

Supporting Statement – Part A
Notice Requirements for Fertility Excepted Benefits
(CMS- 10947/OMB control number# 0938-NEW)

A. Background

Section 2791(c) of the Public Health Service Act (PHS Act), section 733(c) of the Employee Retirement Income Security Act (ERISA), and section 9832(c) of the Internal Revenue Code (Code) establish four statutory categories of “excepted benefits” that are generally exempt from the market requirements added to those laws by the Health Insurance Portability and Accountability Act (HIPAA), the Patient Protection and Affordable Care Act (ACA), the No Surprises Act, and certain other federal laws specifically related to group health plans and group and individual health insurance coverage.

The second category of excepted benefits is “limited excepted benefits,” which includes limited-scope vision or dental benefits, 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 limited excepted benefits also include “such other, similar limited benefits as are specified in regulations” by the Departments of Health and Human Services (HHS), Labor, and the Treasury (collectively, the Departments).

On February 18, 2025, President Trump issued Executive Order 14216,¹ “Expanding Access to In Vitro Fertilization,” which states the policy of the Trump Administration to provide support, awareness, and access to affordable fertility treatments, including reliable access to in vitro fertilization (IVF) treatment, by easing unnecessary statutory or regulatory burdens to make IVF treatment drastically more affordable. In accordance with this directive, the Departments are exercising their statutory authority to recognize fertility benefits as limited excepted benefits, if specific conditions are satisfied.

In the proposed rule “Excepted Fertility Benefits” (the proposed rule), the Departments propose to add new paragraph (c)(3)(ix) of 26 CFR 54.9831-1 and 29 CFR 2590.732, and new paragraph (b)(3)(ix) of 45 CFR 146.145 to establish fertility benefits as a new category of limited excepted benefits. Under the proposed rule, excepted fertility benefits are benefits substantially all of which are for the diagnosis, mitigation, or treatment of infertility or infertility-related reproductive health conditions and substantially all of which are provided by medical professionals authorized to practice under applicable law. The proposed rule would require that plans or issuers offering excepted fertility benefits provide written notice to plan participants and beneficiaries that includes a description of the coverage, including a summary of benefits and limitations of the coverage, including the lifetime dollar limit established by the plan or issuer that complies with the maximum

¹ Exec. Order No. 14219, 90 FR 10451 (February 24, 2025).

lifetime dollar limit described in proposed paragraph (c)(3)(ix)(B) (or paragraph (b)(3)(ix)(B), as applicable), information on how to identify and utilize a network provider, if applicable, and how to submit a claim for reimbursement, including whether the benefit utilizes the same claims procedure as for the sponsor's other group health plans. The notice would be required to be written and presented in a manner calculated to be understood by the average plan participant and provided no later than the first date on which the participant or beneficiary is eligible to enroll in coverage and annually thereafter, as well as upon request of the participant or beneficiary. This notice requirement would ensure that participants and beneficiaries are fully informed about the availability and requirements of their excepted fertility benefits coverage.

B. Justification

1. Need and Legal Basis

The information required under this collection is necessary to implement the Departments' statutory authority under Code section 9832(c)(2)(C), ERISA section 733(c)(2)(C), and PHS Act section 2791(c)(2)(C) to recognize fertility benefits as limited excepted benefits, if specific conditions are satisfied. This authority allows the Departments to specify in regulations additional limited excepted benefits that are similar to the limited benefits specified in the statute² and that either are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of a plan.

The proposed rule at paragraph (c)(3)(ix)(D) of 26 CFR 54.9831-1 and 29 CFR 2590.732 and paragraph (b)(3)(ix)(D) of 45 CFR 146.145 would require plans or issuers offering limited fertility benefits to provide written notice to participants and beneficiaries. This notice requirement would be necessary to ensure that participants and beneficiaries are fully informed about the availability of the excepted fertility benefits coverage, understand the benefits and limitations of such coverage, in order to make informed decisions about whether to enroll in such coverage. Given that participants and beneficiaries may be unfamiliar with how benefits for the diagnosis, mitigation, and treatment of infertility generally work, this notice would also serve as an important educational tool to assist participants and beneficiaries understand what is covered under their excepted fertility benefits, as opposed to under their traditional group health plan.

2. Information Users

Plans and issuers providing excepted fertility benefits would use the notice requirement to inform eligible participants and beneficiaries about the availability of excepted fertility benefits coverage, a summary of benefits and limitations, claims procedures, and other critical information needed to utilize their fertility benefits and receive the promised coverage.

