

Serving Those Who Serve?

Access to IVF for Servicemembers and Veterans

UPDATED MARCH 2026



Servicemembers and veterans appear to face high rates of infertility. Unfortunately, limited information, restrictive laws and policies, high out-of-pocket cost, and other barriers put the fertility health care they need, including IVF, out of reach for many.

This issue brief is the third in a series discussing the unique barriers servicemembers, veterans, and their dependents face in accessing reproductive health services.

This updated issue brief first provides background on infertility generally as well as on racial disparities in incidence rates and access to care. It also highlights how access to fertility health care, including in vitro fertilization (IVF), is an important aspect of comprehensive health care and key to ensuring the full spectrum of reproductive rights. Second, it discusses infertility among servicemembers and veterans, with a particular focus on female infertility, where significant research and knowledge gaps persist. Third, it notes the multiple barriers to IVF for servicemembers, veterans, and their dependents, including legal restrictions on insurance coverage, out-of-pocket cost barriers, and logistical and systemic barriers. Finally, it offers policy recommendations for ensuring equitable and non-discriminatory access to fertility health care, including IVF, for servicemembers, veterans, and their dependents.

To learn more about IVF and about emerging threats to IVF, see [IVF: A Critical Method for Building Families](#) and [IVF Under Attack: Anti-Reproductive Freedom Fertility Doctrines](#).

Background

Human Rights Implicated

Infertility and access to fertility health care implicates multiple human rights, including: a person's right to health, to make reproductive decisions, such as whether and when to have children; to benefit from scientific progress; to equality and non-discrimination; and to informed consent. To recognize and actualize these rights, laws and policies should ensure that people have access to information about and can access fertility health care, including IVF, without discrimination.

Infertility Prevalence

Infertility is a globally recognized public health concern. The World Health Organization estimates that 17.5% of the worldwide population is impacted, accounting for approximately 1 in 6 people.¹ In the U.S., data from the Centers for Disease Control and Prevention ("CDC") National Survey of Family Growth 2015-2019, the most recent survey on this subject, reports that 13.4% of women ages 15-49 in the United States, or 1 in 7, experience impaired fecundity.^{2*} Data from the same survey revealed that 11.4% of men ages 15-49 experience infertility.³

These numbers do not fully represent the communities who need access to fertility health care. That is because they do not account for individuals and couples who do not have a clinical diagnosis of infertility but nonetheless need access to fertility health care, like IVF, to start or grow their families. Infertility is often exclusively understood as clinical. The clinical diagnosis generally describes physiological conditions underlying the inability to reproduce following one year of unprotected sexual intercourse.^{**} This assumes that a person is a) partnered and b) partnered to a person of a different sex (i.e., someone with complimentary gametes.) To better understand the need for fertility health care, however, data must take into account individuals and couples who cannot reproduce via unprotected sexual intercourse because they do not have the necessary gametes. Laws and policies that use more inclusive definitions of infertility and provide fertility health care coverage to everyone who needs it to start or build their family would expand access to more equitable and non-discriminatory care.

Black and Indigenous women of all socioeconomic backgrounds in the United States experience deeply entrenched racial and ethnic disparities in health outcomes,⁴ including in rates of infertility. CDC data from 2006-2010 revealed that non-Hispanic Black women are nearly twice as likely to be diagnosed with infertility than Hispanic or non-Hispanic white women.⁵ CDC data collected between 2002-2013 also showed higher rates of infertility among Black and American Indian/Alaska Native respondents compared to non-Hispanic white respondents.⁶

Given these racial disparities in the general population, it is highly likely that they are mirrored in infertility rates in the military, where female recruits have historically been more racially diverse than both the general population and male recruits.⁷ As of 2023, 32% of active-duty members identify with a racial minority group, and 19.5% of active-duty members are Hispanic or Latino.⁸ Of the estimated two million women veterans living in the U.S. in 2022, approximately 68.6% were white, 20.3% were Black, and 10.3% were Hispanic or Latino.⁹

* Impaired fecundity refers to challenges faced by an individual or couple in getting pregnant or carrying a pregnancy to term. The impaired fecundity statistic provides a better measure because the infertility category captured only married women.

** An updated definition of infertility issued by the American Society for Reproductive Medicine recognizes that evaluations should be initiated after six months where the female partner is 35 years of age or older.

