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July 10, 2026

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

Re: Excepted Fertility Benefits (CMS-9879-P)

Dear Secretary Kennedy:

For over 57 years, the National Health Law Program (NHeLP) has advocated, educated, and litigated to preserve, protect, and expand access to health care for low-income and underserved populations. We appreciate the opportunity to comment on this notice of proposed rulemaking that would amend the regulations regarding excepted benefits under the Employee Retirement Income Security Act of 1974, the Internal Revenue Code, and the Public Health Service Act to designate certain fertility benefits as a new category of limited excepted benefits.[1]

The administration has touted this Proposed Rule as a solution to the widespread problem of lack of insurance coverage of fertility services. However, the proposal seems to target large employer insurance, which represents only a portion of the U.S. health care system. Moreover, large group employers are already more likely than small group employers to include fertility benefits in their employer-sponsored health plans.[2] In fact, the Proposed Rule creates a disincentive to cover assisted reproduction since excepted benefits are traditionally not subsidized by the employer. The Department of Labor, the Department of the Treasury, and the Department of Health and Human Services (hereinafter "the Departments") admit that this Proposed Rule will lead to a drop in coverage since health care plans

will likely remove the coverage they already pay for to instead offer fertility benefits through an excepted benefit plan.[3] They also concede that several employers might not offer these benefits because of religious objections.[4] As such, the impact of this rule will be minimal for most enrollees of employer plans.

Classifying fertility services as excepted benefits will have no discernible impact, and perhaps negative consequences, on access to these services for low- and middle-income individuals receiving coverage through the individual and small group markets. The Proposed Rule could disrupt access to fertility services by interfering with current efforts to include these services in individuals and small group markets as an Essential Health Benefits (EHB), which represents an important tool to address lack of coverage of fertility services. For these reasons, we urge the Departments to withdraw the Proposed Rule and instead utilize mechanisms that would ensure that low- and middle-income individuals have access to IVF, including through the EHB process.

Classifying fertility services as excepted benefits would not improve coverage for low- and moderate-income enrollees in individual and small group market plans

The Affordable Care Act's (ACA) Marketplace has allowed individuals who earn too much to qualify for Medicaid, but who are unable to receive affordable coverage through their employers, to enroll in insurance and access care. The Marketplace provides an important opportunity for low- and middle-income individuals and families to access needed health care services. It captures a significant proportion of families in need of fertility services, the vast majority of which are unable to afford the services out-of-pocket. Yet, despite this need, the Proposed Rule would not make any changes to coverage of benefits in Marketplace plans that would facilitate access to fertility services.

The unavailability of fertility services in the Marketplace is compounded by recent policy decisions that have made coverage less affordable and less comprehensive. After Congress refused to extend enhanced advanced premium tax credits last year, premiums in the Marketplace skyrocketed, which has resulted in many individuals dropping from coverage

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[1] U.S. Depts. of Treasury, Labor, and Health and Human Srvs., *Excepted Fertility Benefits Proposed Rule*, 91 Fed. Reg. 27140–27173 (May 13, 2026), https://www.govinfo.gov/content/pkg/FR-2026-05-13/pdf/2026-09479.pdf (hereinafter "Proposed Rule.").

[2] Gabriela Weigel, Usha Ranji, Michelle Long & Alina Salganicoff, KFF, *Coverage and Use of Fertility Services in the U.S.* (Sep. 15, 2020), https://www.kff.org/womens-health-policy/coverage-and-use-of-fertility-services-in-the-u-s/; KFF, *2024 Employer Health Benefits Survey*, https://www.kff.org/health-costs/2024-employer-health-benefits-survey/ (Oct. 9, 2024) (finding that 27% of large firms offer health benefits cover IVF services).

[3] 91 Fed Reg 27162.

[4] *Id.*

altogether.[5] The administration has also enabled increased availability of alternative plans that do not comply with the ACA's minimum coverage requirements (often called junk plans), and individuals are increasingly resorting to those plans in the wake of increased premiums in the Marketplace.[6] For individuals in need of fertility services, these actions make it even less likely they will be able to afford services given the financial constraints they face due to either increased premiums if they remain enrolled in Marketplace plans or increased out-of-pocket health care costs if they are now uninsured or enrolled in junk plans.

A. States providing and seeking to provide fertility benefits as EHB face uncertainty and added administrative burden

The ACA established EHB as the mechanism for improving access to health care that was previously unavailable. However, this administration has actively undermined the process by which states can strengthen EHB coverage and address remaining gaps.[7] The efforts to improve access to fertility services contained in the Proposed Rule are severely undermined by the actions on the EHB front.

Several states currently provide fertility treatments as EHB, and several more are seeking to add these benefits to their EHB benchmark plans. However, the Proposed Rule fails to adequately address how fertility benefits provided as EHB comports with the designation of fertility treatment as excepted benefits. To date, we have identified at least 13 states that provide some sort of fertility services through their EHB benchmark plans, which may include diagnosis and treatment.[8] Several states have expanded, or are seeking to expand access by updating their EHB benchmark plans, notably:

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[5] Matt McGough, Jared Ortaliza, Justin Lo, & Cynthia Cox, KFF, *What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles* (May 19, 2026), https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/.