Participants and beneficiaries would use this information to understand what coverage is available to them under their excepted fertility benefits, how to access those benefits, and the procedures for filing claims for reimbursement. This information enables informed consumer decision-making

² Section 9832(c)(2) of the Code, section 733(c)(2) of ERISA, and section 2791(c)(2) of the PHS Act.

about whether to enroll in excepted fertility benefit coverage.

3. Use of Information Technology

HHS anticipates that plans and issuers would distribute notices using both electronic and paper methods, consistent with existing distribution practices for other plan documents. The notice would be sent with other materials during periods of open enrollment and could be incorporated into existing communication channels.

4. Duplication of Efforts

This information collection does not duplicate any current information collection.

5. Small Businesses

Small businesses are not significantly impacted by this information collection request (ICR).

6. Less Frequent Collection

If the proposed notice is not provided to participants and beneficiaries consistent with the timing standards in the proposed rule (no later than the first date on which the participant is eligible to enroll in coverage, and annually thereafter, and upon request of the participant or beneficiary) participants and beneficiaries would not be able to understand what is covered under their excepted fertility benefits and navigate their excepted fertility benefits.

7. Special Circumstances

No special circumstances exist for this information collection.

8. Federal Register/Outside Consultation

A notice of proposed rulemaking (NPRM) (“Excepted Fertility Benefits”) will publish in the Federal Register on May 13, 2026, providing the public with a 60-day period to submit written comments on these information collections.

No outside consultation was sought.

9. Payments/Gifts to Respondents

There is no payment or gift to respondents.

10. Confidentiality

The information submitted under this collection is not expected to be treated as confidential. The notices would be provided to plan participants and beneficiaries and would contain general information about coverage benefits and claims procedures.

11. Sensitive Questions

There are no sensitive questions included in this collection effort. HHS does not propose to collect any private information.

12. Burden Estimates (Hours & Wages)

To estimate the burden and equivalent costs associated with this ICR, we used wage estimates developed by the Department of Labor following their standard methodology.³

Table 12.1 Adjusted Median Hourly Wages Used in Burden Estimates

Occupation Title	Occupational Code	Hourly Wage (\$/hr)
Lawyers	23-1011	\$187.58

Notice Requirements for Plans or Issuers Offering Excepted Fertility Benefits (Proposed 26 CFR 54.9831-1(c)(3)(ix)(D), 29 CFR 2590.732(c)(3)(ix)(D), and 45 CFR 146.145(b)(3)(ix)(D))

Under paragraph (c)(3)(ix)(D) of 26 CFR 54.9831-1 and 29 CFR 2590.732 and paragraph (b)(3)(ix)(D) of 45 CFR 146.145, plans or issuers offering excepted fertility benefits would be required to provide written notice to plan participants and beneficiaries. The notice would be required to include a description of the coverage, including a summary of benefits and limitations of the coverage, how to submit a claim for reimbursement, including whether the benefit utilizes the same claims procedure as for the sponsor's other group health plans, and information on how to identify and utilize a network provider, if applicable. The notice would be required to be provided no later than the first date on which the participant or beneficiary is eligible to enroll in coverage, and annually thereafter, as well as upon request of the participant or beneficiary.

HHS estimates that there are 12,569 non-Federal governmental plans⁴ that could potentially offer excepted fertility benefits. The Departments assume that the 811 group health insurance issuers⁵ will be responsible for producing the required notice on behalf of the plans they service, consistent with the role issuers play in providing plan management and administrative support to both fully insured and self-insured group health plans.

HHS estimates that, for each non-Federal governmental plan offering excepted fertility benefits, it would require 2 hours for lawyers (at an hourly rate of \$187.58) to develop and draft the initial

³ Internal DOL calculation based on 2025 labor cost data. For a description of DOL's methodology for calculating wage rates, see <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/rules-and-regulations/technical-appendices/labor-cost-inputs-used-in-ebsa-opr-ria-and-pra-burden-calculations-june-2019.pdf>.

⁴ This is calculated as: 91,489 public-sector employer-sponsored plans × 63% (not currently offering fertility-related benefits) × 37% (expected offer rate) = 27,352 state and local government employer-sponsored plans expected to offer fertility-related excepted benefits. U.S. Census Bureau, 2025 Census of Governments, Organization Tables, <https://www.census.gov/data/tables/2025/econ/gus/2025-governments.html>.

