

The Honorable Dr. Mehmet Oz
Administrator
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244

The Honorable Keith Sonderling
Acting Secretary
Department of Labor
200 Constitution Ave. NW
Washington, DC 20210

The Honorable Scott Bessent
Secretary
Department of the Treasury
1500 Pennsylvania Ave. NW
Washington, DC 20210

July 13, 2026

Submitted electronically via: www.regulations.gov

RE: Excepted Fertility Benefits; Proposed Rules with Comment Period (RIN 1210-AC40, Docket EBSA-2026-0232)

Dear Administrator Oz, Acting Secretary Sonderling, and Secretary Bessent:

On behalf of the Fertility Providers Alliance (FPA), we appreciate the opportunity to comment on the proposed rule governing Excepted Fertility Benefits. FPA is a non-profit business association founded in 2020 representing fertility care providers, private clinics, and the patients they serve. Our mission is to advance, inform, and support the activities of fertility care providers across the United States who deliver critical reproductive medical services to patients experiencing infertility, a recognized medical condition affecting millions of Americans.

FPA's board includes leadership from some of the largest fertility care networks in the United States, collectively representing hundreds of clinic locations across dozens of states. The field is small and specialized: CDC's National ART Surveillance System reported data from 457 fertility clinics performing assisted reproductive technology nationally in 2022, the most recent year for which complete national data has been published¹. FPA's membership includes leadership from a substantial share of that specialized field.

FPA shares the Administration's commitment to expanding access to fertility care, reflected in Executive Order 14216, "Expanding Access to In Vitro Fertilization,"² and in this proposed rule's aim to give employers a new, lower-barrier way to offer fertility benefits. Our members are on the front lines of infertility care and see daily both the promise of expanded coverage and the consequences of coverage that is inadequately defined. We offer the following recommendations in that spirit, to help ensure the final rule delivers the durable, meaningful access to care that the Administration and our members both want to see.

¹Centers for Disease Control and Prevention, National ART Surveillance System (NASS), 2022 National Summary Report (Div. of Reproductive Health, 2024) (reporting 435,426 ART cycles performed on 251,542 unique patients at 457 reporting fertility clinics nationally in 2022, the most recent year for which complete national data has been published).

²Exec. Order No. 14216, "Expanding Access to In Vitro Fertilization," 90 Fed. Reg. 10,451 (Feb. 24, 2025).

The Final Rule Should Define the Benefit by Clinically Appropriate Cycles of Care, Not an Arbitrary Dollar Cap

Infertility treatment is rarely a single intervention. It is a continuum of care that can include diagnostic workups, ovarian stimulation with specialized medications, monitoring, surgical retrieval, laboratory and embryology services, and, for many patients, more than one treatment cycle. A single IVF cycle in the United States commonly costs between \$12,000 and \$25,000³, and most patients require more than one cycle to achieve a live birth, meaning cumulative treatment costs frequently exceed \$40,000 before accounting for donor gametes, additional genetic testing, or fertility preservation.

FPA is not asking the Administration to remove limits on this benefit. We are asking that whatever limit the final rule adopts be tied to medical necessity rather than an arbitrary number, so that patients and employers alike have a predictable, defensible standard. A fixed dollar figure, however calculated, can be exhausted well before treatment is clinically complete for one patient while leaving room to spare for another with the identical diagnosis, not because one patient needed more care, but because of cost factors, donor gametes, additional testing, that have nothing to do with medical necessity. Many existing state mandates avoid this problem by defining the benefit in terms of a minimum number of completed treatment cycles, rather than, or in addition to, a dollar figure.

FPA recommends the final rule adopt a similar approach: a benefit defined primarily by a clinically appropriate minimum number of completed cycles of care, determined in consultation with the treating physician, rather than a dollar cap alone.

If the Administration nonetheless retains a dollar-based limit, either as the primary structure or as a backstop alongside a cycle-based minimum, FPA urges that it be set at a level sufficient to support that same clinically appropriate course of care, and specifically to complete the number of cycles the treating physician determines is medically necessary, rather than a figure that reflects a single, best-case treatment path. A cap that is exhausted before treatment is complete creates the appearance of coverage without its substance, and risks leaving patients who began treatment in reliance on this benefit exposed to exactly the financial barrier the rule is meant to remove.

