

**Defense Advisory Committee on Women in the Services  
December 2022 Request for Information**

**Defense Health Agency Response  
November 2022**

**Background:** The Defense Advisory Committee on Women in the Services (DACOWITS) (the Committee) is seeking information regarding recruitment initiatives to increase women's propensity to serve. The Committee has requested the Defense Health Agency (DHA) to provide information regarding whether there are gaps in institutional policies and procedures that obstruct pregnant Service women from progressing in their military career.

**Question #8:** The Committee requests a written response from the DHA on the following:

- a) What directives regulate the utilization of Assisted Reproductive Services?
- b) How many MTFs provide Assisted Reproductive Services?
- c) Who is authorized to utilize Assisted Reproductive Services (e.g., married couples, non-traditional families, single members, etc.)?
- d) What outreach or marketing strategies have been implemented to ensure Service members are aware that Assisted Reproductive Services exist?
- e) During annual well-women exams, are servicewomen made aware that Assisted Reproductive Services are available (e.g., egg freezing)?
- f) With the merger of DoD/DHA:
  - i. Have Assisted Reproductive Services been standardized?
  - ii. Will Assisted Reproductive Services continue to be provided? If so, where (e.g., MTFs, civilian providers, etc.)?
- g) What accommodations are afforded to servicewomen receiving Assisted Reproductive Services (e.g., suspension of fitness testing)?
- h) Does any data exist that suggests the servicewomen's career progression (retention and advancement) is positively impacted by having access to Assisted Reproductive Services?
- i) Over the last five years, how many servicewomen and servicemen have utilized Assisted Reproductive Services?
- j) At what point in their careers are servicewomen and servicemen using these Assisted Reproductive Services?

**DHA Response:**

**a) What directives regulate the utilization of Assisted Reproductive Services?**

There are no directives (e.g., Department of Defense issuances, Military Service regulations) that regulate utilization of Assisted Reproductive Services<sup>1</sup> for Service members. However,

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<sup>1</sup>For this response, Assisted Reproductive Services are defined as medical procedures in which sperm, eggs, or embryos are handled outside of the body. In general, Assisted Reproductive Services involve surgically removing eggs from a woman's ovaries, combining them with sperm (from donor or spouse) in a laboratory, and then either returning one or more embryos to the woman's body, cryopreserving the embryo(s), and/or donating the embryo(s).

the Secretary of Defense issued a memorandum, “Ensuring Access to Reproductive Health Care,” on October 20, 2022, directing the Department to create additional policy, consistent with federal law, for non-TRICARE-covered reproductive health care, including Assisted Reproductive Services.

By law, TRICARE may only cover services and supplies that are medically or psychologically necessary to prevent, diagnose, or treat a mental or physical illness, injury, or bodily malfunction, including those that cause infertility. Care is authorized to diagnose and treat an illness or injury of the male or female reproductive system to correct the underlying physical cause of infertility, which would then allow for natural conception through coitus (i.e., heterosexual intercourse). Assisted Reproductive Services are specifically excluded from coverage under the TRICARE medical benefit program.

Under separate statutory authority, the Supplemental Health Care Program (SHCP) covers extended benefits, including Assisted Reproductive Services, for seriously ill or injured Service members, defined as being Category 2 or 3 in accordance with Department of Defense Instruction 1300.24, *Recovery Coordination Program*, dated December 1, 2009. These extended benefits include cryopreservation of gametes (also referred to as oncofertility treatment) for members diagnosed with cancer and undergoing a gonadotoxic treatment for their cancer as well as Assisted Reproductive Technology (ART) services for members who have undergone cancer treatment that may have affected their fertility or suffered from urogenital trauma that led to the loss of their natural procreative ability. Details regarding these extended benefits can be found in the TRICARE Operations Manual, Chapter 17, Section 3, under paragraph 2.4.2.<sup>2</sup>

Service members and eligible beneficiaries who either desire or need to conceive via Assisted Reproductive Services may pursue treatments at a military medical treatment facility (MTF) Reproductive Endocrinology and Infertility Graduate Medical Education (GME) Program, which provides Assisted Reproductive Services not otherwise covered at a greatly reduced cost, where available. All such care is subject to space availability at the respective MTF based on the residency and/or fellowship capacity.

#### **b) How many MTFs provide Assisted Reproductive Services?**

As of October 2022, six MTFs provide Assisted Reproductive Services, including: Walter Reed National Military Medical Center, Bethesda, Maryland; Tripler Army Medical Center, Honolulu, Hawaii; Womack Army Medical Center, Fort Bragg, North Carolina; Madigan Army Medical Center, Joint Base Lewis-McChord, Washington; Brooke Army Medical Center, San Antonio, Texas; and Naval Medical Center San Diego, San Diego, California, as part of their GME programs (Obstetrics and Gynecology residencies and/or Reproductive Endocrinology and Infertility fellowship).

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<sup>2</sup> Available at <https://manuals.health.mil/pages/DisplayManualHtmlFile/2022-08-31/AsOf/TO15/C17S3.html>.