[6] See *e.g.*, U.S. Dept. of Health and Human Services, *Notice of Benefit and Payment Parameters for 2027; and Basic Health Program*, 91 Fed. Reg. 29526 - 29877 (May 20, 2026), https://www.govinfo.gov/content/pkg/FR-2026-05-20/pdf/2026-10050.pdf (hereinafter "NBPP/2027"). *See also* Sarah Kwon, CBS News, *Cheaper alternative health plans are having a moment, but critics urge caution* (May 20, 2026), https://www.cbsnews.com/amp/news/aca-health-insurance-alternative-plans-cheaper/.

[7] Amy Lotven, *Stakeholders Push Admin to Restart Review of EHB Benchmark Plans*, INSIDE HEALTH POLICY (Apr. 22, 2026). *See also* Letter, Wayne Turner, et al., to National Assoc. of Insurance Commissioners Government Relations Leadership Council, Re: Protecting state flexibility in Essential Health Benefits (Apr. 2, 2026), https://docs.google.com/document/d/1LblVVLDMhDPut90af1XH5WJgbNr2aaJoQEY0mdLFeWM/edit?tab=t.0.

[8] Arizona, Arkansas, Connecticut, Georgia, Hawaii, Kansas, Maryland, Massachusetts, Minnesota, New York, North Carolina, Pennsylvania, and Virginia. See Ctr. for Consumer Information and Insurance Oversight (CCIIO), https://www.cms.gov/marketplace/resources/data/essential-health-benefits.

- Colorado added fertility treatments to its EHB benchmark plan in 2023;[9]
- In 2024, the District of Columbia added in vitro fertilization (IVF) and other fertility treatments to its EHB benchmark plan;
- Washington added artificial insemination to its Washington's EHB benchmark plan effective plan year 2026;[10]
- In 2024-2025, Maine engaged community stakeholders and conducted actuarial analyses to possibly update its EHB benchmark plan to include fertility treatment, but did not submit an EHB benchmark update;[11]
- In May 2025, California submitted its application to add several benefits including fertility treatments to its EHB benchmark plan, as well as improving other benefits including coverage of durable medical equipment and hearing aids.[12]

Despite the various states are actively seeking changes to their EHB benchmark plans to cover fertility services, in February 2026, HHS confirmed that it halted review of pending EHB benchmark updates.[13] HHS also cancelled, without explanation, EHB Benchmark Modernization grants, which provide funding for states to evaluate benchmark plans for potential changes and to comply with federal actuarial requirements when seeking

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[9] Letter, Ellen Montz, Director, Center for Consumer Information & Insurance Oversight, Ctrs. for Medicare & Medicaid Srvs., to Com. Michael Conway, Colorado Div. of Insurance (Oct. 12, 2021), https://drive.google.com/drive/folders/1osTAAxIZhiSK-C-TwK3VWtAukK2LmlMI; Colorado Div. of Insurance, Biden Administration Announces Approval of Colorado's Inclusive Health Care Plan to Set Colorado's Essential Health Benefits (Oct. 12, 2021), https://doi.colorado.gov/news-releases-consumer-advisories/biden-administration-announces-approval-of-colorados-inclusive.

[10] *See* Ctr. for Consumer Information and Insurance Oversight (CCIIO), https://www.cms.gov/marketplace/resources/data/essential-health-benefits; Office of the Insurance Commissioner, Washington State, Essential Health Benefits Benchmark Plan Update (Oct. 24, 2024), https://www.insurance.wa.gov/sites/default/files/2024-11/EHB-update-table-10-24.pdf; Letter, Ellen Montz, Director, Center for Consumer Information & Insurance Oversight, Ctrs. for Medicare & Medicaid Srvs. To Jane Beyer, Senior Health Policy Advisor, Washington State Office of the Insurance Commissioner (Oct. 7, 2024), https://www.insurance.wa.gov/sites/default/files/2024-11/EHB-Benchmark%20Approval%20Letter%20WA%2010.07.24.pdf.

[11] Maine Bureau of Insurance, *Essential Health Benefits (EHB) Benchmark Plan Update*, 132nd Maine Legislature Health Coverage, Insurance, and Financial Services Committee (Jan 2025), https://www.maine.gov/pfr/insurance/sites/maine.gov.pfr.insurance/files/inline-files/EHB%20Benchmark%20Plan%20Initiative%20HCIS%202025_0.pdf.

[12] California Dept. of Managed Health Care, Press Release, *DMHC Applies to Update California's Benchmark Plan, Expand Essential Health Benefits to Include Fertility Services, Hearing Aids & Wheelchairs* (May 5, 2025), https://dmhc.ca.gov/Resources/Newsroom/PressReleases/May5,2025.aspx.