Fertility health care

The most common form of assisted reproductive technology (ART)^{***} in the United States is IVF.¹⁰ In 2023 alone it accounted for 2.6% of annual births.¹¹ A typical, two-week IVF cycle consists of:¹²

1. Stimulation of the ovaries using fertility medications (ovulation induction);
2. Surgical removal of eggs from the ovaries (egg retrieval);
3. Fertilization of the retrieved eggs with sperm in the laboratory (IVF); and
4. Transfer of an embryo into the uterus or embryo cryopreservation.

This two-week timeline does not include the time required for the patient evaluations and informed consent conversations that happen prior to ovulation induction, or the time after embryo transfer spent waiting to confirm a pregnancy.

ART use has increased significantly since the birth of the first infant in the U.S. using IVF in 1981.¹³ Notably, so has the out-of-pocket cost of such technologies. With the necessary medication and tests, but without insurance coverage, a single IVF cycle in the United States can cost up to \$30,000.¹⁴ Data from 2022 shows that where the patient was under 35 years of age and used their own egg(s), approximately 39% of first-time transfers, resulted in a live birth.¹⁵ For women over age 35, that number dropped to approximately 30% and the likelihood of requiring several transfers and IVF treatment cycles to establish a pregnancy increased substantially.¹⁶ Multiple cycles result in increased out-of-pocket costs, forcing some people to consider taking out loans, change their job, turn to crowdfunding platforms, get treatments in other countries with lower costs, or move to states with IVF insurance mandates.¹⁷ Women who have IVF insurance coverage are more likely to establish a pregnancy and have a live birth because they are able to continue to access care over multiple cycles.¹⁸ Meanwhile, uninsured women are three times more likely than insured women to discontinue IVF after one cycle.¹⁹

While neither intrauterine insemination (IUI)^{****} nor ovulation induction (OI) are categorized as ART, they are commonly used methods of fertility health care in the U.S. The success rate of IUI ranges between 20-50% over multiple cycles and is often the first intervention used before moving on to IVF.²⁰ OI can be used in conjunction with IUI or IVF for people experiencing irregular menstrual cycles or unexplained infertility.²¹

Mental health care is also increasingly recognized as an essential part of fertility health care, as infertility and pregnancy loss create heavy emotional burdens. One study found that women with infertility felt as anxious or depressed as those diagnosed with cancer, hypertension, or those recovering from a heart attack.²² Psychologists are seeing an increase in patients dealing with the mental health trauma of infertility, with one psychologist characterizing it as an “invisible loss” because of the stigma and silence surrounding the inability to conceive.²³

*** Assisted reproductive technologies include all fertility treatments that involve the handling of eggs and sperm and/or embryos. Popular methods of ART include IVF and frozen embryo transfers. ART do not include treatments in which only sperm is handled, as in intrauterine insemination (IUI). They also do not include treatment in which a patient takes hormonal medication to stimulate egg production (OI).

**** IUI is a method of fertility care whereby sperm is transferred directly into a person’s uterus to facilitate fertilization.

Infertility Incidence among Servicemembers and Veterans

While research on infertility incidence and access to fertility health care use in the U.S. is limited, there is even less data available for the military community. However, a 2020 study by the Service Women’s Action Network (SWAN), which surveyed 799 female servicemembers and veterans, revealed that 37% of respondents struggled with infertility—over three times higher than the national average.²⁴ While this is not a nationally representative survey, it nevertheless indicates that infertility is of increasing concern among servicemembers and veterans, particularly as the number of female recruits continues to grow.²⁵ In another survey involving over 20,000 veterans who served in the military between 2001 and 2008, respondents reported that they had experienced infertility at rates higher than the general U.S. population.²⁶ And in 2022, a Department of Defense Women’s Reproductive Health Survey found that 15.2% of active duty servicewomen were unable to establish a pregnancy after 12 months of trying.²⁷ It also documented that 12% of active duty service women reported an unmet need for fertility services after joining the military.²⁸

A Military Health Services report attempts to counter this narrative, but its conclusions may not paint a full picture.²⁹ The report estimates that the average annual prevalence of diagnosed female infertility between 2019-2023 was only 1.6% among service women and that the incidence rate decreased by 22.1% between those years.³⁰ It also concludes that the rate of infertility among servicewomen is far lower than the rate of self-reported infertility documented in the Department of Defense Women’s Reproductive Health Survey (15.2%).³¹ Notably, it is also far below the incidence rates reported in both the SWAN report (37%) and the general population (13.4%).³² The Military Health Services report arrived at its incidence rate only by looking at the rate of *diagnosed clinical* infertility cases in the military and ignoring the rate of *self-reported* infertility. Its findings are misleading, however, because the rate of diagnosed infertility is inherently underinclusive, as it ignores people who experience infertility but are unable to access care or obtain a formal diagnosis. As anecdotal evidence collected in the SWAN survey showed, for example, many female servicemembers and veterans who struggled to become pregnant wanted to seek out or attempted to seek out medical care but faced substantial barriers.

