---|
| **Individual** | 5.6% | 7.2% | 1,692 | 469 | $0.11 | 0.024% |
| **Small Group** | 6.3% | 7.2% | 1,138 | 169 | $0.04 | 0.007% |
| **Large Group** | 6.0% | 7.2% | 2,528 | 513 | $0.07 | 0.012% |
| **Fully Insured** | 5.9% | 7.2% | 5,358 | 1,152 | $0.08 | 0.013% |
| **State Health Plan** | 7.0% | 7.2% | 1,191 | 37 | $0.02 | 0.002% |
| **Medicaid** | 6.1% | 7.2% | 4,681 | 806 | $0.03 | 0.007% |

## 4.7 Results

Because this study was not guided by specific legislative language, precise cost estimates cannot be established. The analysis therefore focused on potential cost implications in the current environment, including the addition of acupuncture services, changes in cost sharing, removal of utilization management, and mandatory provider training. There is also considerable uncertainty due to recent developments, such as new FDA-approved nonhormonal therapies and the removal of boxed warnings for hormone therapy.

BerryDunn estimates that the insurance cost increases associated with covering acupuncture for menopause and removing utilization management would be immaterial. If all cost sharing is removed, the increase to premiums for fully insured could be as high as $0.13 PMPM or 0.02% of premium, and the increase to premium equivalents for State Health Plan could be as much as $0.06 PMPM or 0.01% of premium. Finally, while mandatory provider training is unmeasurable without foreknowledge of the training, it could raise insurance costs increases under the current environment by $0.08 PMPM or 0.013% of premium for fully insured, $0.02 PMPM or 0.002% of premium equivalents for State Health Plan, and $0.03 PMPM or 0.007% of program costs for Medicaid.

# 5.0 Considerations and Limitations

Unlike mandate benefit reviews, this study was not guided by legislative language. With growing attention on menopause treatment, BerryDunn reviewed existing literature and practices in other states to develop estimates aligned with our findings. The scope of this report did not lend itself to deep academic-level analysis, however, to provide the most credible information and estimates possible, data from the MCDB was supplemented by carrier responses and expert interviews with a broad literature review. The goal was to synthesize the best available information to inform decision-making and to equip legislators who may draft a bill with available data, while remaining transparent about the limitations.

Maryland specific data to inform the analyses for this report was not consistently available. Although menopause experiences can differ significantly based on factors such as race, ethnicity, and SES, conducting an analysis at that level of detail, including adjustments for varying utilization patterns, was beyond the scope of this study. As a result, our estimates reflect the best available aggregate data rather than granular, population-specific insights.

Several factors limit the precision of the estimated impact of a potential mandate for menopause-related treatment, care, and provider training. Diagnosis-based identification is limited by inconsistent documentation of menopause symptoms and varying coding practices from providers, affecting who appears in the data. Pharmacy claims do not have a diagnosis attached and the diagnosis is inferred based on a member's medical claims, likely overstating the cost. Additionally, focusing on those experiencing menopause aged 45-55 does not capture the full cost of services related to menopause as the age at which people experience menopause can vary widely [8] and symptoms can persist into postmenopause.[9] Restricting the data output from the MCDB to females may also impact the estimates due to treatment variations based on anatomy as mentioned in 1.1. The final language of any mandate will also influence its fiscal impact, including which services, drugs, and provider types are covered.

Policy levers such as cost sharing and UM introduce further variability. While cost sharing requirements can be limited under a mandate, federal rules restrict eliminating cost sharing for members enrolled in high-deductible health plans with HSAs. Claims data inherently does not enable full visibility into existing UM. Although carriers and experts noted that some drugs face prior authorization and/or step-therapy, the low volume and volatility of claims make it difficult to measure the full effect of these policies. Limited aggregated denial data suggests that relaxing UM would have a minor cost impact under current usage patterns, though uptake of newer therapies such as Veozah and Lynkuet remains uncertain.

Cost offsets tied to improved symptom management, productivity, or quality of life could occur but cannot be quantified in this analysis. Differences between Medicaid and commercial populations are also relevant. Medicaid members often face greater obstacles in accessing medical visits, which likely contributes to lower observed medical utilization relative to commercial populations even when pharmacy use is similar.

The impact of required provider training is also difficult to quantify. The content and intensity of training programs remain unknown, and it is unclear how training would alter provider knowledge, counseling patterns, prescribing behavior, or comfort in managing menopause. Any changes in utilization would be inextricably linked to other factors, including evolving clinical guidelines and market uptake of new therapies. As a result, the potential cost of training-related effects cannot be reliably measured.

