



Fertility Benefits as Limited Excepted Benefits: Proposed Rule By Tri-Agencies

By: Kate Belyayeva

Fertility treatment has become an increasingly important component of family-building for many Americans, yet the cost of care remains a significant barrier to access. Services such as in vitro fertilization ("IVF") often require multiple treatment cycles and can result in tens of thousands of dollars in out-of-pocket expenses. Despite these costs, many individuals report receiving little or no insurance coverage for fertility-related services.

On May 13, 2026, the Departments of Labor, Treasury, and Health and Human Services (the "Departments") published proposed regulations (the "Proposed Rule") that would create a new category of limited excepted benefits for fertility coverage. The Proposed Rule follows Executive Order 14216, which directed federal agencies to identify opportunities to expand access to fertility treatment and reduce associated costs. If finalized, the Proposed Rule would permit employers to offer qualifying fertility benefits through a standalone fertility benefit arrangement similar to existing dental and vision plans. Importantly, qualifying fertility benefits would be treated as limited excepted benefits and thus would not be subject to many requirements applicable to group health plans under HIPAA, the Affordable Care Act ("ACA"), and certain other federal health coverage laws.

This alert summarizes the key provisions of the Proposed Rule and highlights practical considerations for employers evaluating whether to take advantage of this new benefits framework.

Limited Excepted Benefits

Currently, employers offering fertility benefits typically provide such benefits through their group health plans. As a result, fertility coverage is generally subject to the same federal requirements applicable to comprehensive medical coverage. The Proposed Rule would create a new category of limited excepted benefits for fertility coverage. This would allow employers to offer fertility benefits through a standalone fertility benefit arrangement rather than as part of their comprehensive medical coverage. As limited excepted benefits, qualifying fertility benefit arrangements would be administered similarly to existing dental and vision plans.

To qualify, fertility benefits would have to be offered under a separate policy, certificate, or contract of insurance, or otherwise not be an integral part of another group health plan. In addition, the same plan sponsor would have to make available other group health plan coverage that is not limited to excepted benefits. However, employees would not be required to enroll in that other coverage in order to be eligible for fertility benefits. As a result, employees obtaining primary health coverage through another source, such as a spouse's plan, could still access fertility benefits offered by their employer without changing their primary coverage.

Qualifying fertility benefit arrangements

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would also have to limit coverage to benefits substantially aimed at diagnosing, mitigating, or treating infertility or infertility-related conditions. The Proposed Rule explains that treatment would not need to be limited solely to conditions directly causing infertility but could also include treatment of conditions that would worsen infertility if left untreated. Covered benefits generally would need to be provided by medical professionals authorized to practice under applicable law.

Exemptions and Notice Requirements

As limited excepted benefits, qualifying fertility benefit arrangements would be exempt from many federal group health plan requirements, including numerous ACA market reforms and HIPAA portability requirements. This exemption is one of the Proposed Rule's most significant features and reflects the Departments' effort to reduce regulatory barriers that may discourage employers from offering fertility benefits.

Employers offering fertility benefits under this framework would be required to provide written notice describing the available benefits, applicable benefit limits, provider or network information (if applicable), and claims submission procedures. The notice generally would be required upon initial eligibility or enrollment, annually thereafter, and upon request, in addition to complying with other notice requirements applicable to limited excepted benefits.

Spending Limits

The Proposed Rule would impose a lifetime benefits cap of \$120,000 with respect to a participant and the participant's eligible beneficiaries. For plan years beginning on or after January 1, 2028, the lifetime limit would be adjusted for inflation. The Proposed Rule generally would permit fertility benefit arrangements to impose benefit limits and other coverage restrictions, provided the arrangement satisfies the conditions necessary to qualify as a limited excepted benefit.

Employer Impact

Fertility benefits continue to be a highly valued component of employee benefit packages. As employers compete to attract and retain talent, particularly employees seeking fertility treatment or pursuing alternative family-building paths, fertility coverage has become increasingly important.

The Proposed Rule would not require employers to offer fertility benefits. Rather, it would create an additional option for employers that wish to provide fertility benefits to employees. For employers that do not currently offer fertility benefits, the Proposed Rule may reduce administrative and compliance barriers and make it easier for employers, particularly small and mid-sized employers, to offer fertility benefits as part of a competitive benefits package. By allowing fertility benefits to be offered through a standalone fertility benefit arrangement, employers may be able to provide meaningful fertility coverage without modifying their existing medical plan offerings.