The report also disregarded servicemembers who sought fertility health care based on their relationship status or sexual orientation. As reported in 2019, an estimated 16% of female servicemembers and 4% of male servicemembers identified as lesbian, gay, or bisexual.³³ Additionally, unmarried servicemembers represent approximately 49.5% of active duty servicemembers in 2023, 52% of National Guard and Reserve members, and 40% of veterans.³⁴ As will be further explored below, current restrictions on fertility health care coverage limit access for these groups and a number of servicemembers and veterans have been denied services.

Risk factors related to military service may affect infertility incidence rates for servicemembers and veterans

Many servicemembers are exposed to job-related risk factors that can cause infertility or are linked to a greater risk of infertility. While more research is needed to obtain reliable data, it is likely that exposure to these risk factors results in higher infertility rates among servicemembers and veterans. For example, soldiers deployed in combat areas may experience service-related injuries that render them infertile. Combat-related injuries that adversely impact fertility include spine/spinal cord and head injuries, which particularly affect male fertility, and genital/pelvic trauma, which may affect fertility in both men and women.³⁵ Women who are deployed in combat zones may also be exposed to an additional risk factor most men are not: combat gear that

is not designed for use by women. Ill-fitting combat gear can cause injuries, including injuries that could directly or indirectly affect fertility.³⁶

Some military occupations may hold their own, unique risks. Exposure to toxic chemicals can harm the reproductive system and potentially cause infertility.³⁷ As a result, servicemembers who are exposed to harmful chemicals as an essential function of their jobs may be at substantially higher risk of infertility than other servicemembers or the civilian population at large. These include engineers handling solvents to clean or strip plane parts, servicemembers who specialize in hazardous waste cleanup, or those who are exposed to contaminated water and burn pits during deployment. One retired Army Officer reported that exposure to MEK—a liquid solvent used for cleaning or stripping plane parts—caused the total loss of her ovaries at age 21. The military refused to provide her with IVF or other fertility health care.³⁸

Other risk factors include sexual trauma and PTSD. While more research is needed on the link between military sexual trauma and infertility, researchers have shown that women in the military who report surviving attempted or completed sexual assault are more likely to report a history of infertility.³⁹ Likewise, although the relationship between psychological distress and infertility remains unclear,⁴⁰ there is a demonstrated correlation between post-traumatic stress disorder (PTSD) and female infertility.⁴¹ The Department of Defense reports high numbers of sexual assault.⁴² Further, the Department's estimates of PTSD rates among returning servicemembers vary, but the disorder may affect as many as 20-30% of all returning servicemembers.⁴³

Barriers to IVF for Servicemembers and Veterans

Servicemembers and veterans are subject to numerous barriers to IVF services, including discriminatory restrictions on insurance coverage, its high out-of-pocket cost, and logistical and systemic barriers to care.

Legal restrictions on eligibility for insurance coverage

Servicemembers

TRICARE, the Department of Defense (DoD) insurance benefit plan for servicemembers and their dependents, restricts eligibility for fertility health care, making access to care in the military health care system difficult for the vast majority of beneficiaries. While TRICARE beneficiaries include all military personnel and their dependents—including members of the Army, Navy, Air Force, Marines, Coast Guard, and nonactive duty servicemembers, such as the National Guard and Reserves—only certain active duty servicemembers are eligible for IVF coverage.

TRICARE covers medical care for the “diagnosis and treatment for an illness or injury of the male or female reproductive system” that may lead to infertility (e.g., reproductive cancers, hormonal disorders, and erectile dysfunction), but it did not always cover the ART services required as a result of those injuries. In April 2012, the DoD began covering IVF services for “seriously or severely ill or injured” servicemembers via a memorandum,⁴⁴ although it imposed strict eligibility requirements, including that a member must:

- › be on active duty;
- › have experienced a serious illness or injury while on active duty;
- › have lost natural reproductive ability due to that illness or injury;
- › be able to provide their own genetic material to produce a pregnancy; and
- › have a lawful spouse who can also provide their own genetic material.⁴⁵

“ [I’m] frustrated that infertility treatment is treated as an elective rather than a disease. After waiting months on IVF waitlist [...], I sought [a] second opinion through [a] civilian provider. Both options are cost prohibitive to most.”