[13] NBPP/2027, 91 Fed. Reg. 6302. State insurance regulators from California, Utah, and Nevada with pending applications, as well as consumer advocacy organizations, harshly criticized HHS for its lack on action. *See* Amy Lovten, *Stakeholders Push Admin To Restart Review of EHB Benchmark Plans*, INSIDE HEALTH POLICY (Apr. 22, 2026); Letter from NAIC Consumer Representatives to NAIC President Scott A. White, et al., *Re: Protecting state flexibility in Essential Health Benefits* (Apr. 2, 2026), https://docs.google.com/document/d/1LblVVLDMhDPut90af1XH5WJgbNr2aaJoQEY0mdLFeWM/edit?tab=t.0.

changes.[14] These actions have effectively closed the door on the most effective tool states have to improve access to fertility services for low- and middle-income families who earn too much to qualify for Medicaid, but too little to be able to afford the out-of-pocket cost of fertility services. The Proposed Rule gives no indication if, when, and how HHS will allow states to proceed with the EHB benchmark updates.

B. Designating fertility treatments as excepted benefits could eliminate or restrict access to such treatments as an essential health benefit

Although the administration and the Departments purport to improve access to fertility treatments, this Proposed Rule designating such benefits as excepted benefits could have the opposite effect. When read in conjunction with current regulations implementing the ACA's EHB requirement, which bars certain benefits from being offered as EHB because they are excepted benefits, the Proposed Rule could have the unintended consequence of limiting coverage of fertility services in the individual and small group markets. Likewise, the proposal could inadvertently allow plans that cover fertility services, including large group plans, to subject coverage to annual and lifetime limits in states that include fertility treatments as EHB.

If the Proposed Rule is finalized, states may be prohibited from adding fertility services to their EHB benchmark plans. Moreover, states currently offering fertility services as EHB may be barred from doing so. In addition to urging the Departments to withdraw this proposal, we ask HHS to rescind its erroneous legal interpretation that has led to the prohibition of certain excepted benefits as EHBs finalized at 45 C.F.R. § 156.115(d) that prohibit plans from offering specified benefits as EHB because they can be offered as excepted benefits.

In the Proposed Rule, the Departments seem to be only vaguely aware that several states already cover fertility benefits under their EHB benchmark plans and state efforts to add these benefits, and suggest such coverage could continue without even mentioning the current rule prohibiting certain excepted benefits to be covered as EHB:

> The Departments also note that other states have made fertility benefits an EHB. EHBs are prohibited from having annual or lifetime dollar limits, but may have non-dollar limits, such as limits on the number of IVF cycles covered. Proposing a lifetime dollar limit for the excepted fertility benefits would not undermine these State insurance requirements.[15]

[14] EHB-Benchmark Plan Modernization Grant for States with a Federally-Facilitated Exchange, CMS-2U2-25-001, https://www.grants.gov/search-results-detail/356740.
[15] 91 Fed Reg 27148-27149.

The Departments suggest that ACA protections against annual or lifetime caps on fertility treatments provided in states where such treatments are EHB is reassuring. However, the Proposed Rule provides no further detail on how states and insurers could operationalize these dualling provisions. Since levels of coverage vary greatly among states currently covering fertility treatments as EHB, states and insurers presumably would need to crosswalk which benefits are provided pursuant to EHB, where there are no annual or lifetime limits; and excepted benefits plans covering services beyond what is covered under a state's EHB benchmark.

The Proposed Rule does little to answer prevailing questions regarding how the designation of fertility services interacts with EHB coverage (assuming that these services can still be provided as EHB).

1. Through regulation, HHS has arbitrarily banned certain health benefits as EHB because they are offered as excepted benefits

When it originally promulgated § 156.115(d), HHS provided a one sentence explanation that "[i]n contrast with the benefits covered by a typical employer health plan, [routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, and non-medically necessary orthodontia] often qualify as excepted benefits."[16]

[16] NHeLP has long maintained that the regulatory prohibition of specified benefits is directly contrary to the ACA. *See, e.g.*, Geraldine Doetzer et al., Nat'l Health Law Prog., NHeLP Comments on 2027 Notice of Benefit & Payment Parameter NPRM (Mar. 12, 2026), https://healthlaw.org/resource/nhelp-comments-on-2027-notice-of-benefit-payment-parameter-nprm/; Mara Youdelman et al., Nat'l Health Law Prog., NHeLP Comments on Patient Protection and Affordable Care Act; Marketplace Integrity and Affordability Proposed Rule (Apr. 10, 2025), https://healthlaw.org/resource/nhelp-comments-on-notice-of-proposed-rulemaking-regarding-marketplaces/; Héctor Hernández-Delgado & Wayne Turner, Nat'l Health Law Prog., NHeLP Letter to CCIIO on Legal Authorities and Regulatory Changes for Essential Health Benefits (Sep. 13, 2023), https://healthlaw.org/resource/nhelp-letter-to-cciio-on-legal-authorities-and-regulatory-changes-for-essential-health-benefits/; Héctor Hernández-Delgado & Wayne Turner, Nat'l Health Law Prog., *NHeLP Comments on Essential Health Benefits (EHB) Request for Information (RFI)* (Jan. 31, 2023), https://healthlaw.org/resource/nhelp-comments-on-essential-health-benefits-ehb-request-for-information-rfi/; Wayne Turner, Héctor Hernández-Delgado & Alexis Robles-Fradet, Nat'l Health Law Prog., NHeLP Letter to CCIIO Director, Ellen Montz - Re: Request for Modifications to the Federal Prescription Drug and Maternity Care Essential Health Benefit Standards (Aug. 15, 2022), https://healthlaw.org/resource/nhelp-letter-to-cciio-director-ellen-montz-re-request-for-modifications-to-the-federal-prescription-drug-and-maternity-care-essential-health-benefit-standards/. *See* Dept. of Health and Human Srvs., *Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation Proposed Rule*, 77 Fed. Reg. 70644, 70651 (Nov. 26, 2012), https://www.govinfo.gov/content/pkg/FR-2012-11-26/pdf/2012-28362.pdf; 78 Fed. Reg. 12845.

