



July 8, 2026

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration, Room N-5653
Attention: File Code 1210-AC40
U.S. Department of Labor
200 Constitution Avenue NW
Washington, DC 20210

Re: Comments on Proposed Rules for Excepted Fertility Benefits (RIN 1545-BS02; RIN 1210-AC40; RIN 0938-AV94)

Dear Secretary Aronowitz, Chief Executive Officer Bisignano, and Secretary Kennedy:

Americans for IVF respectfully submits these comments in response to the proposed rules published by the Department of the Treasury (Internal Revenue Service), the Department of Labor (Employee Benefits Security Administration), and the Department of Health and Human Services (Centers for Medicare & Medicaid Services) (collectively, the “Departments” or “tri-agencies”) on May 13, 2026, titled “Excepted Fertility Benefits” (the “Proposed Rule”).

Americans for IVF (“AIVF”) is a national advocacy organization dedicated to expanding access to fertility treatment and advancing policies that support individuals and families struggling with infertility, and ensuring that they have access to affordable fertility treatments, including in vitro fertilization (“IVF”). AIVF works with patients, physicians, employers, insurers, policymakers, and other stakeholders to develop practical, market-oriented solutions that increase access to fertility care, including IVF.

We highly commend the Departments for this historic and thoughtful proposed rulemaking. The decision to establish fertility benefits as a new category of limited excepted benefits represents a landmark step forward in the Administration’s commitment to expanding access to fertility treatments, including IVF, and making parenthood more attainable for millions of American families. This initiative is a powerful embodiment of President Trump’s Executive Order 14216’s directive to provide support, awareness, and access to affordable fertility treatments, including reliable access to IVF treatment, by easing unnecessary statutory or regulatory burdens.

We are particularly gratified to see the Departments embrace a flexible, employer-friendly framework that reduces regulatory burden while preserving meaningful coverage options,

including IVF. The Proposed Rule's alignment with Executive Order 14192's deregulatory goals, by offering employers a streamlined pathway outside the full market requirements of ERISA Part 7, Chapter 100 of the Code, and Title XXVII of the PHS Act, is commendable and can encourage broader adoption.

Broader fertility coverage can create a virtuous cycle: when patients have earlier and more consistent access to treatment, providers can follow evidence-based protocols that reduce the need for higher-risk interventions, resulting in fewer multiple births, fewer complications, and lower overall healthcare costs. In turn, expanded coverage in the fertility market, with increased patient access and utilization, will also encourage more providers to enter the field, expand capacity, and compete on quality and efficiency, improving outcomes while helping to control costs.

AIVF is honored to have engaged with the White House and key policymakers on strategies to expand IVF access, including through regulatory reform and voluntary engagement with insurers. We believe this rulemaking, combined with complementary initiatives, can deliver highly consequential results for American families. AIVF is deeply appreciative of President Trump's leadership on fertility policy. Through Executive Order 14216, efforts to reduce the cost of fertility medications, and support for innovative regulatory solutions such as the Proposed Rule, this Administration has elevated infertility and IVF access to a level of national policy attention that is without modern precedent. These unparalleled actions have created meaningful opportunities to expand access to fertility care for millions of Americans.

We are gratified that IVF coverage is proposed to be a core component of the excepted fertility benefit framework. Executive Order 14216 specifically calls for expanding access to IVF and reducing out-of-pocket and health plan costs for IVF treatment. Any regulatory pathway that does not clearly encompass IVF or that allows benefit designs to exclude IVF, would fall short of the Administration's stated objectives and would have limited practical value to the millions of families for whom IVF is the only viable path to parenthood.

While AIVF strongly supports the Proposed Rule's framework, we encourage the Departments to recognize that the excepted-benefit pathway may not, by itself, produce broad near-term adoption without complementary insurer engagement and market-participation strategies. Because the Proposed Rule creates a voluntary pathway rather than a coverage mandate, the Departments should not assume that establishing the excepted-benefit category alone will produce offer rates comparable to dental or vision coverage.

