FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 72

October 16, 2025

Set out below are Frequently Asked Questions (FAQs) regarding implementation of certain provisions of the Affordable Care Act (ACA). These FAQs have been prepared jointly by the Departments of Labor, Health and Human Services (HHS), and the Treasury (collectively, the Departments). Like previously issued FAQs (available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/aca-implementation-faqs and https://www.cms.gov/marketplace/resources/fact-sheets-faqs), these FAQs answer questions from stakeholders to help people understand the law and promote compliance.

Excepted Benefits

Sections 2722 and 2763 of the Public Health Service Act (PHS Act), section 732 of the Employee Retirement Income Security Act (ERISA), and section 9831 of the Internal Revenue Code (the Code) provide that the respective requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code generally do not apply to any individual coverage or any group health plan (or group health insurance coverage) in relation to its provision of certain types of benefits, known as "excepted benefits." Excepted benefits are described in section 2791(c) of the PHS Act, section 733(c) of ERISA, and section 9832(c) of the Code.

These parallel statutory provisions establish four categories of excepted benefits. The first category includes benefits that are generally not health coverage such as automobile insurance, liability insurance, workers' compensation, and coverage only for accident or disability income insurance. The benefits in this category are excepted in all circumstances. In contrast, the benefits in the second, third, and fourth categories are types of health coverage but are excepted only if certain conditions are met.

The second category of excepted benefits is limited excepted benefits, which includes limited-scope vision or dental benefits, and benefits for long-term care, nursing home care, home health care, or community-based care that are offered separately, or any combination thereof. Section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code further provide that this second category of excepted benefits also includes such other, similar limited benefits as are specified in regulations.[1] The Secretaries previously exercised their rulemaking authority to specify certain health flexible spending arrangements (health FSAs), certain employee assistance programs (EAPs), certain health reimbursement

[1] Moreover, section 2792 of the PHS Act, section 734 of ERISA, and section 9833 of the Code authorize the Secretaries of HHS, Labor, and the Treasury (collectively, the Secretaries) to promulgate such regulations as may be necessary or appropriate to carry out the provisions of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code.

arrangements (excepted benefit HRAs), and a pilot program for limited wraparound benefits as limited excepted benefits in the group market.[2]

The third category of excepted benefits, referred to as "independent, noncoordinated excepted benefits," includes both coverage for only a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance.

The fourth category of excepted benefits is supplemental excepted benefits, which includes Medicare supplemental health insurance (Medigap); coverage supplemental to the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) or Tricare; or similar coverage that is supplemental to coverage provided under a group health plan.

Executive Order 14216

On February 18, 2025, the President issued Executive Order 14216, "Expanding Access to In Vitro Fertilization," which directs the Assistant to the President for the Domestic Policy Council (DPC) to submit a list of policy recommendations to protect in vitro fertilization (IVF) access and aggressively reduce out-of-pocket and health plan costs for IVF treatment within 90 days of the order (by May 19, 2025).[3]

As part of those policy recommendations, the Assistant to the President for the DPC recommended issuing regulations or guidance that would allow employers to expand access to coverage for fertility through the provision of an excepted benefit.

The Departments are committed to exploring ways to leverage their existing authority to protect IVF access, reduce costs for IVF, and encourage the adoption of a full range of fertility benefits by employers, including treatments to restore fertility by addressing root causes, in accordance with Executive Order 14216. It is a priority of the Trump Administration to provide options that would increase access and reduce cost for infertility treatment for employees experiencing infertility or who want to purchase coverage to lower associated costs for potential future infertility challenges. Accordingly, this guidance clarifies the existing categories of excepted benefits employers can use to offer fertility benefits, including the categories of independent, noncoordinated excepted benefits and limited excepted benefits. Furthermore, the Departments intend to propose notice and comment rulemaking to provide additional ways that certain fertility benefits may be offered as a limited excepted benefit, if certain conditions are met. The Departments are also considering whether to modify the standards under which supplemental health insurance coverage provided by a group health plan, including a supplemental benefit for fertility coverage, will be considered to satisfy the conditions for being an excepted benefit, such as whether the current limitation-on-value safe harbor of 15 percent that was set forth in guidance should be increased.[4]

---

[2] 26 CFR 54.9831-1(c)(3)(v)-(viii); 29 CFR 2590.732(c)(3)(v)-(viii); 45 CFR 146.145(b)(3)(v)-(viii).
[3] 90 FR 10451 (Feb. 24, 2025).
[4] In 2007 and 2008, the Departments issued guidance on the circumstances under which supplemental health insurance would be considered an excepted benefit under 2791(c)(4) of the PHS Act, section 733(c)(4) of ERISA, and section 9832(c)(4) of the Code. The guidance lists four criteria to qualify as supplemental health insurance. One of the criteria is that the cost of coverage does not exceed 15 percent of the cost of primary coverage. *See* EBSA Field Assistance Bulletin No. 2007-04, available at https://www.dol.gov/agencies/ebsa/employers-and-

