The United States Fertility Benefit Landscape for Self-Insured Employers

Richard A. Brook, MS, MBA[1]; Ian A. Beren, BS[2]; Eric M. Rosenberg, MA[3]

[1]Better Health Worldwide, Inc., Newfoundland, NJ; [2]Workpartners LLC, Loveland, CO; [3]Workpartners, LLC, Pittsburgh, PA

Background

- Infertility is one of the most common health conditions among reproductive-aged individuals, with a global lifetime prevalence of 17.5% among women.[1]
- Assisted reproductive technology (ART)—including fertility medications, in vitro fertilization (IVF), and other procedures involving the handling of eggs or embryos—plays a central role in infertility treatment.[1]
- Fertility medications are typically dispensed through specialty pharmacies due to storage requirements and complex injection protocols.
- Research describing the scope and structure of fertility benefits is limited across US self-insured employers.
- In 2026, the US government proposed fertility as a limited excepted benefit for employers and requires employers:[2]
  - Cover diagnosis, mitigation, or treatment of infertility or related reproductive health conditions
  - Lifetime inflation indexed cap up to $120,000 (participant + dependents)
- The US Government estimates fertility drugs per cycle cost often cost over $5000.

Objectives

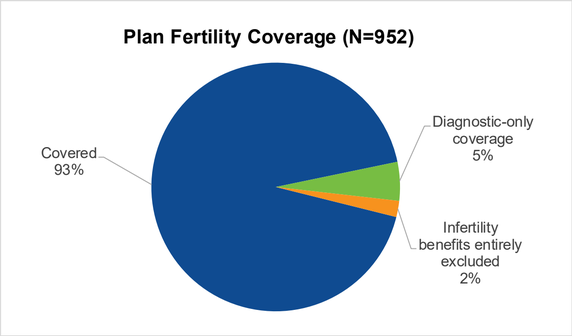
- To evaluate infertility-related benefits offered by US self-insured employers, including coverage levels, benefit limits, and provisions for ART, IVF, and fertility medications.

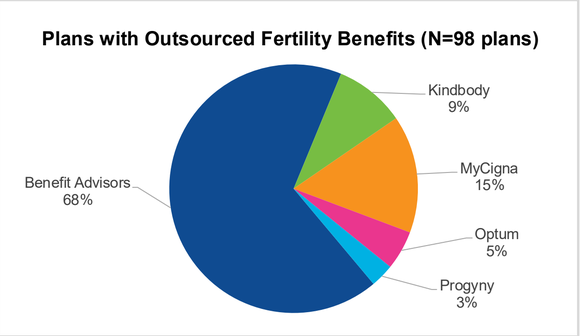
Methods

- Benefit plan information was abstracted from self-insured employers in Workpartners Research and Reference Database (RRDb) from 2001–2025, representing >500 employers.
  - Workpartners' RRDb has been used in prior research on Fertility,[1] employee[3-6] and caregiver[7-9] research
  - Employer coverage is administered by insurance providers
- Employer plans with specific infertility benefit coverage information were reviewed to characterize infertility coverage, including diagnostic-only benefits, outsourced services, annual or lifetime maximums, exclusions, medication coverage, number of covered IVF cycles, and other ART-related treatments.
- Additional plan design elements, such as restrictions on diagnostic testing and utilization requirements, were also captured.

Results

- A total of 952 unique benefit plan-years with specific mention of fertility benefits were evaluated.
- In the 952, analysis of plan benefits yielded the following broad coverage segments: Fertility treatment Coverage ($5,000 to $50,000), Diagnostic only coverage and specific exclusion.
- 22 of 952 (2.3%) of plans have **annual maximums,** 113 of 952 (11.8%) of plans had **lifetime maximums.**





NR, Not restricted

* $2,500 for surgical and nonsurgical treatments AND $2,500 lifetime for prescription drugs

$10,000 Lifetime maximum for infertility medications and/or Infertility treatment. Limited to the diagnosis and treatmentof underlying medical condition, artificial insemination, and ovulation induction to 6 separate attempts per lifetime.

^ Lifetime maximum on Infertility treatment - Artificial insemination, ovulation induction & advanced reproductive technology: Plans with coverage but without a specified limits.

- **IVF cycle limits:** 3 plans covered one lifetime cycle; 9 covered two cycles.
- **Medication coverage:** When included, fertility medications were covered under the standard drug benefit.

Conclusions

- Infertility benefit designs among US self-insured employers vary widely, particularly in coverage limits, outsourcing arrangements, and provisions for ART and fertility medications.
- This variation highlights opportunities for more consistent benefit structures and further research on how plan design influences access to infertility care.
- Fertility benefits are often contracted by a 3rd parties specializing in reproductive care.
- Workpartners RRDb reflects real world benefit utilization among the covered lives.
- Employer plans in the RRDb with specified benefits:
  - All had lifetime benefits below the proposed cap
  - On fertility prescription drugs would be limited to two cycles (based on $5000/cycle)

References

1 Brook RA, et al. The impact of health benefit design on patients with infertility. *Am J Manag Care*. 2025 Aug 1;31(8):e221-e227.
2 US Employee Benefits Security Administration. Release # 26-719-NAT May 10, 2026. www.dol.gov/newsroom/releases/ebsa/ebsa20260510
3 Good CB, et al. Medication Use for Patients With Obesity: Trends and Characteristics for US Employees. *Am J Manag Care*. 2026;32(4):294-300.
4 Brook RA, et al. Hand Eczema in US Employees: A Retrospective Observational Study of Workers' Compensation and Medical Claims. *J Med Econ*. 2026 Dec;29(1):1164-1179.
5 Su J, et al. The impact of hepatitis C virus infection on work absence, productivity, and healthcare benefit costs. *Hepatology*. 2010 Aug;52(2):436-42
6 Yuen K, et al. Health Benefit Costs and Absenteeism Among Employed Patients With Acromegaly. *Endocr Pract*, 2021; 27, 1034-1039
7 Brook RA, et al. Healthcare Costs and Absenteeism Among Caregivers of Adults with Partial-Onset Seizures: Analysis of Claims from an Employer Database. *Am Health Drug Benefits*. 2018 Nov;11(8):396-403.
8 Hendin B, et al. The Clinical and Economic Impact of Employees Who Are Care Partners of Patients with Multiple Sclerosis by Severity. *J Health Econ Outcomes Res* 2023 Apr. 10(1):91-101.
9 Kuvadia H, et al. Direct and Indirect Costs Among Caregivers of Patients With Major Depressive Disorder and Suicidal Ideation or Suicidal Attempt. *Prim Care Companion CNS Disord*. 2021 Aug 12;23(4):20m02893.

Better Health WORLDWIDE

workpartners