- a) For self-insured employers, the Proposed Rule may offer little incremental value, as there is nothing in the excepted benefit framework that would materially change the economics or administration of benefits they are already providing (or not providing). The primary use case for the excepted fertility benefit is to extend coverage to individuals not already enrolled in the employer's group health plan, which is a relatively narrow population and not a driving concern for most self-insured plan sponsors.
- b) For fully insured plans, we are concerned that carriers will struggle to price excepted fertility benefit products at a level most employers would find attractive enough to

contribute toward, given the actuarial challenges of a benefit that attracts predominantly high-utilization enrollees. These concerns inform several of our responses below.

International comparisons suggest that fertility-treatment utilization will increase substantially when financial barriers to care are reduced. Countries and regions that provide broader insurance coverage for fertility care generally experience substantially higher utilization rates than the United States, suggesting significant unmet demand remains among Americans who would pursue treatment if it were more affordable. In the U.S., approximately 9.7 million women experience impaired fecundity, yet fewer than 390,000 ART cycles were performed in 2023. This indicates that only a fraction of Americans who could potentially benefit from fertility treatment are ultimately able to access it.

By comparison, the European Society of Human Reproduction and Embryology (ESHRE) has reported that utilization rates in certain European jurisdictions with broader access to fertility treatment exceed historical U.S. utilization levels by a significant margin.¹

Japan also provides a recent example. In April 2022, to boost birth rates, Japan expanded public health insurance coverage for assisted reproductive technology (ART), including IVF. Subsequent research found that ART utilization increased following the coverage expansion, particularly among younger patients, with one nationwide study reporting a 22.9% increase among patients aged 25–34. Researchers concluded that insurance coverage improved patient access to ART services and reduced financial barriers to treatment. These findings support the principle that reducing the cost of fertility care can meaningfully increase utilization and help more individuals and couples pursue parenthood.²

These comparisons suggest that substantial unmet demand for fertility care remains in the United States, and that reducing coverage barriers can meaningfully expand access. Importantly, the economics strongly support such an approach. AIVF commissioned Avalere Health, a nationally recognized healthcare policy and actuarial consulting firm, to study this issue. Avalere estimated that by leveraging the economics of a diverse risk pool, broad IVF coverage would increase premiums by approximately **\$0.58 per member per month**.³ This finding demonstrates that one of the most common concerns raised regarding IVF coverage—cost—would be substantially less significant than often assumed when coverage is offered across a broad risk pool. Given the relatively limited premium impact and the profound life-changing benefits provided to families struggling with infertility, the Administration should view broad insurer engagement as a practical and highly attainable mechanism for expanding access to fertility care.

Avalere’s analysis for AIVF estimates that expanded coverage would result in thousands of additional American babies per year. That estimate is consistent with international experience, showing that when financial barriers to fertility treatment are reduced, utilization increases and more individuals can pursue family-building through fertility care.

¹ <https://pmc.ncbi.nlm.nih.gov/articles/PMC10504530/>

² https://keio.elsevierpure.com/en/publications/impact-of-insurance-coverage-on-access-to-assisted-reproductive-t/?utm_source=chatgpt.com

³ <https://americansforivf.org/wp-content/uploads/2024/09/Americans-for-IVF-Econ-Analyses-2-2.pdf>

All of this reinforces the case that the regulatory framework established by the Proposed Rule should be complemented by **direct engagement with major health insurance companies to encourage the voluntary adoption of *comprehensive* fertility coverage that includes IVF.** The Departments, in coordination with the White House, should actively convene national and regional carriers, explain the regulatory pathway created by the final rule, and urge them to offer meaningful fertility benefit offerings rather than merely preserving the option to provide them.

Indeed, the Administration's recent highly successful and unprecedented TrumpRx and drug pricing efforts demonstrate that focused federal engagement can secure voluntary industry commitments that materially reduce out-of-pocket costs for families. A comparable engagement strategy with insurers would profoundly help translate the Proposed Rule from a permissive regulatory framework into meaningful comprehensive coverage and real-world access to care.