HHS previously removed the prohibition of routine non-pediatric oral health services from the EHB prohibition list at § 156.115(d).[17] At the time, HHS underscored that "EHB should be equal in scope to the benefits provided under a typical employer plan, regardless of whether such benefit is historically considered a non-excepted "health benefit" or whether such benefit is "typically covered" by an employer's major medical plan."[18] However, HHS recently reinstated the adult dental EHB prohibition in the Notice of Benefit and Payment Parameters Rule for 2027, explaining that "the structure of the excepted benefits framework is relevant evidence that routine non-pediatric dental services are not typically included in employer-sponsored major medical plans."[19]

By designating fertility benefits as excepted benefits, they will likely be subject to limitations that HHS has put in place through rulemaking, which may include the EHB prohibition under § 156.115(d). The departments say as much, stating "[i]n developing this proposal, the Departments considered in what manner a fertility benefit would be sufficiently limited to be similar to the other categories of limited excepted benefits [...] The Departments propose to apply a limiting principle that is similar to limited-scope dental and vision excepted benefits for fertility benefits to qualify as a limited excepted benefit, in addition to proposing to apply a lifetime dollar limit."[20]

The Proposed Rule fails to specify which statutory and regulatory limits for excepted benefits would apply to fertility treatments and which do not. It makes no mention of the EHB prohibition at § 156.115(d), or HHS's latest interpretation of the EHB "typical employer plan" provision with respect to excepted benefits. However, HHS cannot have it both ways. This Proposed Rule fails to explain how some excepted benefits can be considered EHB, while other benefits often provided through excepted benefits plans are prohibited as EHB. In an earlier rulemaking, for example, HHS added gender affirming care, which it called "specified sex trait modification procedures," to the EHB prohibition at § 156.115(d).[21] HHS acknowledged "that other services are excluded from coverage as EHB on the grounds that they are excepted benefits and that specified sex-trait modification procedures are not generally covered as excepted benefits."[22]

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[17] Dept. of Health and Human Srvs., *Notice of Benefit and Payment Parameters for 2025; Updating Section 1332 Waiver Public Notice Procedures; Medicaid; Consumer Operated and Oriented Plan (CO–OP) Program; and Basic Health Program,* 89 Fed. Reg. 26218 – 26426 (Apr. 15, 2025), https://www.govinfo.gov/content/pkg/FR-2024-04-15/pdf/2024-07274.pdf.
[18] 89 Fed. Reg. 26342.
[19] Dept. of Health and Human Srvs., *Notice of Benefit and Payment Parameters for 2027 Final Rule,* 91 Fed. Reg. 29526 - 29877 , 29676 (May 20, 2026), https://www.govinfo.gov/content/pkg/FR-2026-05-20/pdf/2026-10050.pdf.
[20] 91 Fed. Reg. 27145.
[21] Dept. of Health and Human Srvs. 2025 Marketplace Integrity and Affordability Final Rule, 90 Fed. Reg. 27074-27227 (June 25, 2025), (prohibiting "specified sex-trait modification procedures" as EHB), https://www.govinfo.gov/content/pkg/FR-2025-06-25/pdf/2025-11606.pdf.
[22] 90 Fed. Reg. 27156.

These inconsistent, ever-shifting interpretations of excepted benefits and services prohibited as EHB are the very definition of arbitrary and capricious rulemaking. The Departments, particularly HHS, need to examine the ill-considered interpretation that excepted benefits may not be EHB. Absent that, finalizing the rule as proposed is likely to limit access to fertility services in the long run.

2. Banning benefits, including excepted benefits, as EHB is contrary to law

The ACA did not tie EHB to excepted benefits. "Excepted benefits" is a term introduced in the Health Insurance Portability and Accountability Act (HIPAA) to exempt certain plans from the statute's obligations. In its definition of excepted benefits, HIPAA and implementing regulations include limited-scope dental benefits, limited-scope vision benefits, or long-term care benefits "if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a group health plan…."[23] The ACA did not change the definition of excepted benefits nor did it explicitly state that already defined excepted benefits were to be excluded from the definition of EHBs. As a result, a plain reading of the EHB statute lends no support to the notion that under no circumstance could so-called excepted benefits be considered EHBs.

Even if Congress intended to apply the HIPAA excepted benefits provision to the EHB requirement, the original definition of excepted benefits is more specific than the HHS regulation in § 156.115(d) excluding excepted benefits from EHB status. The HIPAA excepted benefits provision extends to benefits that are not an integral part of a group plan. Benefits are not considered an integral part of a group plan if either 1) enrollees may decline coverage for the specific services; or 2) if "claims for the benefits are administered under a contract separate from claims administration for any other benefits under the plan."[24] However, § 156.115(d) bans coverage of these excepted benefits as EHBs regardless of whether these requirements are met, exceeding the limitations on excepted benefits added by the HIPAA statute. Therefore § 156.115(d) is simply not supported by the statutory language in the ACA or HIPAA.

