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Comment on Proposed Rule: Excepted Fertility Benefits
RIN 1545-BS02 (TREAS); 1210-AC40 (DOL); 0938-AV94 (HHS)
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The American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) is the largest non-sectarian life-affirming medical professional organization in the world, representing approximately 8,000 women's healthcare professionals. We were founded to represent the vast majority of OB/GYNs who do not perform induced abortion, which intends the death of our fetal patients. We are passionate about providing excellent, evidence-based healthcare to ALL our patients.

Our members routinely diagnose and treat infertility and other reproductive disorders through ethical, restorative approaches that seek to identify and correct underlying disease rather than bypass normal reproductive physiology. We appreciate the opportunity to comment on the proposed rule establishing Excepted Fertility Benefits and are grateful for the Administration's consideration of this crucial public health topic and desire to promote the offering of fertility benefits to employees. We are particularly encouraged that the proposed rule explicitly includes benefits for diagnosing, mitigating, and treating infertility-related conditions, and that male-factor infertility is considered as well. These provisions represent an important acknowledgment that **true reproductive medicine should prioritize restoring health rather than simply and immediately turning to assisted reproductive technologies in order to produce a baby while ignoring underlying health conditions**.

1. Prioritize Restorative Reproductive Medicine as First-Line Care

The proposed rule appropriately recognizes numerous restorative interventions but ultimately treats them as equivalent options to assisted reproductive technologies. This approach fails to distinguish between treatments that diagnose and correct disease and those that merely bypass it.

Infertility is frequently a symptom of underlying pathology. Conditions such as endometriosis, polyendocrine metabolic ovarian syndrome (formerly PCOS), thyroid disease, male-factor infertility, tubal disease and other reproductive structural abnormalities, as well as other endocrine disorders are common causes of infertility and will often respond to medical or surgical treatments. Evidence-based restorative reproductive medicine (RRM) seeks to identify and treat these underlying causes, allowing couples to conceive naturally whenever possible while simultaneously improving the long-term health of both women and men.

The Departments should expressly recognize restorative reproductive medicine — including comprehensive fertility evaluation, fertility awareness-based methods, hormonal evaluation and correction, treatment of male infertility, surgical restoration of reproductive anatomy, and pre-conception care — as preferred, first-line covered services.

Such an approach pairs seamlessly with the Administration's goal of Making America Healthy Again. RRM advances multiple policy objectives simultaneously by:

- addressing root causes underlying health problems;
- improving overall health rather than merely facilitating conception;
- reducing long-term healthcare expenditures through treatment of chronic disease;
- decreasing reliance on expensive assisted reproductive technologies;
- promoting healthier singleton pregnancies and reducing multiple gestations; and
- providing meaningful treatment options for patients whose moral or religious convictions preclude participation in IVF.

The final rule should encourage insurers and employers to design benefit structures that incentivize restorative care before more invasive reproductive technologies. Utilizing RRM as a first-line approach will make the whole family healthier overall.

Additionally, we encourage adoption of the definition of infertility as used in the RESTORE ACT - "a symptom of an underlying disease or condition within a person's body that makes it difficult or impossible to successfully conceive and carry a live child to term, which is diagnosed after 12 months of intercourse without the use of a chemical, barrier, or other contraceptive method for women under 35 or after 6 months of target intercourse without the use of a chemical, barrier, or other contraceptive method for women 35 and older, where conception should otherwise be possible."[i]

This definition of infertility could encompass male or female factor infertility and would apply to couples having conception-focused intercourse without conceiving.

2. Protect Human Embryos and Promote Ethical Fertility Care

AAPLOG is deeply concerned that the proposed rule broadly includes in vitro fertilization (IVF) without establishing ethical safeguards regarding the creation, transfer, cryopreservation, disposition, or destruction of human embryos. Every human embryo deserves dignity, respect, and ethical protection regardless of developmental stage, genetic condition or perceived likelihood of successful pregnancy.[ii]

AAPLOG

Current IVF practices are unregulated and frequently involve the creation of numerous embryos - many of whom are indefinitely cryopreserved, discarded, subjected to destructive genetic testing, or selected against because of disability, genetic characteristics, or sex. These practices raise profound ethical concerns and are inconsistent with medicine's obligation to protect vulnerable human life.

Moreover, IVF does not treat the underlying pathology responsible for infertility. Rather, it bypasses the reproductive pathway while leaving the underlying pathology unaddressed. This is not consistent with MAHA goals. In contrast, restorative reproductive medicine (RRM) seeks to diagnose and treat the disease processes responsible for infertility while respecting both patients and embryonic human life. Not only does it avoid the ethical implications of creating "surplus" human beings, but it also is often successful when IVF is not, is less expensive than IVF, and does not lead to the increase in pregnancy complications that IVF does.[iii]

Accordingly, AAPLOG recommends that the final rule prioritize RRM before assisted reproductive technologies like IVF. We encourage limitations on what is reimbursable, including:

- number of IVF cycles
- number of embryos created per cycle (only those that will be transferred)
- number of embryos transferred at a time.