Infertility imposes far-reaching emotional, medical, and financial burdens on millions of Americans. For many families, IVF is not elective or optional care: it is the only realistic pathway to having biological children. Expanding access to fertility treatment advances family stability, mental health, workforce participation, and long-term demographic and economic strength. At a time when the United States continues to experience historically low birth rates and fertility rates below replacement level,⁴ policies that help individuals and couples overcome infertility and achieve their desired family size carry broader societal significance as well. While expanding fertility treatment alone cannot reverse this alarming demographic trend, reducing barriers to parenthood for Americans who wish to have children is a practical and family-centered response that supports both individual aspirations and the Nation's long-term demographic and economic vitality.

Engagement with insurance companies is currently, in our view, the most promising near-term pathway to broader fertility benefit access, and the excepted benefit framework should be seen as complementary to that effort. Together, these approaches can help ensure that the promise of the Proposed Rule is translated into essential and affordable access to fertility care for American families all across the nation.

1) Comments on Specific Areas Where Input is Solicited

a. Establishment of Excepted Fertility Benefits, Scope, and Dollar Limits. **Comment Solicited:** The Departments solicit comments on the proposal to establish excepted fertility benefits as a new category of limited excepted benefits, the scope of benefits, and the proposed \$120,000 lifetime dollar limit.

Response: AIVF strongly supports the establishment of excepted fertility benefits as a new category of limited excepted benefits. Approximately 60 percent of employers do not currently offer fertility benefits, indicating substantial room for expansion through voluntary market-based approaches such as the one proposed here. We firmly support the Departments' decision to allow a broad spectrum of treatments within the excepted fertility benefit, ranging from preventive care and initial diagnostic testing to more advanced treatments including IVF. We commend the Departments' recognition that excepted fertility benefits should include medically appropriate

⁴ https://www.cdc.gov/nchs/products/databriefs/db535.htm?utm_source=chatgpt.com

items or services targeted to address infertility-related reproductive health conditions, including underlying medical causes of infertility. This should include, where medically appropriate and connected to infertility or infertility-related reproductive health conditions, evaluation and treatment of conditions such as endometriosis and other reproductive health conditions that impair fertility, as well as medical and surgical treatment of underlying causes of infertility.

This approach recognizes that effective fertility treatment also requires addressing the root causes and underlying medical conditions contributing to infertility, including reproductive health conditions and male-factor infertility.

We also support the inclusion of fertility counseling and general education on fertility within the scope of permissible benefits. The flexibility of the Proposed Rule appropriately allows employers and issuers to structure benefit designs consistent with applicable law, medical standards, and organizational values while still expanding meaningful access to fertility care.

We urge the Departments to clarify in the final rule or accompanying guidance that the phrase “infertility-related reproductive health conditions” is intended to include diagnosis, mitigation, and treatment of conditions that directly impair fertility, such as endometriosis, tubal disease, ovulatory dysfunction, hormonal disorders, and male-factor infertility, when provided by licensed or authorized medical professionals. That clarification would make the rule more clinically coherent and more cost-effective: early diagnosis and treatment of underlying conditions may reduce unnecessary treatment escalation, improve the likelihood that IVF or other assisted reproductive technologies succeed when needed, and reduce avoidable complications, repeat procedures, and prolonged time to pregnancy. Such clarification would not require plans to cover every general reproductive-health service; rather, it would confirm that services targeted to infertility or infertility-related reproductive health conditions fall within the permissible scope of excepted fertility benefits.

We respectfully submit that IVF coverage is indispensable to the success of this regulatory framework. The Departments rightly rejected the alternative of limiting excepted fertility benefits to only diagnostic procedures and pre-IVF items and services. IVF is the treatment upon which many American families facing serious infertility challenges ultimately depend, including families experiencing diagnosed infertility, unexplained infertility, male-factor infertility, diminished ovarian reserve, tubal-factor infertility, endometriosis-related infertility, or other conditions for which lower-complexity interventions are ineffective or inappropriate. A benefit framework that permits plan designs excluding IVF would undermine the practical purpose of this rulemaking. We urge the Departments to make clear, whether in the final rule or in accompanying guidance, that excepted fertility benefits are intended to encompass IVF and that plan sponsors should be strongly encouraged to include IVF coverage within their benefit designs.