Like dental and vision coverage, employers would have the option of contributing toward fertility benefits but would not be required to do so. Employers most likely to be affected by the Proposed Rule are those that currently offer fertility benefits through their group health plans, particularly employers operating in states that mandate some form of fertility coverage. States with fertility

coverage mandates include, among others, Arkansas, California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Utah, and the District of Columbia, although the scope of required coverage varies among jurisdictions. However, employers should carefully evaluate applicable state insurance mandates and consult with benefits counsel before making any plan design changes.

Potential Challenges

While the Proposed Rule is intended to expand access to fertility services, employers should be mindful of potential challenges. For example, employees who currently receive fertility coverage through a comprehensive medical plan may perceive a move to a standalone fertility benefit arrangement as a reduction in benefits, particularly if separate enrollment or employee contributions are required. Employers considering such changes should carefully evaluate employee-relations implications and develop an appropriate communication strategy.

In addition, because coverage would be limited to fertility-related services, enrollment may be concentrated among individuals expecting to utilize those benefits, which could result in higher premiums or participant costs than might otherwise be expected under a comprehensive medical plan. Employers should also be mindful that the Proposed Rule does not eliminate the need to consider other applicable legal requirements, including state insurance mandates, plan administration considerations, and other issues that may arise depending on the structure of the fertility benefit arrangement.

Conclusion

The Proposed Rule represents a significant development in the employee benefits landscape and reflects the federal government's continued efforts to expand access to fertility care. If finalized as proposed, the Proposed Rule generally would apply to plan years beginning on or after January 1, 2027. Employers should review their current fertility benefit offerings, evaluate whether a standalone fertility benefit arrangement may be appropriate, and consider submitting comments before the July 13, 2026 deadline.

We will continue to monitor developments and provide updates as the rulemaking process progresses.



Association Plan or MEWA: DOL Issues Advisory Opinion Addressing Whether Farm Bureau Federation Health Plan Qualifies as ERISA Plan

By Abby Blankenship

On May 1, 2026, the Department of Labor's ("DOL") Employee Benefits Security Administration ("EBSA") issued Advisory Opinion 2026-01A, addressing whether a group health plan sponsored by the Idaho Farm Bureau Federation ("IFBF") would qualify as a single "employee welfare benefit plan" under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and whether it would constitute a multiple employer welfare arrangement (known as a MEWA).

Background

The IFBF is a long-standing nonprofit federation of 39 county farm bureaus (the "County Farm Bureaus") representing thousands of farmers and ranchers across Idaho. Each County Farm Bureau is affiliated through an agreement with the IFBF but remains an independent nonprofit entity.

The IFBF proposed to establish the IFBF Employer Consortium (the "Consortium") and a fully insured group health plan through Blue Cross of Idaho providing coverage to employees of eligible IFBF members that elect to participate in the plan (known as "Participating Employers"). Participating Employers must meet the following requirements: (1) they must be actively engaged in the business of producing agricultural products; (2) they must be based in Idaho; (3) they must employ at least two full-time employees (working a minimum of 30 hours per week, including at least one common-law employee); and (4) they must sign a Participation Agreement.

Under the proposed structure, a Benefits Committee, elected by and composed only of employees of Participating Employers, would serve as plan fiduciary and administrator. Additionally, Participating Employers would retain the authority to elect Benefits Committee members and conduct other business through annual meetings.

Definition of "Employee Welfare Benefit Plan"

The term "employee welfare benefit plan" as defined in ERISA includes, among other things:

any plan, fund, or program . . . established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise . . . medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment . . .

The DOL's Analysis

The DOL assessed whether this arrangement would be considered a bona fide group or association of employers for purposes of ERISA. Previous advisory opinions have addressed this topic, and the DOL relied on the facts-and-circumstances analysis it has outlined previously.

Among the factors considered are the following: (1) how members are solicited; (2) who is entitled to participate and who actually participates in the association; (3) the process by which the association was formed, the purposes for which it was formed, and what, if any, were the preexisting relationships of its members; (4) the powers, rights, and privileges of employer members that exist by reason of their status as employers; and (5) who actually controls and directs the activities and operations of the benefit program.