**c) Who is authorized to utilize Assisted Reproductive Services (e.g., married couples, non-traditional families, single members, etc.)?**

- Services to diagnose and treat the physical causes of infertility are covered for all Service members and other eligible beneficiaries, regardless of their marital status or sexual orientation.
- Oncofertility treatment coverage under the Supplemental Health Care Program (SHCP) extended benefit applies to ADSMs who are seriously or severely ill (Category 2 or 3) as a result of their cancer and will or have undergone cancer therapy that may affect their fertility, regardless of gender, sexual orientation, or marital status.
- Assisted Reproductive Services are available for qualifying ADSMs with severe illness or injuries (Category 2 or 3) resulting in the loss of their natural procreative ability. The benefit is limited to permitting a qualified Service member to procreate with their lawful spouse, who is also an eligible beneficiary. The benefit is designed to allow the Service member and their spouse to become biological parents (using the member's gametes) through reproductive technologies. Donor gametes and surrogacy are excluded.
- MTF GME programs also take all eligible beneficiaries. There is no requirement for the beneficiary to be married or have a partner. Additionally, beneficiaries may provide donated gametes (that they have obtained at their own expense) for the procedure.

**d) What outreach or marketing strategies have been implemented to ensure Service members are aware that Assisted Reproductive Services exist?**

The Department of Defense has not implemented outreach or marketing strategies because Assisted Reproductive Services are not a TRICARE-covered benefit.

**e) During annual well-women exams, are servicewomen made aware that Assisted Reproductive Services are available (e.g., egg freezing)?**

DoD health care providers, including both primary care and women's health providers (e.g., obstetricians/gynecologists), routinely provide reproductive-age Service women with clinical guidance on fertility, infertility diagnosis and treatment, and Assisted Reproductive Services. Health care providers routinely discuss and provide counseling on reproductive health as part of any comprehensive well-women exams. Moreover, specialty providers, such as oncologists, are aware of the SHCP benefit and may counsel Service members on availability of applicable Assisted Reproductive Services, when appropriate.

**f) With the merger of DoD/DHA:**

**i. Have Assisted Reproductive Services been standardized?**

The realignment of MTFs under the DHA has not impacted the individual MTF GME programs whose criteria are standardized based on Accreditation Council for Graduate Medical Education criteria.

**ii. Will Assisted Reproductive Services continue to be provided? If so, where (e.g., MTFs, civilian providers, etc.)?**

Existing services available through the MTFs GME programs will continue to be provided for the foreseeable future, and Service members may also pursue Assisted Reproductive Services through private sector care at their own expense. SHCP extended benefits remain in place for severely ill and injured ADSMs.

**g) What accommodations are afforded to servicewomen receiving Assisted Reproductive Services (e.g., suspension of fitness testing)?**

Accommodations for Service members are based on Military Service policies and the Service member's profile. Additionally, consistent with the Secretary of Defense's direction in his October 20, 2022, memorandum, "Ensuring Access to Reproductive Health Care," the Department is in the process of creating additional policy, consistent with federal law, for non-TRICARE-covered reproductive health care, including Assisted Reproductive Services.

**h) Does any data exist that suggests the servicewomen's career progression (retention and advancement) is positively impacted by having access to Assisted Reproductive Services?**

The most recent data is available through the Women's Reproductive Health Survey of Active-Duty Service Women, conducted by RAND National Defense Research Institute under contract with DoD.<sup>3</sup> The Department is fully committed to understanding the impact access to family building care, including Assisted Reproductive Services, has on our Service members and will continue to assess through all available avenues.

**i) Over the last five years, how many servicewomen and servicemen have utilized Assisted Reproductive Services?**

The most recent data regarding utilization of Assisted Reproductive Services via the MTF GME programs and SHCP extended benefit are included in the 2020 Report to Congress, Study on Infertility in Members of the Armed Forces.<sup>4</sup> This study notes the following: "In 2019, Reproductive Endocrinology and Infertility GME programs conducted more than 1,700 IVF cycles (note, this is not unique individuals, and is inclusive of all beneficiaries, not just ADSMs). This volume is prescribed to meet the GME program needs rather than the needs or demands of ADSMs or other beneficiaries."

The DHA does not have any data on how many Service members have utilized private sector Assisted Reproductive Services at their own expense.

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<sup>3</sup> Meadows, Sarah O., Rebecca L. Collins, Megan S. Schuler, Robin L. Beckman, and Matthew Cefalu, The Women's Reproductive Health Survey (WRHS) of Active-Duty Service Members. Santa Monica, CA: RAND Corporation, 2022. [https://www.rand.org/pubs/research\\_reports/RRA1031-1.html](https://www.rand.org/pubs/research_reports/RRA1031-1.html).

<sup>4</sup> Available at: <https://www.health.mil/Reference-Center/Reports/2020/11/04/Study-on-Infertility-in-Members-of-the-Armed-Forces>.