According to CDC data, 389,993 ART cycles were performed in the United States in 2023, reflecting continued growth in demand for fertility treatment nationwide.⁵ The volume of treatment cycles underscores that infertility is not a niche medical condition and that meaningful benefit limits are necessary if fertility coverage is to provide practical value to American

⁵ <https://www.cdc.gov/art/success-rates/index.html>

families. In addition, millions of Americans experience infertility or impaired fecundity. CDC data indicates that approximately 1 in 5 married women aged 15–49 with no prior births are unable to get pregnant after one year of trying, further demonstrating the substantial unmet need for fertility care and treatment.⁶

We support the proposed \$120,000 lifetime dollar limit. Fertility treatment often requires multiple treatment cycles, and many patients incur substantial costs before achieving a successful pregnancy. A lifetime limit set at this level is more likely to provide meaningful access to care than a lower cap that could be exhausted after only a small number of treatment attempts. The proposed limit appropriately balances affordability and flexibility while recognizing the clinical realities of infertility treatment. Importantly, the proposed limit provides sufficient flexibility to accommodate the wide variation in patient circumstances, treatment pathways, and clinical outcomes that characterize infertility care.

We would not oppose an alternative annual-benefit structure, provided that the cumulative maximum remains sufficient to support multiple treatment cycles when medically necessary. Likewise, we support indexing the limit using the medical care component of the Consumer Price Index for All Urban Consumers (CPI-U), although the Departments should continue to monitor whether a fertility-specific cost index becomes available in the future.

b. “Not an Integral Part of the Plan” Standard. **Comment Solicited:** The Departments solicit comments on the approach that participants need not enroll in the traditional group health plan to qualify for the fertility benefit.

Response: We strongly support the proposed standard allowing participants to access excepted fertility benefits without enrolling in the traditional group health plan. This is particularly important for participants covered under a spouse’s or partner’s plan. This approach mirrors health Flexible Spending Accounts (FSAs) and excepted benefit Health Reimbursement Arrangements (HRAs), and is a pragmatic, pro-family design choice.

c. Employee Premiums, Contributions, and Cost Sharing. **Comment Solicited:** The Departments solicit comments on whether plans and issuers should have flexibility to charge premiums or contributions and impose cost sharing.

Response: We recommend that plans and issuers retain flexibility to charge premiums or contributions and impose cost sharing. Prohibiting premiums would significantly reduce the number of employers willing to offer these benefits. The analogous limited excepted benefit categories (*e.g.*, dental, vision, and long-term care) all permit premiums and cost sharing and maintaining this consistency will promote broader adoption. At the same time, the Departments should monitor whether this flexibility results in products that are predominantly or exclusively employee-funded. If employees are expected to bear the full premium cost, standalone fertility coverage may function less like insurance and more like a tax-advantaged financing mechanism, limiting its practical effect for families who cannot afford treatment out of pocket. While we initially recommend full flexibility to charge premiums, this area should be monitored.

⁶ <https://www.cdc.gov/reproductive-health/infertility-faq/index.html>

d. Applicability Date. **Comment Solicited:** The Departments solicit comments on the proposed applicability date and whether the rules should instead be applicable upon the effective date of the final rules.

Response: We strongly recommend the earliest possible applicability date, ideally upon the effective date of the final rules. Many employers and specialty vendors are already structured to offer these benefits consistently with the Proposed Rule. Given the voluntary nature of the pathway, an immediate effective date simply provides optionality to early adopters, consistent with the Administration's deregulatory priorities.

e. Individual Market. **Comment Solicited:** HHS seeks comments on all aspects of the approach under consideration for the individual market.

Response: We strongly encourage HHS to finalize individual market standards for excepted fertility benefits. Extending this framework to the individual market would reach millions of Americans without employer-sponsored coverage, including self-employed individuals and gig workers. The approach HHS is considering (*i.e.*, applying the same scope, lifetime dollar limit, and notice requirements as in the group market) is sensible and workable. We note that voluntary insurer engagement is already underway, and a clear regulatory pathway would accelerate these efforts. As with the group market, we urge HHS to ensure that individual market excepted fertility benefits are designed to encompass IVF coverage.

f. Number of Affected Entities. **Comment Solicited:** The Departments seek comments on the number of affected entities and expected enrollment.