The Departments should clarify that the HIPAA excepted benefits provision applies to specific types of *plans* rather than types of benefits. While the HIPAA statutory provision in question talks about "benefits," Congress's unambiguous intention was to exclude limited-benefit *plans* (such as stand-alone dental and stand-alone vision plans) from HIPAA requirements, not the benefits themselves.

[23] 26 U.S.C. § 9832(c)(2)(A); 29 C.F.R. § 2590.732(c)(3).
[24] 45 C.F.R. § 146.145(b)(3)(ii).

The ACA gave the HHS Secretary broad authority to define EHB coverage, except that EHB coverage must always extend to at least the ten EHB categories listed in the statute.[25] Furthermore, the HHS Secretary has the authority and responsibility to periodically review and update EHB coverage when such review shows that updates are necessary to account for changes in medical evidence or scientific advancement or to close remaining gaps in coverage.[26] The framework that Congress put in place to periodically review and update EHB is directly contrary to regulations that would exclude certain benefits as EHB.

The Proposed Rule excludes other key populations in need of fertility services

The Proposed Rule excludes low- and moderate-income IVF seekers who are precisely the group with the least means to access fertility coverage.[27] As indicated above, the Proposed Rule will severely risk IVF access for enrollees in individual and small group plans that are enrolled in qualified health plans. Neither does this Proposed Rule offer any support for Medicaid beneficiaries, who are the least likely to have IVF coverage. Only one state covers some type of fertility treatment for Medicaid beneficiaries, and no Medicaid program covers artificial insemination or IVF.[28] More women with low incomes (*i.e.*, those on Medicaid) report failing to access needed fertility services compared to their more affluent counterparts. These exclusions are particularly harmful for BIPOC populations who are over-represented in the Medicaid population.[29] To add insult to injury, this administration has in multiple ways further diminished access to sexual and reproductive health, principally through its enactment of the so-called "One Big Beautiful Bill" Act.[30]

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[25] 42 U.S.C. § 18022(b)(1).
[26] 42 U.S.C. § 18022(b)(4)(G)–(H).
[27] Usha Ranji, Karen Diep, Brittni Frederiksen, Ivette Gomez & Alina Salganicoff, KFF, *Access to Fertility Care: Findings from the 2024 KFF Women's Health Survey* (Oct. 21, 2024). https://www.kff.org/womens-health-policy/access-to-fertility-care-findings-from-the-2024-kff-womens-health-survey/ (finding that among women who said they at some point needed fertility services, a quarter (24%) with lower incomes cite cost as the main reason they could not obtain fertility services, compared to 6% of women with higher incomes).
[28] Gabriela Weigel et al., *Coverage and Use*, *supra* note 2.
[29] The Medicaid program covers three in ten (30%) who are Black and one quarter who are Hispanic (26%), compared to 15% who are White. KFF, *Distribution of the Medicaid Population by Race/Ethnicity (Timeframe 2024)*, https://www.kff.org/medicaid/state-indicator/distribution-of-the-medicaid-population-by-race-ethnicity (last visited June 18, 2026).
[30] Christina Piecora, Nat'l Health Law Prog. *OBBBA's Unprecedented Attack on Medicaid and the Impact on Access to Sexual and Reproductive Health Care* (Aug. 22, 2025), https://healthlaw.org/obbbas-unprecedented-attack-on-medicaid-and-the-impact-on-access-to-sexual-and-reproductive-health-care/.

Contrary to racist assumptions, Black women and other women of color have lower fertility rates than their White counterparts and are also more likely to lack the resources to afford expensive infertility treatments.[31] In other words, they have the greatest need, but the least resources to access assisted reproduction which is likely to be exacerbated by this Proposed Rule.[32] This is a result of many factors, including lower incomes among Black and Hispanic women as well as barriers and misconceptions that dissuade women from seeking assistance with fertility.[33]

In addition to only benefiting the more privileged sector of fertility treatment seekers, the lifetime limits proposed by this rule are insufficient to reach the family creation goals of most fertility treatment seekers in the United States. The Proposed Rule does not fully take into account that multiple cycles are often needed to achieve a successful pregnancy and live birth.[34] KFF data from 15 years ago found that the cost for IVF per successful outcome is $62,000 and with donor eggs is $73,000.[35] It is fair to say that the costs would be a lot higher in 2026. Neither does this Proposed Rule consider additional costs in storage, transportation, genetic testing, and additional medication. Furthermore, imposing a cap on costs will prevent family formation for people with conditions that require additional support like people with disabilities, chronic health conditions, and other health factors. It is neither clear that this Proposed Rule makes room for coverage of oocyte donors or surrogates, who have been essential in family formation plans for people who are LGBTQI+, unpartnered, and many others.[36]

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[31] These misconceptions are based on stereotypes that Black women are hyperfertile. Combined with a history of discriminatory health care and bodily harm, some of them do delay having a family.