⁵ A health insurance company is a legal entity with subsidiaries that are each licensed to sell health insurance in one specific State, while an issuer is one of those subsidiaries. HHS estimates 811 group health insurance issuers when considering the total number of subsidiaries licensed to sell health insurance in a specific state. Data source: Centers for Medicare and Medicaid Services, 2023 Medical Loss Ratio Data, <https://www.cms.gov/marketplace/resources/data/medical-loss-ratio-data-systems-resources>.

notice in the first year. The total burden for developing the initial notice would be 2 hours, with an equivalent cost of approximately \$375.16 per issuer. In subsequent years, HHS estimates that it would require 1 hour for lawyers (at an hourly rate of \$187.58) to review and update the notice as necessary. The total burden for reviewing and updating the notice would be 1 hour, with an equivalent cost of approximately \$187.58 per issuer. Each issuer's lawyer is expected to draft the notice once in the first year and review and update it once annually in subsequent years, as a single notice developed by the issuer will apply to all plans it services.

Therefore, the total burden for all issuers that might provide excepted fertility benefits to non-Federal governmental plans to develop the initial notice in the first year would be 1,622 hours (811 issuers x 2 hours), with an equivalent total cost of approximately \$304,255. In subsequent years, the total burden for all issuers to review and update the notice would be 811 hours (811 issuers x 1 hour), with an equivalent total cost of approximately \$152,127. These 811 issuers serve as the burden-bearing entities for notice drafting across all group health plans – including both private-sector plans and non-Federal governmental plans – as issuers are expected to prepare a single notice applicable to all plans they service, regardless of plan type.

Table 12.2 Estimated Burden for Plans to Develop Notice (First Year)

Respondent	Number of Respondents	Burden (Hours)	Labor Cost	Total Burden (Hours)	Total Cost
Issuers	811	2	\$375.16	1,622	\$304,255

Table 12.3 Estimated Burden for Plans to Review and Update Notice (Subsequent Years)

Respondent	Number of Respondents	Burden (Hours)	Labor Cost	Total Burden (Hours)	Total Cost
Issuers	811	1	\$187.58	811	\$152,127

Table 12.4 below provides a three-year average for the burden and costs associated with the notice requirement.

Table 12.4 Three-Year Average Burden and Costs

Year	Number of Respondents (Issuers)	Total Hours	Total Costs
Year 1	811	1,622	\$304,255
Year 2	811	811	\$152,127
Year 3	811	811	\$152,127
3 Year Average	811	1,081	\$202,837

13. Capital Costs

Under paragraph (c)(3)(ix)(D) of 26 CFR 54.9831-1 and 29 CFR 2590.732 and paragraph (b)(3)(ix)(D) of 45 CFR 146.145, plans or issuers offering excepted fertility benefits must provide written notice to plan participants and beneficiaries.

HHS estimates that each issuer would provide the notice to an average of 11,561,954 non-Federal governmental plan participants and beneficiaries annually.⁶ HHS estimates that the notice would require one page, at a cost of \$0.05 per page for printing and materials, and that 66 percent⁷ of the notices would be sent to eligible plan participants and beneficiaries. HHS expects that notices sent to plan participants and beneficiaries would be sent with other plan documents at minimal cost. Therefore, the total printing cost for providing 7,630,890 notices by mail would be \$381,544 annually.

Table 13.1 Annual Cost to Issuers and Plans to Print and Mail the Notice to Participants and Beneficiaries

Respondent	Number of Respondents	Number of Mailed Notices	Total Annual Estimated Printing and Materials Cost
Non-Federal Governmental Health Plans	32,545	7,630,890	\$381,544

14. Cost to Federal Government

This information collection does not impose costs on the Federal Government.

15. Changes to Burden

⁶ The Departments estimate this figure by applying the relevant share of non-Federal governmental plan participants to the total eligible population, accounting for the share of plans not currently offering fertility benefits and the expected offer rate for excepted benefits coverage; for a full description of the methodology and underlying data sources, see the proposed regulation "Excepted Fertility Benefits" [xx-xx-2026].

⁷ The Departments assume that approximately 34% of plan documents would be sent electronically, while 66% would be physical notices mailed to participants. According to data from the National Telecommunications and Information Agency, 34 percent of households in the United States accessed health records or health insurance online. <https://www.ntia.doc.gov/blog/2020/more-half-american-households-used-internet-health-related-activities-2019-ntia-data-show>.

This is a new information collection request.

16. Publication/Tabulation Dates

HHS does not plan to publish or tabulate the information collected under this ICR.

17. Expiration Date

There are no instruments associated with this information collection.

18. Certification Statement

There are no exceptions to the certification statement.