The Final Rule Must Not Allow Excepted Benefits to Displace Existing State-Mandated Coverage

As of January 2026, 25 states and the District of Columbia mandate some level of private insurance coverage for fertility care, 15 of which specifically require coverage for IVF, and 21 states and the District of Columbia require some coverage for fertility preservation⁴. As proposed, the rule creates a material risk that employers in these states could substitute a limited excepted benefit for existing comprehensive major medical fertility coverage, particularly for self-funded plans navigating a market-competitive need to offer some form of fertility coverage.

Without clarification, an excepted fertility benefit could be read as satisfying a state coverage mandate, allowing plans to sidestep the consumer protections that come with comprehensive coverage, including network adequacy standards, cost-sharing limits, and prompt payment requirements.

FPA recommends the final rule explicitly state that it does not preempt, override, or otherwise satisfy existing state-mandated coverage requirements, and that it establish a floor for benefit adequacy so excepted benefits function as a supplement to comprehensive coverage rather than a lower-cost substitute for it.

³Exec. Order No. 14216, “Expanding Access to In Vitro Fertilization,” 90 Fed. Reg. 10,451 (Feb. 24, 2025) (citing a per-cycle IVF cost range of \$12,000 to \$25,000). Independent cost analyses place the current national average nearer the higher end of that range once medications and standard lab services are included; see, e.g., Kaiser Family Foundation, Coverage and Use of Fertility Services in the U.S. (2025), noting that per-cycle costs have risen substantially since a 2009 baseline estimate of approximately \$12,500 and that most patients require more than one cycle to achieve a live birth.

⁴RESOLVE: The National Infertility Association, Family Building & Fertility Coverage: State Insurance Laws (data as of Jan. 1, 2026) (reporting that 25 states and the District of Columbia have enacted fertility insurance coverage laws, 15 of which specifically require coverage for IVF, and that 21 states and the District of Columbia have enacted fertility preservation coverage laws).

The Rule Should Define a Clear, Minimum Scope of Covered Services

The proposed rule does not define "infertility-related health conditions," leaving significant room for restrictive plan interpretation that could exclude conditions such as male factor infertility and endometriosis, or omit services such as fertility preservation.

FPA urges the Administration to establish a defined baseline of required covered services. At minimum, the final rule should specify inclusion of diagnostic evaluation, fertility preservation, ovulation induction, intrauterine insemination, in vitro fertilization, prescribed fertility medications, and the standard embryology, cryopreservation, and storage services associated with a covered treatment cycle. A defined scope gives patients, employers, and providers a shared, predictable understanding of what the benefit actually covers, and prevents the benefit from becoming nominal rather than meaningful.

The Final Rule Should Provide Clear Coordination-of-Benefits Guidance

The proposed rule does not address how an excepted fertility benefit should coordinate with major medical coverage when a service, such as diagnostic monitoring or bloodwork, is potentially payable under both. Left unaddressed, this ambiguity will produce claim disputes, payment delays, and administrative burden for providers, plans, and patients alike.

FPA recommends the final rule designate major medical coverage as the primary payer for services that overlap between the two, and establish a uniform coordination-of-benefits framework before the excepted benefit is widely adopted, rather than leaving this to be resolved plan by plan after adoption.

Root-Cause and Restorative Care Are Already Part of Comprehensive Fertility Treatment, and the Final Rule Should Reimburse Them as Such

FPA has closely followed the public comment record developing on this docket, where a substantial share of commenters have urged the Administration to ensure the final rule covers diagnostic and restorative approaches to infertility care, alongside a smaller number asking the Administration to build broad conscience-based exemptions into the rule for employers who do not wish to fund in vitro fertilization specifically. FPA offers the following perspective from our members' clinical experience on both points.