[32] *See* Ashley Wiltshire et al., *Infertility Knowledge and Treatment Beliefs among African American Women in an Urban Community*, 4 CONTRACEPTION REPRODUCTIVE MED. 16 (2019), https://pubmed.ncbi.nlm.nih.gov/31572616 (concluding that Black women between the ages of 33-44 are twice as likely to experience infertility as white women in the same age demographic).

[33] Gabriela Weigel et al., *Coverage and Use*, *supra* note 2.

[34] Michael Ha et al., *In vitro fertilization: a cross-sectional analysis of 58 US insurance companies*, J. ASSISTED REPRODUCTION & GENETICS 2022 Dec 21;40(3):581–587, https://pmc.ncbi.nlm.nih.gov/articles/PMC10033791/ (concluding that successful live birth rate is approximately 30% after one IVF cycle, which increases to a success rate of 64% when at least six cycles are performed).

[35] Gabriela Weigel et al., *Coverage and Use*, *supra* note 2.

[36] Liz McCaman Taylor, Jennifer Lav, Abigail Coursolle & Fabiola De Liban, Nat'l Health Law Prog., *NHeLP Principles on Assisted Reproduction* (Sept. 27, 2021), https://healthlaw.org/resource/nhelp-principles-on-assisted-reproduction/ (All assisted reproduction policies should protect the rights and health coverage needs of all parties involved, whether they are oocyte, embryo, or sperm donors as well as surrogates).

This administration's attacks on sexual and reproductive health care render futile the Proposed Rule's purported purpose

The purported purpose of the Proposed Rule operates in contradiction to this administration's reproductive health policy restrictions that prevent IVF access. This very same HHS dismantled critical teams at the Centers for Disease Control and Prevention (CDC) that were responsible for studying assisted reproduction, which will halt efforts for expansion.[37] Adequate safeguards and continuous research are vital to ensure that assisted reproduction procedures are safe and effective.[38]

Neither can fertility services happen without access to the full range of sexual and reproductive health care, which this administration has continuously attacked. For example, HHS has taken measures to curtail essential access to contraceptives, which are frequently used in assisted reproduction treatments. Contraceptives help to time IVF cycles, control menses, reduce the risk of ovarian cysts at in vitro fertilization cycle initiation, and optimize visualization before hysteroscopy. In addition, hormonal contraception can be used in third-party reproductive cycles to coordinate the oocyte donor with the oocyte recipient.[39] With so many state efforts to cut contraception (with support from this administration) as well as severe cuts to the Medicaid and Title X programs, access to contraceptives for assisted reproductive will become more limited.[40]

Intrinsic to assisted reproduction is the manipulation of embryos, which legally conflicts with state abortion bans legitimized by the *Dobbs v. Jackson Women's Health Organization*, a case lauded by this administration. According to Pregnancy Justice, laws or judicial decisions in more than 14 states make IVF vulnerable to a legal challenge.[41] Additionally, more states give "fetal rights" that also risk access to IVF.[42] Embryo management for fertility purposes involves practices like pre-implantation genetic testing, storage and transportation of embryos, and disposal of those unlikely to have reproductive potential.[43]

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[37] Sabrina Malhi & Meryl Kornfield, Wash. Po., *Fertility and maternal health programs slashed, alarming experts* (April 19, 2025), https://www.washingtonpost.com/health/2025/04/19/cdc-cuts-maternal-mortality-fertility/
[38] Liz McCaman Taylor et al., *NHeLP Principles*, *supra* note 36.
[39] Am. Soc'y for Reproductive Med., *The use of hormonal contraceptives in fertility treatments: a committee opinion* Vol 122. No 2 (Aug. 2024), https://www.asrm.org/practice-guidance/practice-committee-documents/the-use-of-hormonal-contraceptives-in-fertility-treatments-a-committee-opinion-2024/
[40] *See* Christina Piecora, *OBBBA's Attack on Medicaid and Sexual and Reproductive Health Care*, *supra* note 30.
[41] Pregnancy Justice, Laws by State https://www.pregnancyjusticeus.org/legal-landscape/ (last visited June 18, 2026).
[42] *Id.*
[43] Gerard Letterie & Dov Fox, *Legal personhood and frozen embryos: implications for fertility patients and providers in post-Roe America*, 10 J. LAW BIOSCI.1 (May 19, 2023), https://pmc.ncbi.nlm.nih.gov/articles/PMC10200124/.

Approximately 63% of embryos created through IVF in the United States are discarded outside a uterus, and depending on patient age, 56% to 90% of frozen embryos transferred into a uterus perish before a live birth.[44] The Heritage Foundation has itself rejected IVF because it interferes with their goal to promote "life from fertilization."[45] In other words, a person cannot have true access to assisted reproduction if anti-abortion or personhood laws exist. People need the freedom to make decisions about parenthood and pregnancy, including whether to use fertility care to grow their family, use contraception to prevent or space out their pregnancies, or have abortions to end their pregnancies. None of these can happen with the policies advanced by the Departments and others in this administration.

Outside of imposing attacks against reproductive health, this administration is espousing other policies that make it difficult to form a family.