The DOL's Conclusions

Applying this framework, the DOL concluded that the arrangement satisfied the above criteria. Among the factors the DOL highlighted were that the IFBF has existed since 1942 for agricultural advocacy purposes – not to sell insurance, that only employer members may participate in the plan, and that those employers share a decades-long history of collaboration on behalf of Idaho's farming community. Additionally, the plan's governance structure gives Participating Employers sole authority to elect and remove Benefits Committee members, placing control in their hands.

Based on these factors, the DOL concluded that the Participating Employers would, at least in form, qualify as a bona fide group or association of employers and that the Plan would be a single employee welfare benefit plan under ERISA. The DOL did caution, however, that it was not opining on whether employers exercise control "in substance," as that is a factual question that depends on how the arrangement actually operates. The DOL also confirmed that because the plan covers employees of more than one employer, it is a MEWA.

Key Takeaways

Employer associations considering group health arrangements should evaluate whether they satisfy the DOL's criteria. Additionally, the Advisory Opinion emphasizes the importance of governing documents, as the DOL focused its analysis on the Consortium Bylaws and Benefits Committee Charter as evidence of employer control.

Organizations considering similar arrangements should consult legal counsel and, potentially, seek their own advisory opinion from the DOL given the revitalized opinion letter program.



Federal Student Loan Caps Take Effect July 1: How Employer Educational Assistance Programs Can Help

By: Dawnielle Wright

Beginning July 1, 2026, sweeping changes to federal student loan programs enacted as part of the One Big Beautiful Bill Act (OBBBA) will significantly reduce access to federal borrowing for students across the country. For many employees and for employers trying to attract and retain talent, these changes will increase the appeal of employer-sponsored educational assistance programs as a meaningful and tax-efficient workplace benefit. Recent IRS guidance issued in April 2026 provides clarification on how these programs work and what employers can offer on a permanent basis going forward.

What Changes July 1, 2026

The OBBBA eliminates Graduate PLUS loans entirely as of July 1, 2026, sets new annual and lifetime borrowing caps for graduate and professional students, and replaces most income-driven repayment plans with a new Repayment Assistance Plan. Graduate students are now limited to \$20,500 per year in unsubsidized loans, subject to a \$100,000 lifetime cap, while professional students in programs such as medicine, law, and dentistry face a \$50,000 annual cap. A \$257,500 overall lifetime borrowing limit applies across all federal loan programs. Parent PLUS loans are capped at \$20,000 per year per dependent child with a \$65,000 lifetime limit, and any Parent PLUS loans made after July 1, 2026 are ineligible for income-driven repayment.

These changes represent a significant reduction in available federal funding for graduate and professional education, the population that many employers are trying hardest to recruit and retain. According to a February 2025 Congressional Research Service report, nearly 43 million individuals, or one in six adult Americans, carry federal student loan debt with an aggregate value exceeding \$1.6 trillion. As federal borrowing becomes more restricted, employer-sponsored educational assistance will become an increasingly important piece of the employee benefits picture.

Section 127 Educational Assistance Program Basics

Under Section 127 of the Internal Revenue Code, employers can provide employees with up to \$5,250 per year toward qualified educational expenses without those benefits becoming taxable income to the employee. Amounts paid under a Section 127 educational assistance program are generally deductible by the employer as a business expense.

Qualifying expenses include tuition, fees, books, supplies, and equipment for undergraduate or graduate coursework. Notably, the courses do not need to be work-related. An employer can reimburse an employee for any degree program regardless of whether it relates to the employee's current job. To offer this benefit, employers must maintain a written educational assistance plan that meets certain content requirements under the Code. The plan must be maintained for the exclusive benefit of employees, must not discriminate in favor of highly compensated employees, and employees must receive reasonable notification of the program's availability and terms.

Student Loan Repayment Assistance Now Permanent

Perhaps the most significant development for employers is the permanent extension of student loan repayment assistance as a qualifying benefit under Section 127. During the COVID-19 pandemic, legislation temporarily expanded Section 127 to include employer payments toward employees' qualified education loan principal and interest. While that temporary expansion was set to expire at the end of 2025, the OBBBA made the student loan repayment portion of this benefit permanent, effective immediately upon enactment in July 2025.

Earlier IRS guidance reflected the prior statutory sunset scheduled for January 1, 2026. The revised April 2026 FAQs eliminate all references to that expiration, confirming that employer payments of principal and interest on qualified education loans may be provided indefinitely on a tax-free basis under Section 127.