European countries already have successfully set limitations on IVF and embryo creation and transfer, while the United States has none.

We also urge that certain actions be explicitly excluded as non-reimbursable, including:

- intentional embryo destruction or selective reduction;
- embryo selection based upon genetic screening disability;
- egg freezing;
- anonymous sperm donation;
- gestational surrogacy and related commercial arrangements. Commercial surrogacy essentially amounts to the selling of children and exploits the women who serve as surrogates – stripping their rights and potentially forcing them into procedures that are dangerous for their own health.[iv]

None of the above actually treat infertility, the stated goal of this proposed rule. In fact, some of the above listed actually harm our patients' health and lives, the opposite intent of medicine. We also encourage that the scope of coverage be limited to spouses, consistent with the spousal model found in other employer insurance programs.

These recommendations are consistent with longstanding principles of medical ethics that physicians should avoid intentionally causing harm to vulnerable human beings while pursuing therapeutic goals.

3. Preserve Robust Federal Conscience Protections

AAPLOG appreciates the flexible and voluntary nature of the benefit addressed in the proposed rule and encourages retention of that aspect so employers can use the fertility benefits to cover RRM wholly or in part. This aspect ensures protection of conscience for employers and their ability to customize the scope of the benefits.

Congress has repeatedly enacted federal conscience protections recognizing that healthcare professionals should never be compelled to participate in procedures that violate their moral or religious beliefs. As fertility technologies continue to evolve, similar protections should be expressly preserved for physicians, hospitals, employers, insurers, and healthcare professionals who object to embryo creation or destruction, embryo experimentation, embryo selection, third-party gamete donation, or commercial surrogacy.

We would encourage inclusion of explicit conscience protection language that "Nothing in this rule shall be construed to require a plan sponsor, issuer, healthcare professional, or healthcare institution to provide, facilitate, refer for, or cover any fertility-related service in violation of applicable federal or state conscience protections."

4. Improve Transparency Through Federal Data Collection

AAPLOG encourages using this proposed rule to improve transparency by expanding federal reporting requirements associated with fertility services covered under this rule. Current reporting largely emphasizes pregnancy and live birth outcomes but provides comparatively little information regarding embryo creation, embryo disposition, maternal complications, neonatal outcomes, or the comparative effectiveness of restorative reproductive medicine. More comprehensive reporting would better inform patients, physicians, employers, insurers, researchers, and policymakers.

AAPLOG recommends that the Departments coordinate with the appropriate federal agencies to collect and publicly report standardized, de-identified data regarding:

- the number of embryos created, transferred, cryopreserved, discarded, donated, or abandoned;
- maternal complications associated with assisted reproductive technologies;
- neonatal outcomes, including prematurity, low birth weight, congenital anomalies, stillbirth, and multifetal pregnancies;

AAPLOG

- utilization and outcomes of restorative reproductive medicine;
- comparative pregnancy and live birth outcomes following restorative treatment versus assisted reproductive technologies;
- long-term maternal health outcomes following fertility treatment;
- utilization of donor gametes and gestational surrogacy arrangements; and
- patient satisfaction and cost-effectiveness across fertility interventions.

Greater transparency would promote informed consent, facilitate comparative effectiveness research, improve quality improvement efforts, and enable future policy decisions based upon comprehensive clinical evidence rather than procedure utilization alone.

AAPLOG appreciates the Administration's recognition that infertility deserves comprehensive medical attention and applauds the inclusion of diagnostic evaluation, treatment of underlying disease, fertility awareness-based methods, and restorative interventions within the proposed framework.

At the same time, the final rule should more clearly prioritize restorative reproductive medicine, safeguard the lives and dignity of human embryos, explicitly exclude commercial surrogacy from covered fertility benefits, preserve longstanding federal conscience protections, and improve transparency through enhanced federal data collection.

We respectfully urge revision of the proposed rule accordingly. Doing so would promote ethical, evidence-based fertility care that restores reproductive health, protects vulnerable human life, respects the physician-patient relationship, supports families, advances medicine without compromising fundamental principles of medical ethics, and Makes Americans Healthier Again.

Respectfully submitted,

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[i] https://www.congress.gov/bill/119th-congress/senate-bill/1882/text
[ii] https://aaplog.org/wp-content/uploads/2024/11/2024.11.19-WEBSITE-CO-12-Ethical-Treatment-of-Human-Embryos-final.pdf
[iii] https://rrmjournal.org/index.php/jrrm/article/view/9
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[iv] Zaçe D, Pasciuto T, Corrado G, Cavallo CMP, Thiella S, Di Pietro ML. Maternal, pregnancy, and neonatal outcomes associated with surrogacy: a scoping review. Reprod Biol Endocrinol. 2026 Jan 8;24(1):20. doi: 10.1186/s12958-025-01513-w. PMID: 41507984; PMCID: PMC12870930.
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