PUBLICATION

Proposed Rule Will Allow Employers to Establish Stand-Alone Fertility Benefits

On May 13, 2026, the Internal Revenue Service, Department of Labor, and Department of Health and Human Services (collectively, the "Departments") published a Proposed Rule (https://www.federalregister.gov/documents/2026/05/13/2026-09479/excepted-fertility-benefits) (the "Proposed Rule") that will, if adopted, allow employers to offer fertility coverage as a "limited excepted benefit." An employer would be allowed to offer fertility coverage on a standalone basis, exempt from certain compliance requirements under such federal laws as the Portability rules under the Health Insurance Portability and Accountability Act ("HIPAA"), the Affordable Care Act ("ACA"), and the No Surprises Act.

Expanding Fertility Benefits Part of President's Agenda

The Department of Labor ("DOL") news release accompanying the Proposed Rule called it "a central component" of the Trump Administration's policy to expand access to fertility benefits by ensuring reliable and affordable access to in vitro fertilization ("IVF"). Over the past year, the Trump Administration has taken several actions to push its fertility benefits agenda.

On February 18, 2025, President Trump issued Executive Order 14216, "Expanding Access to In Vitro Fertilization," directing the Assistant to the President for Domestic Policy to provide policy recommendations for lowering costs and reducing barriers to IVF. Then, on October 15, 2025, the Trump Administration announced a two-part IVF initiative. First, the administration announced agreements with EMD Serono, a drug manufacturer, to offer certain fertility medications at discounted prices when sold to patients directly and on TrumpRx.gov. Second, the Departments issued FAQs declaring their commitment to exploring options for reducing IVF costs and encouraging the adoption of extensive fertility benefits. These FAQs clarified the existing categories of excepted benefits that employers can use to offer fertility benefits (e.g., independent, non-coordinated excepted benefits and limited excepted benefits).

Employer Coverage of Fertility Benefits

Although employer and employee interest in fertility benefits has grown over the past decade, many employer-sponsored group health plans do not cover fertility benefits. For the employers that do offer fertility benefits, the benefits are often carved out from major medical coverage and administered by specialty vendors (e.g., separate provider networks, separate deductibles and out-of-pocket limits) or offered as a health reimbursement arrangement ("HRA") that is integrated with major medical coverage (either the employer's own group health plan or other employer-sponsored coverage, such as the spouse's employer's group health plan coverage).

There are also gaps in mandated fertility benefits, as only a handful of states require health insurance coverage to include IVF benefits, and whether fertility benefits are required as an Essential Health Benefit ("EHB") depends on the state and issuer. Further, employer-sponsored self-funded group health plans are not subject to these insurance mandates or EHB requirements.

It is important to note that the Proposed Rule is not a mandate for employers to offer fertility benefits. However, the Departments state that creating the ability for employers to offer separate excepted fertility benefits that are exempt from various ACA market requirements will overall expand access to fertility by reducing the regulatory burden that may have been a barrier to more employers offering fertility coverage.

Current Excepted Benefits Rules

Currently, stand-alone fertility benefits are subject to various legal compliance obligations that must be taken into account when an employer designs its fertility benefit. For example, a stand-alone fertility benefit must comply with laws such as Employee Retirement Income Security Act of 1974 ("ERISA"), HIPAA Portability, and the ACA market reforms. Often, stand-alone fertility benefits often are not designed to satisfy ACA market reform requirements, such as covering preventive care (e.g., mammograms, etc.) without cost-sharing, providing dependent child coverage until age 26, and restrictions on annual and lifetime benefit limits. As a result, employers currently comply with the ACA by integrating their fertility benefit with an employer-sponsored major medical plan (i.e., limiting enrollment in the fertility benefit to those who are also enrolled in the employer's major medical plan).

In the preamble to the Proposed Rule, the Departments state that there may be scenarios where an employer wants to offer fertility benefits "without regard to whether their employees have other coverage at all, or without regard to whether their employees have coverage that is subject to and satisfies the market requirements"—and that this can be accomplished by categorizing certain fertility benefits as a "limited excepted benefit." Group health plan benefits that are deemed "excepted benefits" are not subject to the ACA market reform requirements, HIPAA Portability, and the No Surprises Act. Currently, the four statutory categories of excepted benefits are:

1. Excepted in all circumstances (e.g., automobile insurance, workers' compensation, AD&D);
2. Limited excepted benefits (e.g., limited scope dental or vision, long-term care) that are provided under a separate policy, or are not an integral part of the plan;
3. Independent, non-coordinated excepted benefits for specified disease/illness coverage or fixed indemnity insurance that meets certain conditions; and
4. Supplemental excepted benefits that are provided under a separate policy, certificate, or contract of insurance (e.g., Medigap).

The Proposed Rule would establish fertility benefits as a new type of limited excepted benefits (category 2 above) by amending the regulations regarding excepted benefits under ERISA, the Internal Revenue Code ("IRC"), and the Public Health Service Act.

What Benefits May Be Provided Through an Excepted Fertility Benefit?

The Proposed Rule states that coverage under an excepted fertility benefit is limited to benefits which are (i) for the diagnosis, mitigation, or treatment of infertility or infertility-related health conditions, and (ii) provided by licensed medical professionals. The Departments clarify in the preamble to the Proposed Rule that the

definition of covered fertility benefits is intended to provide employers with flexibility to cover a "broad spectrum of treatments and interventions for infertility related and pre-conception care."