Response: The use of dental and vision offer rates as a proxy is not the best comparison given the substantially higher costs and smaller eligible population for fertility benefits. We are skeptical that self-insured plan sponsors, which represent the majority of covered lives, will adopt excepted fertility benefits in meaningful numbers through this pathway alone.

g. Number of Issuers. **Comment Solicited:** The Departments request comments on the number of issuers that might provide such coverage.

Response: We anticipate that major national health insurance companies that have shown willingness to engage on voluntary fertility coverage would likely participate if the Departments provide clear rules and actively encourage market entry. We eagerly encourage the Departments to engage directly with these entities to refine estimates, identify operational barriers, and secure voluntary commitments to offer meaningful products. Likewise, we encourage stakeholders, including insurers and the Departments, to work directly with existing fertility benefit companies (*e.g.*, Maven, Carrot, Progyny, etc.) which possess substantial operational experience in administering fertility benefits and may be helpful in expanding access while controlling costs.

2) Specific Regulatory Impact Questions

1. Does the offering of excepted benefits vary by plan sponsor size? We expect offering rates to vary significantly by employer size, with larger employers more likely to adopt initially.

Given the higher costs compared to dental and vision benefits, adoption rates for fertility benefits will likely be lower, particularly among smaller employers. In addition, larger employers generally possess greater administrative capacity and resources to evaluate and implement new benefit offerings. Note that once employers reach a few hundred employees, they are more likely to be self-insured for medical benefits.

2. Would employers that already offer fertility benefits choose instead to only offer this coverage through an excepted benefit? It is reasonable to expect that employers already offering fertility benefits will have limited incentive to migrate to the excepted benefit pathway, at least initially. These employers are offering benefits for talent-attraction and employee-retention purposes, and the Proposed Rule offers them little incremental value. The possibility exists that some employers facing cost pressures may move from a more robust self-insured arrangement to a limited excepted benefit, potentially depriving employees of more comprehensive coverage, including full IVF access. We recommend the Departments monitor this dynamic to ensure that the Proposed Rule expands access rather than unintentionally encouraging benefit reductions.

3. How many plans might be created? Would there be immediate mass adoption? We anticipate a gradual ramp-up. Early adopters may include smaller employers in states where fully insured benefits do not include a fertility mandate. Over time, adoption may increase as insurers develop standardized products, administrative processes mature, and employers become familiar with the regulatory framework.

4. How would State requirements impact employers' decision to offer the excepted benefit? A state-by-state analysis would need to be done to determine whether a fully insured excepted benefit fertility policy issued in a state that has an existing fertility mandate must comply with such state laws, although we suspect in many cases that will be the case. In order to ensure meaningful coverage, we would encourage the Departments to require that any excepted fertility benefits provided under the Proposed Rule meet at least those standards set by state mandates with respect to comprehensive plans. Additionally, it is worth noting that even in states that currently mandate fertility coverage, the Proposed Rule may lead to offerings with increased coverage beyond what is state mandated, including enhanced or supplemental fertility benefits that expand access beyond state-law minimum requirements. Overall, however, we anticipate that employers with fully insured plans in states that mandate fertility coverage may be more inclined to determine that existing state-mandated coverage in their comprehensive fully insured medical plans sufficiently address employee needs, which could reduce demand for separate excepted fertility benefit offerings in those respective states.

5. What share of premiums would plan sponsors contribute? We question whether carriers will price these products at levels most employers would find attractive enough to subsidize. We expect many employers will offer the benefit on a fully employee-funded basis, if at all. This is particularly concerning with respect to IVF coverage: if employer contributions are absent, the premium cost of a plan that includes IVF may be prohibitive for many employees, limiting the real-world impact of the benefit. As the above-mentioned Avalere study showed, when this benefit is offered broadly, the per member per month cost falls significantly. This reinforces the need for the Departments to encourage broad-based carrier participation and employer

contributions, rather than relying solely on narrow, employee-pay-all products that may attract only those already expecting immediate high-cost utilization.

