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New Mechanisms for Employers to Expand Employee Access to Fertility Benefits

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Late last year, the Departments of Labor, Health and Human Services, and Treasury (collectively, the Departments) provided long-awaited guidance clarifying two new ways — in addition to the already-existing mechanisms — for employers to expand fertility benefit offerings. The Departments jointly published *FAQs about Affordable Care Act Implementation Part 72* (FAQs), which implement President Donald Trump's Executive Order 14216, *Expanding Access to In Vitro Fertilization (IVF)*.

The FAQs address how the new options fit into the current regulatory framework established by the Affordable Care Act, Public Health Service Act (PHS Act), Employee Retirement Income Security Act (ERISA), and Internal Revenue Code (IRC). Below is a practical overview for employers interested in expanding access to IVF and related services through one of the two new options.

Background

Employer-sponsored benefits providing medical care are generally group health plans that are subject to numerous compliance requirements under applicable law unless an exception applies. To provide fertility benefits that comply with applicable

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requirements under the Affordable Care Act and other laws, employers cover the benefits within the employer's major medical plan or integrate the benefits with the major medical coverage (often by providing them through an integrated health reimbursement arrangement (HRA) that is only available to employees and dependents enrolled in the major medical plan). Importantly, those options remain available to employers; however, in addition to those options, employers may now provide certain fertility benefits as an excepted benefit.

Excepted benefits are not a new concept. Under already-existing regulations and guidance, benefits satisfying the conditions of excepted benefits are not required to comply with the Affordable Care Act mandates and most of the portability requirements under the Health Insurance Portability and Accountability Act (HIPAA). For example, limited scope vision or dental benefits, health flexible spending accounts, long-term care benefits, and hospital indemnity insurance may constitute excepted benefits if they meet the applicable requirements. Now, fertility benefits may also be an excepted benefit.

Key Takeaways from the FAQs

The FAQs explain how employers can provide fertility benefits as either (1) independent, non-coordinated excepted benefits or (2) limited excepted benefits.

Independent, Non-Coordinated Excepted Benefits

Independent, non-coordinated excepted benefits include coverage only for a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. Employers may offer fertility benefits through a fully insured specified disease or illness policy, provided certain conditions are met:

- **Separate Policy:** The coverage must be under a separate policy, certificate, or contract of insurance. Self-funded benefits provided by the employer will not satisfy this condition.
- **No Coordination:** There must be no coordination between the provision of the excepted benefit and any exclusion under the employer's group health plans.
- **Independent Payment:** Benefits are paid regardless of whether group health plan coverage maintained by the same employer or individual coverage maintained by the same health insurance issuer applies to the same event.

The FAQs also clarify:

- Enrollment in fertility coverage that is provided as an independent, non-coordinated excepted benefit does **not** affect an individual's eligibility to contribute to a Health Savings Account (HSA). If the individual is otherwise eligible to contribute to an HSA, he or she remains eligible.
- Employees do **not** need to be enrolled in the employer's traditional group health plan for the specified disease or illness coverage to qualify as an excepted benefit.

Limited Excepted Benefits

Employers may also use certain limited excepted benefit vehicles to provide fertility benefits and other fertility support:

- **Excepted Benefit Health Reimbursement Arrangements (HRAs):** HRAs are employer-funded (no employee contributions are permitted), tax-advantaged arrangements that reimburse employees for qualified medical expenses. Under the FAQs, an HRA may pay for out-of-pocket fertility costs and constitute an excepted benefit provided that:

- The HRA is not an integral part of the employer's group health plan (i.e., other non-excepted major medical group health coverage is offered by the employer).

- The maximum benefit provided through the HRA for each plan year does not exceed the indexed cap ($2,200 for 2026).

- The HRA does not reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA), or Medicare, unless the coverage consists solely of excepted benefits.

- The HRA is made available on the same terms and conditions to all similarly situated individuals, regardless of any health factor.

Certain ERISA notice requirements apply to an excepted benefit HRA, so employers should take care to understand those requirements.

- **Employee Assistance Programs (EAPs):** EAPs are excepted benefits if they do not provide significant benefits in the nature of medical care and satisfy all other requirements under the Departments' regulations.Accordingly, the FAQs confirm that EAPs may be used to provide fertility-related support as long as:

- The EAP does **not** provide significant benefits in the nature of medical care and satisfies all of the other requirements under the already-existing regulations. The FAQs confirm that an EAP will not be considered to provide significant medical benefits solely because it offers benefits for coaching and navigator services to help individuals understand their fertility options.

    - The EAP is not coordinated with benefits under another group health plan, does not require any employee contributions as a condition of participation, and has no cost-sharing.

Practical Considerations for Employers

Employers considering expanding or changing their fertility benefit offerings should:

- **Evaluate and Plan:** Carefully consider which of the available options for offering fertility benefits best suits both the employer's workforce and the employer's own resource and business considerations, and what specific fertility benefits will be provided.
- **Select a Compliant Option:** Determine whether to offer benefits as part of the employer's major medical coverage, integrated with the employer's major medical coverage, as an independent non-coordinated excepted benefit, or as a limited excepted benefit.
- **Implement the Option in Accordance with Applicable Requirements:** Each of the available options requires careful attention to ensure applicable compliance requirements are satisfied.
- **Consider Enhancements to EAPs:** Evaluate whether to add fertility coaching and navigation services to EAPs, but avoid providing medical care through EAPs.
- **Documentation and Communication:** Clearly communicate benefit offerings to employees and maintain documentation reflecting the chosen benefit structures. Many ERISA notice requirements still apply.
- **Ongoing Monitoring and Oversight:** An employer has an ongoing obligation to ensure the selected option is operated and administered in accordance with applicable requirements.

As always, employers should consult with experienced benefits counsel to ensure compliance with all applicable laws and regulations. Akerman's Labor and Employment and Employee Benefits and Executive Compensation teams are available to assist with compliance and implementation.