In addition to restricting other forms of reproductive health that facilitate assisted reproduction, this administration is advancing damaging socio-economic policies that make it difficult to start or expand childrearing. The main reason people are delaying fertility or not having the number of children they want is because they no longer feel economically secure to have them.[46] Last year, this administration signed the so-called "One Big Beautiful Bill Act" (OBBBA) into law, enacting the most sweeping—and harmful—Medicaid cuts in history. The law slashes $990 billion from Medicaid over the next decade, eliminating Medicaid coverage for more than 10 million people and destabilizing the health care infrastructure.[47] At the same time, Congress's failure to extend the enhanced premium tax credits for Marketplace enrollees has driven up premium payments from enrollees by an average of 58% and dropped enrollment by over 23.1 million, the sharpest single-year drop since the marketplaces launched.[48] When people are paying more for health care or

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[44] Katie Watson, *Rethinking the Ethical and Legal Relationship Between IVF and Abortion*, 334 JAMA 1, 19 (July 1, 2025).

[45] *See* Emma Waters, The Heritage Foundation, *A Christian's Practical Guide to Reproductive Technology* (June 6, 2024), https://www.heritage.org/life/commentary/christians-practical-guide-reproductive-technology.

[46] *See* Anita Li, U.S. Census, *While Share of Younger Women Without Children Increased, More Women Had Children as They Entered Their Late 40s From 2014 to 2024* (Sept. 23, 2025); https://www.census.gov/library/stories/2025/09/older-mothers.html (last visited June 17, 2026). *See also,* Anna Louie Sussman, *Why So Few Babies? We Might Have Overlooked the Biggest Reason of All*, N.Y. TIMES (May 7, 2026), https://www.nytimes.com/2026/05/07/opinion/birthrate-kids-parents-demographics-future.html.

[47] *See* Christina Piecora, OBBBA's Attack on Medicaid and Sexual and Reproductive Health Care, *supra* note 30.

[48] Matt McGough, Jared Ortaliza, Justin Lo, & Cynthia Cox, KFF, *What We Know So Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles* (May 19, 2026), https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/.

drop coverage altogether, it comes to no surprise that they decide to postpone the formation of their families or forgo it altogether.

This administration cannot be pro-family when it reduces food assistance, separates children from their parents, and lowers childcare subsidies. Not only did OBBBA cut health care access for millions of people in the United States, but it also made deep cuts to the federal funding for food assistance through the Supplemental Nutrition Assistance Program (SNAP).[49] Estimates predict that enrollment in this critical program will fall by 10%.[50] When parents cannot feed their children, they cannot be expected to raise them. HHS has also taken steps to undermine the childcare system by freezing critical federal funding for some states and imposing vague and burdensome reporting requirements on all states.[51] When this government removes access to health care, eliminates protections for women in the workforce, reduces food assistance, separates families, and lowers childcare subsidies, those concerns become even more acute.

The right to raise a family with dignity demands comprehensive health care access without discrimination, paid family leave, affordable childcare, investments in education and housing, living wages, safe communities, and a federal commitment to democracy, equity, and the conditions in which all families can flourish and feel secure. Once the government can guarantee these rights, people will feel more compelled to start their families sooner or expand them. This extremely limited and watered down rule fails to really offer the solution.

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[49] *See* An Act to Provide for Reconciliation Pursuant to Title II of H. Con. Res. 14, Pub. L. No. 119-21, § 10101 – 10108, 139 Stat. 80 – 85 (2025) [hereinafter OBBBA] (cutting SNAP plus almost $1 trillion in Medicaid and failing to extend the enhanced premium tax credits for ACA Marketplace enrollees).

[50] *See* Dottie Rosenbaum, Joseph Llobrera, Catlin Nchako & Luis Nuñez, Ct. on Budget & Pol'y Priorities, *SNAP Tracker: People Are Losing Food Assistance as the Republican Megabill Is Implemented*, https://www.cbpp.org/research/food-assistance/snap-tracker-people-are-losing-food-assistance-as-the-republican-megabill (last visited June 22, 2026).

[51] Nat'l Women's Law Center, *The Trump Administration's Ongoing Attacks on Child Care & Working Women* (March 30, 2026), https://nwlc.org/resource/the-trump-administrations-ongoing-attacks-on-child-care-working-women/ (last visited June 22, 2026)

This Proposed Rule is part of this administration's pronatalist, white supremacist, anti-LGTBQI+, and patriarchal agenda

Pronatalism is founded on the belief that our government has a duty to encourage more people to have more children in order to protect the country.[52] Throughout U.S. history, procreative regulation has arisen from lawmakers' desire to maintain white supremacy, uphold patriarchy, and reinforce the proper roles for women, especially married heterosexual white women, as wives and mothers.[53] This Proposed Rule blatantly propagates this pronatalist sentiment by centering its purpose with declining birth rates and exclusion of BIPOC, LGTBQI+, and low-income populations.

Consistent with this administration's playbook, Project 2025, the Proposed Rule advances a pronatalist agenda where the birth of babies from privileged white, heterosexual couples are preferred over Black, Indigenous, and other babies of color, low-income families, LGTBQI+ populations, and single people. It is very clear that the Departments aim to expand the population of only certain types of people. For instance, this policy does nothing to offer single people the opportunity to meet their family formation goals.[54] Similarly, the Proposed Rule is silent regarding protections regarding LGTBQI+ parenthood. Such omission is dangerous since LGBTQI+ individuals face heightened barriers to accessing fertility care, as they often do not meet definitions of "infertility" that would qualify them for covered services.