Note: The Proposed Rule does not limit fertility coverage to items and/or services that are for IRC section 213(d) medical care. Accordingly, it appears that an employer could cover fertility items and/or services beyond IRC section 213(d) medical expenses. In other words, an employer's limited excepted fertility benefit could potentially cover fertility services and/or items that are for IRC section 213(d) medical care, as well as taxable fertility benefits such as long-term egg preservation. More guidance on this issue from the Departments would be welcome.

Lifetime Dollar Limits

Under the Proposed Rule, the total lifetime benefit per participant is $120,000. For plan years beginning after December 31, 2027 (i.e., January 1, 2028 for calendar year plan years)—this maximum lifetime limit would be indexed for medical inflation.

Note: It is not clear whether the $120,000 lifetime limit applies on a plan-by-plan basis. For example, could an individual participate in different employer-sponsored excepted fertility benefits (e.g., a current employer and a former employer's excepted fertility benefit plan) and incur up to $120,000 under each plan? Further guidance on this issue would be welcome.

Not an Integral Part of the Plan

Under the Proposed Rule, the fertility benefit must: (1) be provided under a separate policy, certificate, or contract of insurance, or (2) otherwise not be an integral part of the plan. A fully-insured fertility policy would be able to satisfy the first test, but self-funded fertility coverage would need to satisfy the second test. To be considered "not an integral part of the plan," the Proposed Rule requires the employer to offer a group health plan that is not limited to excepted benefits and that is not an HRA or other account-based group health plan to fertility plan participants. The Departments state that participants are not required to enroll in the other group health plan coverage—merely that the employer makes such other group health plan coverage available.

Note: We suspect that offering an individual coverage health reimbursement arrangement ("ICHRA") would not satisfy the "not an integral part of the plan" requirement of the Proposed Rule. Further, the preamble to the Proposed Rule states several times that only individuals who are offered "the traditional group health plan" would be eligible for the excepted fertility benefit.

Notice Requirements

An employer that sponsors an excepted fertility benefit is required to provide "notice" of this benefit to participants and beneficiaries. The Proposed Rule's notice requirement is meant to function as a "quick reference guide" for excepted fertility benefits.

- *Content*. The notice must be written to be understandable to the average plan participant and include: (i) a summary of benefits and a description of coverage limits (including the lifetime dollar amount limit established by the plan); (ii) information regarding network providers; and (iii) claims submission procedures.
- *Timing*. The plan sponsor must provide this notice no later than the first date on which the participant and/or beneficiary is eligible to enroll in plan coverage as well as annually thereafter (e.g., at open

enrollment). Further, the notice must be provided upon request.

- *Distribution*. The plan sponsor can satisfy the notice distribution requirements by providing the notice to the participant and any beneficiaries at the participant's last known address. However, if the beneficiary's last known address is different from the participant's last known address, then a separate notice must be provided to the beneficiary.
- *The notice may be provided with other ERISA-required materials.* For example, if multiple documents are provided as part of an open enrollment packet, the excepted fertility benefits notice may be included as part of that packet.

This new notice requirement is in addition to the plan sponsor's normal ERISA obligation to provide plan participants with a copy of an ERISA summary plan description for the fertility benefit.

Health Savings Account Implications

Under the IRS rules governing Health Savings Account ("HSA") eligibility, a participant cannot be covered under non-High Deductible Health Plan coverage prior to meeting their statutory deductible, with the exception of preventive care, permitted insurance, and permitted coverage which may be offered on a first dollar basis. Excepted fertility benefits do not fall under these exceptions, because these benefits do not qualify as preventive care, permitted insurance or permitted coverage). Accordingly, in order to avoid becoming HSA-ineligible, a participant must satisfy their statutory deductible before gaining access to the excepted fertility benefit.

Excepted Fertility Benefits Will Still Be Subject to Other Laws

Excepted benefits, including the new excepted fertility benefit, are still required to comply with other laws that apply to group health plans such as COBRA continuation coverage, HIPAA privacy and security, and other ERISA requirements (e.g., summary plan descriptions, claims and appeals procedures, etc.).

Conclusion

It remains to be seen whether the Proposed Rule, if adopted, will prompt employers to adopt or expand fertility benefits for employees. For employers that already provide fertility benefits through their major medical plans and/or through fertility HRAs, it is unclear whether an employer would terminate their existing fertility arrangement in favor of an excepted fertility benefit program that has set dollar limits, or adopt an excepted fertility benefit to supplement their existing fertility coverage. Further, the Proposed Rule indicates that employers would still need to offer participants a traditional group health plan; therefore, the new rule would not help small employers provide fertility benefits unless they already offer other health coverage.

Excepted benefit status may assist employers who sponsor a fertility HRA to avoid the ACA-HRA integration rules (i.e., the rules requiring the HRA to integrate with other major medical plan coverage). However, to date, this integration requirement has not been a significant hurdle since these rules allow integration with any employer-sponsored plan (including employees who waive the employer's major medical plan in favor of other employer-sponsored major medical plan coverage through a spouse, etc.). Lastly, aside from supposed cost-savings gained by avoiding regulatory compliance requirements, such as ACA market reforms, the new excepted fertility benefit does not address the cost of providing fertility benefits. Although the Proposed Rule would provide more flexibility to employers in offering fertility benefits, we will have to wait and see whether this new excepted benefit pathway is persuasive to employers that are on the fence about offering fertility benefits.

