Congress of the United States

Washington, DC 20515

November 5, 2026

The Honorable Robert F. Kennedy, Jr.
Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

We write on behalf of patients, clinicians, researchers, and women's health organizations to urge the U.S. Department of Health and Human Services (HHS), including the Centers for Medicare & Medicaid Services (CMS), to address significant gaps in insurance coverage for pelvic floor physical therapy (PFPT) for individuals with endometriosis, chronic pelvic pain, and related pelvic floor dysfunction.

Specifically, we ask HHS to examine whether there is coverage parity for endometriosis-related pelvic floor physical therapy with requirements for postpartum pelvic floor physical therapy, and to and to clarify for public and private insurers that there should be parity in coverage for pelvic floor rehabilitation whether a patient is postpartum or impacted by endometriosis.

Endometriosis affects an estimated 8.3 million women in the United States and is a leading cause of chronic pelvic pain, infertility, and disability among reproductive-aged women.[1] Chronic pelvic pain affects an estimated 15–26% of U.S. women and is associated with substantial healthcare utilization, reduced workforce participation, and diminished quality of life.[2]

Despite its prevalence, endometriosis is associated with an average diagnostic delay of approximately 7–10 years. During this period, many patients experience repeated healthcare visits, multiple diagnostic evaluations, escalating pain, worsening functional impairment, and delayed access to effective treatment.

Improving access to evidence-based conservative and rehabilitative treatments, including pelvic floor physical therapy, may help reduce this downstream burden while improving function and quality of life.

Pelvic floor dysfunction is common among individuals with endometriosis and chronic pelvic pain. Pelvic floor muscle dysfunction, myofascial pain, muscle guarding, dyspareunia, urinary symptoms, bowel dysfunction, and neuromuscular pain can all contribute to the overall symptom burden experienced by these patients.[3]

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[1] Fuzak Nunziato M, Yan B, Schliep KC, et al. Endometriosis subtypes and risk of type 2 diabetes: the Advancing Research on Cardiovascular Health and Endometriosis Study (ARCHES) retrospective cohort study. Diabetologia. Published online August 6, 2026. doi:10.1007/s00125-026-06828-w

[2] As-Sanie S, Ross WT, Till SR. Evaluation and Treatment of Chronic Pelvic Pain. Obstet Gynecol. 2026;147(1):21-43.

[3] Fraga MV, Oliveira Brito LG, Yela DA, de Mira TA, Benetti-Pinto CL. Pelvic floor muscle dysfunctions in women with deep infiltrative endometriosis: An underestimated association. Int J Clin Pract. 2021;75(8):e14350.

Phan VT, Stratton P, Tandon HK, et al. Widespread myofascial dysfunction and sensitisation in women with endometriosis-associated chronic pelvic pain: A cross-sectional study. Eur J Pain. 2021;25(4):831-840.

The American College of Obstetricians and Gynecologists (ACOG) recognizes pelvic floor physical therapy as an important component of multidisciplinary treatment for chronic pelvic pain. ACOG further recognizes pelvic floor physical therapy and related interventions as treatment options for neuromuscular chronic pelvic pain and associated dyspareunia.[4]

Yet insurance coverage has not consistently evolved alongside the clinical understanding of these conditions, and there is particular concern about disparity between access to pelvic floor rehabilitation following childbirth and access following treatment for endometriosis. Limited data exists around coverage and access to this treatment.

Pelvic floor rehabilitation is commonly recognized as appropriate care for pelvic floor dysfunction associated with pregnancy, childbirth, and certain surgical procedures. Yet patients who experience significant pelvic floor dysfunction related to endometriosis—or following complex endometriosis excision surgery—may encounter visit limits, high cost-sharing, coverage denials, or difficulty locating an in-network pelvic floor physical therapist.

The underlying clinical need does not disappear because the cause of pelvic floor dysfunction is different.

A patient experiencing pelvic floor dysfunction after childbirth may require rehabilitation to restore strength, coordination, mobility, bladder and bowel function, and sexual function. A patient recovering from extensive endometriosis excision may require many of these same rehabilitative services, particularly when disease or surgery has involved the bowel, bladder, pelvic sidewall, pelvic nerves, reproductive organs, or surrounding musculature.

Federal policy for public insurers, and guidance to private insurers, should reflect functional impairment and medical necessity—not create different standards based primarily on how that impairment developed.

We therefore urge HHS to examine whether current coverage policies create an unintended disparity between postpartum pelvic rehabilitation and pelvic rehabilitation required following endometriosis treatment and excision surgery; and to clarify for public and private insurers that there should be parity in coverage for pelvic floor rehabilitation whether a patient is postpartum or impacted by endometriosis.

Sincerely,

Nikema Williams
Member of Congress

[4] Chronic Pelvic Pain: ACOG Practice Bulletin, Number 218 (2020). Obstetrics & Gynecology, 135(3), e98-e109.

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