**j) At what point in their careers are servicewomen and servicemen using these Assisted Reproductive Services?**

Any data relevant to this question would be included in the Women's Reproductive Health Survey of Active-Duty Service Women.

## Basic Description of Non-Coital Fertility Treatment

Assisted Reproductive Services (ARS) or Assisted Reproductive Technology (ART) can be defined in different ways. For purposes of this response, ARS refers to medical procedures that aim to achieve pregnancy in those who are unable to achieve pregnancy through standard heterosexual intercourse. These complex treatments involve influencing gametes (i.e., eggs and sperm) to increase the chances of fertilization and implantation. ARS includes all fertility treatments in which sperm, eggs, or embryos are handled outside of the body. In general, ARS procedures involve surgically removing eggs from a woman's ovaries, combining them with sperm (from donor or partner) in a laboratory, and then either returning one or more embryos to the woman's body, cryopreserving the embryo(s), and/or donating the embryo(s). In persons with limited reproductive capacity due to genetic, surgical, traumatic, and/or medical complexities, ART can allow them to use their own or donated gametes to create embryos for immediate (i.e., to transferred into the uterus) or future use (i.e., cryopreserved for use at another time). As a family formation process, ARS facilitates interconnections of sexuality, gender, race, socioeconomic status, family structure, with access to healthcare services. ARS affords individuals of all groups (heterosexual people as well as members of the lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA+) community) the ability to meet their reproductive needs.

**Unassisted Reproduction:** In order to understand ARS, it is important to understand how conception takes place naturally. Ovulation occurs when a mature egg is released from the ovary; the egg then travels to the fallopian tube, where sperm can fertilize it. If the egg is fertilized, the resulting embryo travels to the uterus, which may take several days. If the embryo implants, pregnancy can result.

**ARS:** ARS includes processes and procedures combining sperm and eggs outside of the body, and subsequently placing them in a uterus to develop into a pregnancy. Methods are based on the underlying etiology and altered functionalities of the individual(s).

***Ovarian stimulation*** is administration of medication to increase the number of eggs growing in the ovaries (vice the single egg that typically is released each month during natural conception). Eggs can then be released via triggering ovulation or be removed (i.e., harvested). If harvested, eggs can be fertilized with sperm outside of the body to create an embryo, or they can be cryopreserved for future use.

- ***In-vitro fertilization (IVF)***, or embryo transfer, refers to the egg and sperm being fertilized outside of the body, and allowed to develop into an embryo (typically, within three to five days after fertilization). The embryo is then transferred into the uterus (fresh IVF transfer) or cryopreserved for future use (frozen embryo transfer).
- ***Intracytoplasmic sperm injection (ICSI)*** is a technique used during in vitro fertilization (IVF) where a single sperm is injected directly into the egg for the purpose of fertilization. This technique is used during IVF improve the chance of fertilization. During conventional IVF, an egg is placed in a culture dish with many sperm, and fertilization occurs if/when one sperm penetrates the egg naturally, leaving fertilization up to chance. ICSI ensures penetration of the egg by a sperm.

- **Third-party ARS** is when an individual donates eggs, sperm, or embryos to be used for pregnancy by a designated recipient, unknown recipient, or gestational carriers. A gestational carrier, or surrogate, is a woman carrying and bearing a genetically unrelated child for another person (although there are some cases in which genetically related carriers (e.g., sister, mother, cousin) could carry a pregnancy for another family member). Gestational carriers are typically utilized when there is a serious health issue, damaged uterus, a lack of uterus in women, and/or for same-sex male couples or single men seeking to create a family. IVF can be utilized to create a pregnancy in a person unrelated to the embryo. Third party ARS can include:
  - Egg donation: includes harvesting eggs, through ovarian stimulation (see above), for use by a recipient or surrogate, donated, or stored for future use;
  - Sperm donation: is the provision of sperm with the intention for use by a recipient or surrogate, donated, or stored for future use; and/or
  - Embryo donation: wherein embryos are created for use by designated recipient or surrogate, donated, or stored for future use.
- **Cryopreservation** refers to a process for freezing either gametes (i.e., eggs or sperm) or embryos. They can then be stored for future use by the donor, a designated person, or open donation. Of note, ARS centers are increasingly cryopreserving gametes (especially eggs) for persons who receive treatments or procedures that may affect their future fertility, such as chemotherapy for cancer (i.e. oncopreservation). While people may choose to freeze eggs, sperm, or embryos for future use or donation, consideration must be given for what will be done with the remaining gametes and/or embryos after families have been completed (typically donated or destroyed) or if the donor dies or is unable to be reached for continued cryopreservation storage responsibilities.

**Other fertility treatments**: Another procedure for treatment of infertility, which does not fall under the umbrella of ARS, is intrauterine insemination (IUI). IUI, also referred to as artificial insemination, includes medications to stimulate egg production followed by the injection of sperm into the cervix at the time of ovulation. While this not considered ARS (since it includes only the handling of sperm, not eggs or embryos), this procedure is considered a non-coital means of reproduction.

Prepared By: Defense Health Agency