Independent, Noncoordinated Excepted Benefits in the Group Market

Independent, noncoordinated excepted benefits are defined under section 2791(c)(3) of the PHS Act, section 733(c)(3) of ERISA, and section 9832(c)(3) of the Code and include coverage only for a specified disease or illness (such as cancer-only policies), and hospital indemnity or other fixed indemnity insurance. These benefits are excepted from the requirements of title XXVII of the PHS Act, part 7 of ERISA, and chapter 100 of the Code only if all of the following conditions are met: (1) the benefits are provided under a separate policy, certificate, or contract of insurance; (2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such event under any group health plan maintained by the same plan sponsor or, with respect to individual coverage, under any health insurance coverage maintained by the same health insurance issuer.[5]

Q1: May an employer offer fertility benefits as an independent, noncoordinated excepted benefit?

Yes, an employer may offer fertility benefits as an independent, noncoordinated excepted benefit, if the applicable conditions are met. For example, an employer could offer a specified disease or illness policy that covers benefits related to infertility as a type of independent, noncoordinated excepted benefit, if it meets the requirements to qualify as an independent, noncoordinated excepted benefit in the group market under sections 2722(c)(2) and 2791(c)(3) of the PHS Act, sections 732(c)(2) and 733(c)(3) of ERISA, and sections 9831(c)(2) and 9832(c)(3) of the Code and their implementing regulations.[6]

Q2: If an employer offers a traditional group health plan and a specified disease or illness policy that covers fertility benefits, must participants and beneficiaries enroll in the employer's traditional group health plan in order for the specified disease or illness policy to qualify as an excepted benefit?

No. The statute does not require an employer to offer, or participants or beneficiaries to enroll in, a traditional group health plan in order for a specified disease or illness policy to qualify as an independent, noncoordinated excepted benefit. However, where an employer offers both an independent, noncoordinated excepted benefit and other group health plan coverage, the excepted benefit must be provided under a separate policy, certificate, or contract of insurance. Further, there must be no coordination between the provision of the benefits under the excepted

---

advisers/guidance/field-assistance-bulletins/2007-04.; CMS Insurance Standards Bulletin 08-01, available at http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf; and IRS Notice 2008-23, available at https://www.irs.gov/irb/2008-07_IRB#NOT-2008-23.

[5] Section 9831(c)(2) of the Code, section 732(c)(2) of ERISA, and sections 2722(c)(2) and 2763(b) of the PHS Act.

[6] Additionally, to the extent employers provide hospital indemnity or other fixed indemnity insurance that pays a fixed dollar amount per period of hospitalization or illness related to infertility (for example, $100/day) regardless of the amount of expenses incurred, such coverage may also qualify as an independent, noncoordinated excepted benefit, if it meets the other applicable requirements of section 2722(c)(2) of the PHS Act, section 732(c)(2) of ERISA, and section 9831(c)(2) of the Code and their implementing regulations.

benefit coverage and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits provided by excepted benefit coverage must be paid without regard to whether benefits are provided with respect to the same event under any group health plan maintained by the same plan sponsor.

Q3: Can specified disease or illness coverage, such as coverage only for infertility, be self-funded by the employer and qualify as an independent, noncoordinated excepted benefit?

No. Under section 2722(c)(2)(A) of the PHS Act, section 732(c)(2)(A) of ERISA, and section 9831(c)(2)(A) of the Code and their implementing regulations, to be considered an independent, noncoordinated excepted benefit, the benefit must be provided under a separate policy, certificate, or contract of insurance. Therefore, coverage only for a specified disease or illness cannot be offered as a self-funded arrangement and qualify as an independent, noncoordinated excepted benefit. As stated above, the Departments intend to undertake future notice and comment rulemaking to provide additional ways that certain fertility benefits may be offered as a type of limited excepted benefit. The Departments intend to address as part of the proposed rulemaking, recognition of fertility benefits as other, similar limited benefits that qualify as an excepted benefit that an employer could offer on a self-funded basis if the applicable conditions to be considered a limited excepted benefit are met.

Q4: Would an individual who is enrolled in fertility benefit coverage provided as an independent, noncoordinated excepted benefit be permitted to contribute to a health savings account (HSA)?

Yes. Generally, under section 223(c) of the Code, individuals eligible to contribute to an HSA are individuals who are covered under a high deductible health plan (HDHP) as of the first day of the month and who have no other coverage other than those specifically allowed. Insurance for a specified disease or illness is a type of insurance in which an individual is specifically allowed to be enrolled and still contribute to an HSA, provided they are covered by an HDHP and do not have any other types of coverage that would disqualify the individual from contributing to an HSA.