The COVID-19 Public Health Emergency Medicaid continuous coverage and subsequent continuous coverage unwinding (MCCU) impacted enrollment and utilization from 2020 to 2024. Medicaid enrollees who had coverage extended (March 2020 to March 2023) and were disenrolled due to the MCCU (April 2023 to June 2024) likely had other insurance coverage that was primary, thus lowering their Medicaid claims. It is unclear how their utilization for menopause services will differ. In addition, for simplicity, members eligible for a partial month were counted as eligible for the entire month, which may slightly overstate the total member months.

Finally, insurance cost and retention levels are uncertain, and actual retention levels may differ from the simplified assumptions used in these insurance cost PMPM estimates. Deviations from these factors could materially affect the projected PMPM cost impacts.

Taken together, these limitations reflect that the results should be interpreted as directional rather than predictive. While the analysis provides a structured estimate of possible fiscal effects under a potential future mandate, substantial uncertainty remains due to coding variation, evolving utilization patterns, unknown market behavior for emerging treatments, and challenges in isolating the impact of provider training. Rising mandate-related costs may constrain some employers, particularly small firms, from offering comprehensive benefits or may lead to increased employee cost sharing. Over the past five years, the average annual premium for family coverage has increased by 24%, reflecting continued upward pressure on employer-sponsored health plan costs.[102] However, mandates can improve access to high-value medical services, which may enhance employee health, treatment outcomes, and productivity, potentially offsetting employer cost pressure over time.

# Appendix A Terminology

**Table 18 – Common Terminology[9]**

| Term | Acronym | Definition |
|---|---|---|
| Menopause | - | Menopause occurs when an individual with ovaries has gone 12 consecutive months without a period |
| Perimenopause | - | The transitional period leading up to menopause, often indicated by fluctuating hormone levels and irregular periods |
| Postmenopause | - | The time after a person with ovaries has undergone menopause |
| Hormone Therapy | HT | The use of systemic hormonal treatments (often estrogen and/or progestogens) to relieve menopausal symptoms |
| Vasomotor Symptoms | VMS | Symptoms of body temperature dysregulation, such as hot flashes and night sweats |
| Osteoporosis | - | Conditions related to low bone density, a common symptom of menopause |
| Genitourinary Syndrome of Menopause | GSM | An umbrella term for changes in the genital and lower urinary tract such as atrophy, dryness, and urinary disfunction, often due to low estrogen in individuals with menopause |
| Selective Serotonin Reuptake Inhibitor | SSRI | A prescription medication designed to treat anxiety and depression, which can also be used in the treatment of menopause |
| Selective Norepinephrine Reuptake Inhibitor | SNRI | A prescription medication designed to treat anxiety and depression, which can also be used in the treatment of menopause |
| Cognitive Behavioral Therapy | CBT | A structured, short-term psychological treatment that helps women manage hot flashes, night sweats, mood changes, and sleep disturbances by identifying and changing unhelpful thoughts and behaviors related to these symptoms |

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# Appendix B Comparison of State Legislation

**Table 19: Comparison of State Legislation: Menopause-Related Treatment, Care, and Provider Training**

| State | Effective Date | Required Legislation | Relation to Maryland |
|---|---|---|---|
| California[103] | N/A | *AB 432*; Requires continuing education for physicians and health insurance coverage without UM for FDA-approved HT, nonhormonal medications, medication for GSM, and one drug to prevent and treat osteoporosis. | Provider training and coverage of menopause-related treatments |
| Illinois[104] | January 1, 2026 | *HB 5295*; Coverage for provider-determined medically necessary FDA-approved hormonal and nonhormonal treatments. Medicaid coverage for medically necessary HT for hysterectomy-induced menopause. | Coverage of menopause-related treatments |
| New Jersey[105,106] | N/A | *A 5278 and SB 4148*; Requires coverage for medically necessary perimenopause and menopause treatments for state-regulated insurers and Medicaid. Coverage includes hormone and nonhormonal treatments including bioidentical hormone treatments, behavioral healthcare, PFPT, bone health treatments (screenings, drugs, supplements), preventive services (cardiovascular disease, osteoporosis, cancer), and menopause management counseling. | Coverage of menopause-related treatments |
| New Jersey[107,108] | Passed both houses, not yet enacted | *A 5309 and S 4147;* Would allow advanced practice nurses and physicians to receive up to three CME credits for menopause training. | Provider training |
| New York[109] | N/A | *A 5444A;* Requires coverage for perimenopausal and menopausal care and treatment for certain menopause-related symptoms (irregular menstruation, hot flashes/night sweats, chills, slowed metabolism, vaginal or bladder problems, decreased fertility, bone loss, increased cholesterol, and sleep disruption). | Coverage of menopause-related treatments |

| State | Effective Date | Required Legislation | Relation to Maryland |
|---|---|---|---|
| Louisiana[110] | August 1, 2024 | *HB 392, Act no. 784*; Requires coverage of all provider-determined medically necessary perimenopausal and menopausal care for Medicaid and commercially insured individuals without prior authorization or step-therapy. | Coverage of menopause-related treatments |
| Oregon[111] | January 1, 2026 | *HB 3064*; Requires coverage for FDA-approved HT, SSRIs/SNRIs, vaginal estrogen, drugs to prevent/treat osteoporosis, neurokinin B antagonists, topical HT, and bioidentical hormones. | Coverage of menopause-related treatments |
| Washington[112] | January 1, 2026 | *HB 1971*; Requires health insurers to cover 12-month refill of HT. | Coverage of HT |