6. What is the expected take-up rate if premiums approach the full cost of treatment? Take-up will be limited to those employees who see a tax advantage in paying for coverage pre-tax rather than post-tax. If premiums are set near the cost of IVF treatment itself, the benefit becomes little more than a tax-advantaged savings vehicle, rather than an insurance product designed to achieve the core objectives of risk pooling and expanding access. In that scenario, enrollment would likely be limited and the overall impact on access to fertility care would be substantially reduced, which is inconsistent with the objectives reflected in Executive Order 14216.

3) Plan Design and Utilization

Comment Solicited: The Departments request comments on potential plan design and utilization.

Response: Adverse selection is a real concern, and we encourage the Departments to explore enrollment mechanisms that mitigate it, such as waiting periods, tiered benefit structures, or coupling enrollment with major medical open enrollment. We note that plan designs that exclude IVF will attract a different (and potentially less commercially viable) risk pool than those that include it, since IVF is the benefit that most enrollees will be seeking. Plans that include IVF coverage may benefit from a more predictable utilization pattern. In other words, because IVF is the primary coverage sought by most prospective enrollees, benefit designs that clearly include IVF may ultimately produce more stable and predictable enrollment behavior than partial-benefit designs that create uncertainty regarding meaningful access. From a workforce capacity perspective, many areas of the U.S. already experience meaningful delays to see a Reproductive Endocrinologist (REI). Fertility treatment is highly time-sensitive, and interruptions in coverage or treatment continuity can materially reduce clinical success rates, particularly for women of advanced maternal age. Regulatory frameworks and plan designs that facilitate stable, continuous access to fertility care are therefore especially important. Plan designs should consider referral pathways that allow general OB/GYNs to perform initial evaluations and low-complexity procedures, with escalation to REI specialists for IVF and advanced care.

4. Quantification of Health Benefits. **Comment Solicited:** The Departments request comment on data that might allow quantification of benefits.

Response: Comprehensive state IVF insurance mandates are associated with greater IVF utilization and more favorable IVF practice patterns and outcomes. In a 2022 study of 2018 CDC-reported IVF cycles, Peipert et al. found that IVF utilization was 132% higher in states with comprehensive mandates than in noncomprehensive states after age adjustment. The study also found higher live birth rates per cycle, lower multiple birth rates, and fewer embryos transferred per transfer in comprehensive-mandate states. These findings suggest that coverage may support safer, more evidence-aligned embryo-transfer practices by reducing financial pressure to transfer multiple embryos in a single cycle, although the study establishes association

rather than causation.⁷ Expanded access to IVF may also reduce reliance on certain non-IVF fertility treatments, including ovarian stimulation with or without intrauterine insemination (IUI), that can carry a higher risk of multifetal gestation. To the extent coverage supports access to IVF and evidence-based embryo-transfer practices, it may help reduce avoidable multiple pregnancies and associated maternal, fetal, neonatal, and health-system costs. Research also links persistent infertility with increased mental-health medication use and increased divorce risk. Expanded access to fertility treatment may help mitigate these harms for many families by reducing financial barriers to timely, clinically appropriate care.⁸

5. Employee Tenure and Productivity. **Comment Solicited:** The Departments request comments on quantifying tenure and productivity benefits.

Response: Research indicates that workers whose plans covered IVF were more likely to remain in their job long-term and recommend their employer. There are also downstream cost savings from coverage designs that support evidence-based fertility care, including single-embryo transfer where clinically appropriate, resulting in more singleton births, fewer preterm births, and reduced neonatal intensive care stays.

6. Administrative Expenditures. **Comment Solicited:** The Departments request comments on average administrative expenditures.

Response: Administrative costs will vary based on whether the employer uses an existing specialty vendor or builds a new plan. The existing vendor ecosystem suggests costs for most adopters will be manageable. Advances in AI and automation in fertility care, particularly in embryology, treatment planning, and tele-fertility, may further reduce administrative and clinical coordination costs over time.

7. Employer Contributions. **Comment Solicited:** The Departments request comments on the share of employers that might contribute toward premiums.