Should the administration desire to advance a pro-family agenda, we invite it to follow the guidance of the reproductive justice framework.[55] Rather than opposing DEI initiatives, cutting childcare subsidies, separating families, and diminishing health care access, the administration should advance the right of everyone who desires to have a child. Laws,

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[52] HHS Secretary Robert F. Kennedy Jr. said that the U.S. is facing a "fertility crisis," which represents "a threat not only to our economy, to our national security. *See* Maria Ramirez Uribe, PBS, *Trump has a proposal to expand fertility benefits. Here's how that would work* (May 12, 2026), https://www.pbs.org/newshour/health/trump-has-a-proposal-to-expand-fertility-benefits-heres-how-that-would-work

[53] *See* Kimberly Mutcherson, *The Past is Prologue: IVF, Abortion, and State Regulation of Procreation: A Response to The New Abortion by Dov Fox and Mary Ziegler*, 125 COLUMBIA L. REV. 6 (151-182) (Oct. 31, 2025).

[54] *See* Ramirez Uribe, Trump had a proposal to expand fertility benefits, supra note 52 (quoting President Trump maintaining, "This will hopefully reduce the number of *couples* who ultimately need to resort to IVF." *See also* Exec. Order No. 14216 (highlighting the importance of family formation, and emphasizing that "as a Nation, our public policy must make it easier for loving and longing mothers and fathers to have children.")

[55] *See* SisterSong, *Reproductive Justice*, https://www.sistersong.net/reproductive-justice (last visited July 8, 2026) Recognizing myriad ways in which the law denied Black women and other women of color access to pregnancy and the tools of pregnancy creation, reproductive justice leaders set the right to have children as the first tenet of their movement, followed by the rights not to have children and to parent children in safe and healthy environments."

policies, and practices should protect everyone involved in the assisted reproduction process from discrimination based on race, color, sex, language, ethnicity, gender identity, income, age, national origin, religion, marital or partnership status, sexual orientation, disability, place of residence, socio-economic, genetic information, family history, or immigration status.[56] As argued above, Black, Indigenous, and other people of color, low-income people, people with disabilities, and the LGBTQI+ community access fertility treatment at disproportionately low rates in the United States. This proposed policy will further the gap between these vulnerable populations and their privileged counterparts.

Conclusion

The Proposed Rule would appear to do little, if anything, to improve and expand access to fertility services. Given the uncertainty regarding future coverage of these services as EHB, we urge the Departments to withdraw this rule until HHS rescinds regulatory prohibitions on EHB codified at 45 C.F.R. § 156.115(d). We once again urge HHS to rescind 45 C.F.R. § 156.115(d) in its entirety, because it conflicts with the plain language, design, and intent of the ACA's provision establishing EHB, and mechanisms to update EHB.[57] The Departments should not add fertility or other benefits to excepted benefits unless and until HHS rescinds regulatory prohibitions on certain excepted benefits, and others, as EHB.[58]

We have included citations and direct links to research and other materials. We request that the full text of material cited, along with the full text of our comment, be considered part of the formal administrative record for purposes of the Administrative Procedure Act. If HHS is not planning to consider these citations part of the record as we have requested, we ask that you notify us and provide an opportunity to submit copies of the studies into the record.

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[56] Liz McCaman Taylor et al., *NHeLP Principles*, *supra* note 36.

[57] Mara Youdelman et al., Nat'l Health Law Prog., *Comments on the Notice of Benefit and Payment Parameters for 2025 (*Jan. 8, 2024) at 28, https://healthlaw.org/resource/comments-on-the-notice-of-benefit-and-payment-parameters-for-2025/.

[58] Note that on June 15, 2026, HHS issued a request for information (RFI) regarding EHB with a 30-day comment period. See Dept. of Health and Human Srvs., *Request for Information; Comprehensive Review of the Essential Health Benefits Framework and Typical Employer Plan Standard*, 91 Fed. Reg. 35938 – 35944 (June 15, 2026), https://www.govinfo.gov/content/pkg/FR-2026-06-15/pdf/2026-11994.pdf. However, it is unclear if this latest RFI will lead to any regulatory action. In 2022, HHS also issued a RFI regarding EHB, but nothing came from that effort and the 2026 RFI makes no mention of it. *See* Dept. of Health and Human Srvs., *Request for Information; Essential Health Benefits*, 87 Fed. Reg. 74097 – 74102 (Dec. 2, 2022), https://www.govinfo.gov/content/pkg/FR-2022-12-02/pdf/2022-26282.pdf. *See also* Héctor Hernández-Delgado & Wayne Turner, Nat'l Health Law Prog., *NHeLP Comments on Essential Health Benefits (EHB) Request for Information (RFI)* (Jan. 31, 2023), https://healthlaw.org/resource/nhelp-comments-on-essential-health-benefits-ehb-request-for-information-rfi/.

Thank you for the opportunity to comment on these important issues. If you have any questions, please contact Fabiola De Liban at deliban@healthlaw.org.

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