Diagnostic evaluation of underlying causes is a standard part of the care our members provide, and we support it being explicitly reimbursed as such. As a matter of standard practice, FPA members' evaluation of a new fertility patient includes hormonal evaluation, ultrasound assessment, and, where clinically indicated, diagnosis and treatment of underlying conditions such as endometriosis, polycystic ovary syndrome, and male factor infertility, before a course of treatment is recommended. In many cases, this workup and treatment resolves the underlying condition. In others, it identifies a condition, such as tubal factor infertility, severe male factor infertility, or age-related decline in ovarian reserve, that root-cause treatment alone cannot fully address, and for which in vitro fertilization is the clinically appropriate next step. IVF is frequently not a substitute for restorative care but its continuation, offered by the same physicians, for the patients whose diagnoses require it.

The timing of that continuum matters as much as its content. Patients age 35 and older already account for a majority of ART cycles performed nationally, and CDC's own surveillance data shows live birth rates per egg retrieval falling from 49.7% for patients under 35, to 36.3% for patients age 35 to 37, to 23.1% for patients age 38 to 40, to 7.7% for patients over 40⁵. For many patients, fully addressing an underlying condition, for example, through weight management, surgical treatment of endometriosis, or correction of a hormonal imbalance, can take months or even years. For some patients that timeline is compatible with their reproductive window. For others, particularly the many patients who are already in their late 30s or older by the time they seek care, it is not, and completing restorative treatment before proceeding to IVF would mean losing time those patients do not have, at potential cost

⁵Centers for Disease Control and Prevention, National ART Surveillance System (NASS), 2022 National Summary Report (Div. of Reproductive Health, 2024) (reporting that patients age 35 and older accounted for a majority of the 435,426 ART cycles performed nationally in 2022, and that live birth rates per intended egg retrieval decline from 49.7% for patients under 35, to 36.3% for patients age 35 to 37, to 23.1% for patients age 38 to 40, to 7.7% for patients over age 40).

to their ovarian reserve and their chances of success. This is precisely why the sequencing and pace of care must remain a clinical judgment made by the patient and their physician together, and not a pathway the final rule should assume applies uniformly to every patient.

The gap patients experience today is not a clinical one, it is a reimbursement one. Diagnostic and restorative services are often not separately covered under existing benefit structures, leaving patients to pay out of pocket for exactly the root-cause care commenters on this docket are asking the Administration to prioritize.

FPA supports explicitly including diagnostic evaluation and treatment of underlying reproductive health conditions within the scope of covered services outlined above, precisely because our members already provide this care and believe it should be reimbursed as the meaningful, medically necessary treatment that it is.

Because root-cause and restorative treatment and assisted reproductive technology are stages of a single continuum of care rather than competing alternatives, FPA would caution the Administration against structuring the final rule in a way that allows an employer to satisfy the fertility benefit requirement with diagnostic or restorative coverage alone, while excluding assisted reproductive technology entirely. Whatever an employer's reason for structuring benefits this way, the effect on the patient is the same: coverage that ends exactly where their treatment plan requires it to continue. Such a structure would leave patients who need IVF, often after months or years of root-cause treatment that did not resolve their diagnosis, without coverage for the very next step in their own care plan. The strongest version of this rule covers the full continuum of fertility treatment for the patients who need each stage of it, rather than treating restorative care and assisted reproductive technology as an either-or choice.

FPA would urge the Administration to ensure the final rule preserves the treating physician's and patient's discretion over the pace and sequence of care, rather than assuming a single pathway applies to every patient regardless of age or diagnosis. A mandatory sequence of that kind would risk costing time-sensitive patients their reproductive window while an underlying condition is addressed, as described above, and it would substitute a one-size-fits-all regulatory pathway for the individualized clinical judgment of licensed, board-certified reproductive endocrinologists and the patients in their care, who are best positioned to determine the appropriate pace and sequence of treatment for each patient's age, diagnosis, and ovarian reserve.

Conclusion

FPA supports the Administration's efforts to expand access to fertility care, and believes the recommendations above will help the final rule achieve that goal durably: a benefit defined by clinically appropriate cycles of care rather than an arbitrary dollar cap, protection for existing state coverage frameworks, a clearly defined scope of covered services, workable coordination-of-benefits guidance, and a definition of covered care that adds options for patients without narrowing access to established, evidence-based treatment. FPA and our member providers, who treat patients navigating infertility every day, are glad to serve as a resource to the Administration as this rule is finalized.

Respectfully submitted,

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President
Fertility Providers Alliance