Response: The fundamental challenge is pricing. Fertility benefits carry per-claimant costs orders of magnitude higher than dental or vision, and the enrollee pool will be heavily skewed toward high-utilizers. Carriers face a difficult choice between actuarially sound premiums that are too expensive for most employers to subsidize, or artificially low premiums that create unsustainable loss ratios. We anticipate most employers who offer the benefit will do so on a fully employee-funded basis, which makes the inclusion of IVF in plan designs even more important. If employees are bearing the full cost, the benefit must be valuable enough to justify enrollment, and IVF is the benefit that most prospective enrollees will be seeking.

8. Adverse Selection. **Comment Solicited:** The Departments request comments on the extent to which issuers and participants would offer and enroll.

⁷ <https://pubmed.ncbi.nlm.nih.gov/35283088/>

⁸ Striking costs of infertility point to importance of IVF access and affordability | Stanford Institute for Economic Policy Research (SIEPR)

Response: Adverse selection is a legitimate concern. Mitigating factors include the lifetime dollar cap, waiting periods, and the possibility of employer-subsidized broad enrollment. The insurance industry has experience managing adverse selection in analogous standalone categories. The key to viable risk pools will be broad enrollment and appropriate premium structures, both of which are more achievable when the benefit includes IVF, the coverage that drives enrollment interest.

9. Offer Rates. **Comment Solicited:** The Departments request comments on employer offer rates.

Response: The excepted fertility benefit pathway may appeal primarily to employers who do not currently offer fertility coverage and find the reduced regulatory burden attractive.

10. Migration from Existing Plans. **Comment Solicited:** The Departments request comments on the likelihood of employers moving existing fertility coverage to excepted benefit plans.

Response: We do not expect significant migration. Employers offering robust fertility benefits, including IVF, through major medical plans are doing so for talent-attraction and retention purposes, and the Proposed Rule offers them little incremental value. Respectfully, the Proposed Rule solves a problem these employers do not have. Should migration occur, participants could lose ACA market reform protections, and we recommend the Departments monitor this dynamic.

11. State Insurance Requirements. **Comment Solicited:** The Departments seek input on the effects of State insurance requirements.

Response: Fully insured plans in states that mandate IVF coverage would generally not utilize the excepted benefit pathway. Self-insured plans in those states not subject to state mandates represent an opportunity. States that mandate fertility care but not specifically IVF may see employers use the excepted benefit pathway to add IVF-specific benefits, which would be a positive outcome consistent with the goals of Executive Order 14216.

Conclusion

AIVF commends the Departments for this groundbreaking Proposed Rule. It represents a meaningful, flexible, and legally sound approach to expanding fertility coverage, including IVF, for millions of Americans. We urge prompt finalization with the earliest possible effective date, extension to the individual market, and clear guidance that excepted fertility benefits are intended to encompass IVF coverage and medically appropriate diagnosis, mitigation, and treatment of infertility-related reproductive health conditions, including conditions such as endometriosis when directly connected to infertility.

We also urge complementary attention to workforce capacity and voluntary insurer engagement to ensure that coverage expansion delivers real, timely, and equitable access to fertility care for all American families. In particular, the Departments should actively engage major insurance carriers, as the Administration has successfully done with industry participants in connection

with TrumpRx and drug pricing efforts, to encourage prompt, meaningful product offerings under the final rule.

At the same time, we respectfully caution that without addressing the fundamental pricing and adverse selection challenges inherent in standalone fertility coverage, the Proposed Rule may not produce the breadth of employer adoption the Departments anticipate, making it all the more important that complementary strategies be pursued in parallel.

Nevertheless, if paired with thoughtful implementation, voluntary insurer participation, and continued engagement with employers and other stakeholders, the Proposed Rule has the potential to significantly expand access to fertility care and help more Americans achieve their dream of building a family. AIVF stands ready to assist the Departments in that effort and appreciates the opportunity to provide these comments

Respectfully submitted,



Rabbi Moshe Margaretten⁹
Chairman
Americans for IVF (AIVF)

⁹ AIVF wishes to express enormous gratitude to Alan Hahn, Esq., Dr. Kaylen Silverberg, M.D., and Dr. Joshua Klein, M.D., for their instrumental assistance and counsel to formulate this letter. We also thank the other members of its Advisory Board for their invaluable input and guidance.