Limited Excepted Benefits

Limited excepted benefits are excepted 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. As stated above, section 2791(c)(2)(C) of the PHS Act, section 733(c)(2)(C) of ERISA, and section 9832(c)(2)(C) of the Code provide that other, similar limited benefits can be specified in regulations as "limited excepted benefits." In 2019, the Departments issued final rules that set forth conditions under which certain HRAs and other account-based group health plans (other than health FSAs) are recognized as limited excepted benefits. These excepted benefit HRAs qualify as limited excepted benefits if they satisfy all of the following conditions:

1) Otherwise not an integral part of the plan. Other group health plan coverage that is not limited to excepted benefits and that is not an HRA or other account-based group

health plan is made available by the same plan sponsor for the plan year to the participant.

2) Benefits are limited in amount. Amounts newly made available for each plan year under the HRA or other account-based group health plan do not exceed $1,800, adjusted for inflation ($2,150 for plan years beginning in 2025[7]).
3) Prohibition on reimbursement of certain health insurance premiums. The HRA or other account-based group health plan must not reimburse premiums for individual health insurance coverage, group health plan coverage (other than COBRA continuation coverage or other continuation coverage), or Medicare Part A, B, C, or D, except that the HRA or other account-based group health plan may reimburse premiums for such coverage that consists solely of excepted benefits.
4) Uniform availability. The HRA or other account-based group health plan is made available under the same terms to all similarly situated individuals, regardless of any health factor.[8]

These final rules also highlighted the applicable ERISA notice requirements (or, for plans subject to the PHS Act, required that excepted benefit HRAs provide a notice that describes conditions pertaining to eligibility to receive benefits, annual or lifetime dollar limits, or other limits on benefits under the plan, and a description or summary of the benefits); and provided a special rule prohibiting reimbursement of short-term, limited-duration insurance premiums in certain situations.[9]

Q5: Under existing regulations, may an employer plan sponsor offer an excepted benefit HRA that reimburses an employee's out-of-pocket costs with respect to fertility benefits?

Yes. To the extent the HRA or other account-based plan meets the requirements of 26 CFR 54.9831-1(c)(3)(viii), 29 CFR 2590.732(c)(3)(viii), and 45 CFR 146.145(b)(3)(viii), such an HRA or other account-based plan can qualify as an excepted benefit HRA, and generally would not be subject to the requirements of chapter 100 of the Code, part 7 of ERISA, and title XXVII of the PHS Act.

Q6: May an employer offer benefits for coaching and navigator services to help employees and their dependents understand their fertility options under an EAP that qualifies as a limited excepted benefit?

Yes. EAPs are excepted benefits if they do not provide significant benefits in the nature of medical care and satisfy all of the other requirements under the Departments' regulations.[10] The regulations provide that for the purpose of determining whether an EAP provides benefits that are significant in the nature of medical care, the amount, scope, and duration of covered services are taken into account.[11] An EAP will not be considered to provide benefits that are significant in

---

[7] *See* Rev. Proc. 2024-25, available at https://www.irs.gov/pub/irs-drop/rp-24-25.pdf.
[8] 26 CFR 54.9831-1(c)(3)(viii); 29 CFR 2590.732(c)(3)(viii); 45 CFR 146.145(b)(3)(viii).
[9] 26 CFR 54.9831-1(c)(3)(viii)(E)-(F); 29 CFR 2590.732(c)(3)(viii)(E)-(F); 45 CFR 146.145(b)(3)(viii)(E)-(F).
[10] 26 CFR 54.9831-1(c)(3)(vi); 29 CFR 2590.732(c)(3)(vi); 45 CFR 146.145(b)(3)(vi). *Also see* 79 FR 59130 (Oct. 1, 2014).
[11] 26 CFR 54.9831-1(c)(3)(vi)(A); 29 CFR 2590.732(c)(3)(vi)(A); 45 CFR 146.145(b)(3)(vi)(A).

the nature of medical care solely because it offers benefits for coaching and navigator services to help individuals understand their fertility options.[12] The EAP would not constitute a limited excepted benefit, however, if it offers any fertility benefits that are significant benefits for medical care. Additionally, to qualify as a limited excepted benefit, the EAP cannot be coordinated with benefits under another group health plan, no employee premiums or contributions can be required as a condition of participation, and there must be no cost sharing under the EAP.[13]

[12] See 79 FR 59130, 59134, fn. 20 (Oct. 1, 2014) (providing examples of other EAPS that do not provide significant benefits in the nature of medical care).
[13] 26 CFR 54.9831-1(c)(3)(vi)(B)-(D); 29 CFR 2590.732(c)(3)(vi)(B)-(D); 45 CFR 146.145(b)(3)(vi)(B)-(D).