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# Appendix C Carrier Survey

Maryland Health Care Commission

The Maryland General Assembly has tasked the MHCC with conducting a study to estimate the impact of mandating insurance coverage for the following two areas:

1. Requiring comprehensive insurance coverage for menopause-related treatment and care; and
2. Assessing the market impact of requiring clinicians to receive menopause-specific training.

The Maryland Health Care Commission (MHCC) has engaged BerryDunn to conduct a medical and social evaluation of these services, and to estimate potential cost impacts. This study is not yet associated with legislation.

This survey asks about current coverage practices and how insurers may respond if these services and training were to be required. Please note that neither MHCC nor BerryDunn take a position on whether these services should be required.

We appreciate your time and effort in completing this survey. Please return responses by October 3, 2025. Please direct survey responses to Jason Caplan, Chief of Special Projects of MHCC, jason.caplan3@maryland.gov and Dina Nash, Manager at BerryDunn, dina.nash@berrydunn.com.

Thank you for your input and support.

**Questions:**

1) Please tell us to what extent this type of care is already offered or covered by:
    a. Individual market
    b. Small group market
    c. Fully insured group market
    d. Self-insured group market
    e. State employee health plan
    f. Medicaid

2) Please complete the following table with how many people are enrolled in the following lines of business as of June 30th, 2025.

| Individual Market | Small Group Market | Fully Insured Group Market | Self-insured Group Market | State Employee Health Plan | Medicaid |
|---|---|---|---|---|---|
| | | | | | |

3) Please complete the following table with average monthly premium in the following lines of business as of June 30th, 2025.

| Individual Market | Small Group Market | Fully Insured Group Market | Self-insured Group Market | State Employee Health Plan | Medicaid |
|---|---|---|---|---|---|
| | | | | | |

For the following questions, please respond by market segment if possible.

4) Please describe any medical necessity criteria applied to services.

5) Please describe any coverage limitations, prior authorization requirements, or utilization management protocols associated with menopause-related treatment and care including:
    a. Treatments for alleviating vasomotor symptoms (e.g., hot flashes and night sweats) including standard treatments (both hormonal and nonhormonal); coverage for selective serotonin reuptake inhibitors (SSRIs), serotonin-norepinephrine reuptake inhibitors (SNRIs), gabapentin, and fezolinetant to treat vasomotor symptoms; and coverage for cognitive behavioral therapy (CBT) and clinical hypnosis to treat vasomotor symptoms

b. Treatments for genitourinary syndrome of menopause (GSM) including low-dose vaginal estrogen, vaginal prasterone, oral ospemifene, and nonhormonal vaginal moisturizers.
c. Standard treatments for menopause-related sleep disturbances as well as CBT and clinical hypnosis to treat sleep disturbance.
d. Standard treatments for menopause-related mood changes.
e. Standard treatments for menopause-related changes in sexual functioning.
f. Hormone replacement therapy (i.e., all FDA-approved treatments).
g. Treatment for other menopause-related conditions (e.g., osteoporosis, heart disease, etc.), or any other treatments not listed above.

If any limitations vary by age or gender, please include that information by treatment.

6) Does your organization anticipate an increase in utilization of menopause-related services expected if these services were to be required? If yes, please quantify and explain the observed or anticipated impact.

7) Does your organization currently track or identify claims associated with menopause-related treatment (e.g., through diagnosis codes, procedure codes, or internal flags)? If so, please describe how these claims are identified and whether that methodology would be used to monitor utilization.

8) Please describe the nature and volume of denied claims for menopause-related treatment and care for 2022, 2023, and 2024 (separated by year), including related grievances. If possible, please provide the associated diagnosis codes for the denials. If the reasons for denials were included, please provide this information.

9) Given your anticipated level of demand if these services were to be required, is there adequate availability of providers who deliver menopause-related treatment and care? How might the requirement for menopause-specific clinician training impact provider availability, access, or quality of care?

10) What operational, administrative, or data system changes would be necessary for your organization to comply if these services were required to be covered? Please estimate the anticipated implementation timeframe and cost if possible.

11) Please indicate how your cost sharing (including copays, coinsurance, or deductibles) would change if these services were required to be covered.

12) Please provide us with any general comments on requiring coverage of these services.

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