This permanence matters for plan design. Employers who previously hesitated to build student loan repayment assistance into their benefits programs due to uncertainty about the benefit's future can now do so with confidence. Importantly, qualified education loans can be incurred before employment, meaning employer repayments can be made in later years even if the loans were taken out before the individual was hired. This is a meaningful distinction from other educational expenses under Section 127, which must be incurred during the period of employment. Payments may be made directly to a loan servicer or directly to the employee.

The \$5,250 annual limit applies as a combined cap across both student loan repayment and traditional educational assistance benefits. An employer offering both benefits to the same employee cannot exceed \$5,250 in total tax-free assistance in a single year. Starting with taxable years after December 31, 2026, the \$5,250 cap will be indexed for inflation.

Practical Considerations for Employers

For employers that already sponsor a Section 127 program that includes student loan repayment assistance, the primary near-term action item is reviewing the plan document to confirm it no longer contains any sunset language tied to the prior temporary extension and that it accurately reflects the permanent nature of the benefit. Employers should also consider whether plan language is flexible enough to accommodate future inflation-adjusted limit increases without requiring frequent amendments. The IRS has released an updated sample plan document, IRS Publication 5993, which employers can use as a starting point for drafting or revising a Section 127 plan.

For employers that sponsor a Section 127 program covering only traditional tuition assistance and have not yet added student loan repayment, now is an opportune time to amend the plan to include this benefit. Given that federal loan caps take effect July 1, employees with existing or anticipated student loan obligations will increasingly look to employer assistance to fill the gap.

For employers that do not yet sponsor any Section 127 program, the combination of the July 1 federal borrowing changes and the permanence of student loan repayment assistance under the OBBBA provides a compelling basis to consider implementing one. A written plan document meeting the statutory requirements, proper nondiscrimination testing, and coordination with payroll to ensure correct tax treatment are the key compliance components.

Conclusion

The federal student loan changes taking effect July 1, 2026 will reduce access to borrowing for millions of current and prospective employees at precisely the moment employer-sponsored educational assistance has been made a permanent and more flexible benefit. Section 127 educational assistance programs, now permanently inclusive of student loan repayment, represent a straightforward and tax-efficient way for employers to address a growing financial concern among their workforces. The April 2026 IRS guidance provides clear direction on how these programs should be structured and administered, making this an ideal time for employers to review, update, or implement a Section 127 program.



Compliance Corner: Understanding and Providing Compliant Summary of Benefits And Coverage (SBC) Disclosures

By: Kate Belyayeva

One of the Affordable Care Act's ("ACA") key participant disclosure requirements is the Summary of Benefits and Coverage ("SBC"). The SBC is designed to help participants understand and compare health coverage options by providing standardized information regarding plan benefits, cost-sharing obligations, and coverage limitations in a concise and consumer-friendly format.

Although the SBC requirement has been in place for more than a decade, employers continue to encounter compliance challenges, particularly during open enrollment, when changing insurance carriers, or when making mid-year plan design changes. This Compliance Corner provides a high-level overview of the SBC rules and common compliance considerations for employers.

What is an SBC?

The SBC is a standardized disclosure document that outlines a health plan's expenses, benefits, covered services, exclusions, and other key features. It is intended to help individuals evaluate, compare, and select the health coverage that best meets their needs. In addition to the SBC, plans and issuers generally must make available a Uniform Glossary that defines common health insurance and medical terms used in the SBC.

The SBC is not intended to replace a Summary Plan Description ("SPD"), insurance booklet, or other governing plan document.

Rather, it serves as a simplified summary that allows individuals to compare health coverage options more easily.

Which Plans Must Provide SBCs?

The SBC requirement generally applies to group health plans and health insurance issuers offering medical coverage, including:

- Fully insured group health plans;
- Self-insured group health plans;
- High deductible health plans ("HDHPs");
- PPO and HMO plans; and
- Grandfathered group health plans.

Certain excepted benefits are generally exempt, including stand-alone dental and vision plans, most excepted-benefit Health FSAs, certain employee assistance programs, and other benefits classified as excepted benefits. Employers offering multiple medical plan options generally must provide a separate SBC for each benefit package.

Who Must Receive an SBC?

SBCs generally must be provided to individuals eligible for coverage under the plan, including:

- Newly eligible employees;
- Employees enrolling during open enrollment;
- COBRA qualified beneficiaries;
- HIPAA special enrollees; and
- Current participants and beneficiaries upon request.

When Must SBCs Be Provided?

