I

119TH CONGRESS
1ST SESSION

H. R. 3480

To amend the Patient Protection and Affordable Care Act to include fertility treatment and care as an essential health benefit.

IN THE HOUSE OF REPRESENTATIVES

MAY 19, 2025

Ms. UNDERWOOD introduced the following bill; which was referred to the Committee on Energy and Commerce

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A BILL

To amend the Patient Protection and Affordable Care Act to include fertility treatment and care as an essential health benefit.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Coverage for Inclusive and Valued Families Act of 2025'' or the ''Health Coverage for IVF Act of 2025''.

SEC. 2. INCLUDING FERTILITY TREATMENT AND CARE AS AN ESSENTIAL HEALTH BENEFIT.

(a) IN GENERAL.—Section 1302(b) of the Patient Protection and Affordable Care Act (42 U.S.C. 18022(b)) is amended—

(1) in paragraph (1)—

(A) in the matter preceding subparagraph (A), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (6)''; and

(B) by adding at the end the following new subparagraph:

''(K) Fertility treatment and care.''; and

(2) by adding at the end the following new paragraph:

''(6) FERTILITY TREATMENT AND CARE DEFINED.—For purposes of paragraph (1)(K), the term 'fertility treatment and care' means the following medically appropriate items and services furnished to an individual:

''(A) Preservation of human oocytes, sperm, or embryos for later reproductive use.

''(B) Artificial insemination, including intravaginal insemination, intracervical insemination, and intrauterine insemination.

''(C) Assisted reproductive technology, including in vitro fertilization and other treat-

ments or procedures in which reproductive genetic material, such as oocytes, sperm, fertilized eggs, and embryos, are handled, when clinically appropriate, and including at least 3 complete oocyte retrievals and an unlimited number of embryo transfers from such retrievals (regardless of whether such retrieval was performed on, before, or after the date of the enactment of this paragraph) in accordance with the guidelines of the American Society for Reproductive Medicine and using single embryo transfer when recommended and medically appropriate.

''(D) Genetic testing of embryos.

''(E) Medications prescribed, as indicated for fertility.

''(F) Gamete donation.

''(G) Such other information, referrals, treatments, procedures, medications, laboratory testing, technologies, and services relating to fertility as the Secretary determines appropriate.''.

(b) ADDITIONAL REQUIREMENTS.—Subpart II of part A of title XXVII of the Public Health Service Act (42 U.S.C. 300gg–11 et seq.) is amended by adding at the end the following new section:

"SEC. 2730. REQUIREMENTS RELATING TO FERTILITY TREATMENT AND CARE.

"(a) IN GENERAL.—In the case of health insurance coverage offered in the individual or small group market that provides both medical and surgical benefits and benefits for fertility treatment and care (as defined in section 1302(b) of the Patient Protection and Affordable Care Act), such coverage shall ensure that—

"(1) the financial requirements applicable to such fertility treatment and care benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the coverage, and there are no separate cost sharing requirements that are applicable only with respect to fertility treatment and care benefits; and

"(2) the treatment limitations applicable to such fertility treatment and care benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the coverage and there are no separate treatment limitations that are applicable only with respect to fertility treatment and care benefits.

"(b) PROHIBITION ON DENIAL OF CARE.—A health insurance issuer offering health insurance coverage in the

individual or small group market may not deny benefits for fertility treatment and care for individual on the basis that such individual lacks a diagnosis of infertility.

''(c) UTILIZATION MANAGEMENT TOOLS.—

''(1) IN GENERAL.—A health insurance issuer offering health insurance coverage in the individual or small group market that imposes any utilization management tool with respect to fertility treatment and care shall, for each of the first 5 plan years beginning on or after the date that is 1 year after the date of the enactment of this Act (and, upon request of the Secretary or the Comptroller General of the United States, for any subsequent plan year), conduct an analysis of the application of any such tool to such treatment and care and submit such analysis to the Secretary and to the Comptroller General of the United States. Such analysis shall contain the following information:

''(A) The specific coverage terms or other relevant terms regarding the application of such tools to such benefits and a description of all such benefits.

''(B) The factors used to determine when utilization management tools apply to such benefits.

"(C) The evidentiary standards used in designing the application of such tools with respect to such benefits and any other source or evidence used to determine the application of such tools to such benefits.

"(D) Information demonstrating how application of such tools to such benefits are consistent with clinical guidelines for fertility treatment and care.

"(E) Any findings by the issuer that such coverage is not in compliance with this section.

"(2) REPORT.—For plan years beginning on or after the date that is 1 year after the date of the enactment of this section, the Comptroller General of the United States shall submit to Congress and make publicly available a report that contains the following:

"(A) A summary of the analyses submitted under paragraph (1) with respect to such plan year.

"(B) An identification of each health insurance issuer that failed to submit an analysis under paragraph (1).

"(C) With respect to each health insurance issuer that did submit such an analysis, a speci-

fication as to whether such issuer submitted information sufficient to determine whether such issuer was in compliance with such requirements.

''(D) For each health insurance issuer that did submit information sufficient to determine such compliance, a finding of whether such issuer was in compliance with such requirements.

''(d) DEFINITIONS.—The terms 'financial requirement', 'predominant', and 'treatment limitation' have the meaning given such terms in section 2726(a)(3).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan years beginning on or after the date that is 1 year after the date of the enactment of this Act.

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