Key SBC distribution requirements include:

- **Initial Enrollment:** Generally with enrollment materials or, if none are provided, no later than the first date an individual is eligible to enroll.
- **Open Enrollment:** For each benefit package for which a participant is eligible.
- **Special Enrollees:** Generally no later than the deadline for providing an SPD following enrollment (typically within 90 days after enrollment).
- **Upon Request:** As soon as practicable, but no later than seven business days after the request.
- **Mid-Year Changes:** At least 60 days before the effective date of certain material modifications that affect SBC content and are not reflected in a previously distributed SBC.

SBCs may be distributed in paper form or electronically, provided applicable electronic disclosure requirements are satisfied.

What Information Must Be Included?

Federal agencies prescribe standardized SBC templates and instructions. Required content generally includes:

- Covered benefits and services;
- Deductibles, copayments, coinsurance, and other cost-sharing requirements;
- Significant limitations and exclusions;
- Information regarding minimum essential coverage and minimum value;
- Contact information for questions and appeals;
- Internet addresses for provider directories, prescription drug formularies, and the Uniform Glossary; and

- Information regarding how participants may obtain additional plan documents.

The SBC also must be provided in a culturally and linguistically appropriate manner when applicable requirements are met.

Penalties for Noncompliance

Failure to comply with SBC requirements may result in significant penalties, participant complaints, and regulatory scrutiny. Employers should not assume that responsibility for SBC compliance rests solely with insurers or third-party administrators and should periodically confirm that required SBCs are being prepared and distributed appropriately.

Best Practices for Employers

To help minimize compliance risks, employers should:

- Confirm that current SBC templates and instructions are being used;
- Ensure SBCs are distributed with enrollment materials;
- Establish procedures for responding to participant requests;
- Review mid-year plan changes for additional notice requirements;
- Maintain records documenting SBC distributions; and
- Confirm that electronic delivery methods comply with applicable rules.

Conclusion

The SBC remains one of the ACA's most important participant disclosure requirements. By periodically reviewing SBC compliance procedures and coordinating with insurers and third-party administrators, employers can help ensure timely and accurate disclosures while reducing compliance risk and promoting informed health care decisions among employees and their families.



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- The IRS has announced the 2027 inflation-adjusted penalty amounts under the Affordable Care Act's (ACA) employer shared responsibility provisions. Under the ACA, applicable large employers (ALEs) – generally, employers with 50 or more full-time employees (including full-time equivalents) – can face penalties if they do not offer adequate health coverage to their full-time workforce. Under Section 4980H(a), an ALE that does not offer minimum essential coverage to at least 95% of its full-time employees (and their dependents, excluding spouses) may owe a penalty of \$3,780 per full-time employee for 2027 (minus the first 30 employees) – a \$440 increase from 2026. Under Section 4980H(b), an ALE that offers coverage that is not affordable or does not provide minimum value may owe a penalty of \$5,670 per full-time employee who receives subsidized coverage through a Marketplace – a \$660 increase from 2026. Both penalties apply only when at least one full-time employee actually enrolls in subsidized Marketplace coverage.
- With summer internship programs underway, employers should be mindful of their potential obligations under the ACA employer mandate with respect to intern populations. Under the ACA, applicable large employers are required to offer minimum essential coverage to employees working an average of 30 or more hours per week, and interns are not categorically exempt from that definition. Employers that use the look-back measurement method for seasonal or variable hour employees should confirm that intern hours are being tracked correctly, and those using the monthly measurement method should assess whether any interns are expected to meet the 30-hour threshold during their program. Employers with questions about how intern classifications interact with their ACA compliance obligations should consult their benefits advisors before internship programs are underway.
- On May 29, 2026, the US Department of Labor (“DOL”) issued [four new opinion letters](#) on key principles of federal Fair Labor Standards Act compliance, including (1) overtime and salary implications when an exempt worker performs secondary duties compensated at an hourly rate; (2) how bonus payments to hourly, non-exempt employees affect the regular rate of pay during the period for which the bonus is earned, affecting overtime due; (3) when guard gates and controlled access points traversed during a meal break may affect the deductibility/compensability of the meal break period; and (4) how certain pre-shift work responsibilities should be treated for the purposes of compensable time. While DOL opinion letters are premised on fact and circumstance specific questions from employers and employees, alike, they often result in DOL's explanation of key principles that can benefit employer compliance strategies more broadly.

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