—Air Force Officer, Active Dutyⁱⁱ

Pursuant to a legal challenge, the DoD expanded its coverage in 2024. Under the amended policy, active duty servicemembers are no longer required to be married to access coverage. Servicemembers who use donor gametes are also now eligible for coverage.⁴⁶ An eligible servicemember or the lawful spouse of such a servicemember may receive up to three completed cycles of IVF from either a military treatment facility or a civilian provider, capped at six total cycles.⁴⁷

Notwithstanding these updates, TRICARE’s insurance coverage requirements continue to discriminate against beneficiaries who cannot prove that a service-connected illness or injury caused their infertility, which is often difficult to demonstrate unless it manifests as physical trauma to the reproductive organs.⁴⁸

Veterans

Veterans face similar eligibility restrictions to accessing IVF. Veterans who receive an honorable discharge are eligible for health care benefits through the Veterans Health Administration (“VHA”) system, which provides nearly all essential services at VHA facilities.⁴⁹ VHA is the country’s largest integrated health care system, with more than 1,200 care locations serving nearly nine million veterans with essential health services each year.

The VHA medical benefits package specifically excludes coverage for IVF.⁵⁰ However, pursuant to a provision first attached to the annual appropriations bill in 2016 and included every year since then, VHA currently funds IVF for a narrow subset of veterans. Under the provision, veterans who had a service-connected condition that led to their inability to procreate with their spouse without the use of fertility treatment are eligible for IVF.⁵¹ The VHA’s eligibility requirements are designed to mirror those under TRICARE.⁵² As a result, single and unmarried veterans, those in same-sex marriages, and those who cannot prove a service-connected illness or injury were until recently ineligible for IVF services and driven to seek care from non-VA providers, where they face substantially higher out-of-pocket costs that are prohibitive to many.

Pursuant to the same legal challenge that led the DoD to update its eligibility requirements in 2024, veterans and their dependents who receive their care through the VHA no longer need to meet a marital status requirement or use their own gametes to be eligible for IVF coverage. However, as with the DoD policy, the requirement to prove a service-connected illness or injury remains. Additionally, because the current provision is tied to the annual appropriations package, the funding for even this narrow population of veterans is not permanent. It is limited to the current fiscal year and must be renewed by Congress with every appropriations cycle.

High out-of-pocket costs

High out-of-pocket costs of fertility health care are a significant barrier that affects even those servicemembers who are eligible for IVF treatment coverage. Individuals who qualify for TRICARE coverage and are able to access care may still have to pay a substantial amount in out-of-pocket costs, even with discounts offered due to their military status.⁵³ For example, the cost of one IVF cycle at the Walter Reed ART Institute in Bethesda, Maryland for a covered, eligible individual ranges from \$4,800 to \$7,000.⁵⁴ One Air Force member who became pregnant through IUI while on the waitlist for IVF services at Walter Reed found that even with the discounted services, her out-of-pocket costs were equivalent to seeing a civilian provider because TRICARE did not cover all the necessary medications.⁵⁵

Costs for service vary dramatically based on the specific military treatment facility’s (MTF) contracts with civilian partners and regional cost differences. One Air Force Officer who received fertility health care from both a MTF and a civilian provider noted that the quality of care and service at the MTF was not worth the amount of money she paid out-of-pocket.⁵⁶

“

Frustrating!! My military OB/GYN at my last base was trained to do IUI. We tried this option four times without success. [...] I feel disadvantaged because I'm not stationed in Hickam, San Antonio or the National Capital region where IVF could have been an option.”

– Air Force Officer, Active Dutyⁱⁱⁱ

“

“It has been frustrating receiving treatment for infertility through the military healthcare system. After receiving a diagnosis that required IVF in order to conceive, I was referred to a military treatment facility for IVF. I have been on a waitlist for IVF for over a year. Even getting an initial appointment took several months. The closest military treatment facility that offers IVF is three hours away, requiring me to take significant time off work to accomplish appointments.”

– Air Force Officer, Active Duty^{iv}

Logistical and systemic barriers

Servicemembers and veterans face parallel logistical and systemic barriers that impede their access to care. Such barriers include limited availability of healthcare facilities that provide the needed care; excessive delays and wait times for appointments due to high demand and limited facilities; a perceived low quality of care; and inadequate and/or confusing referrals. In addition, servicemembers also face unique barriers because the nature of IVF care can impact their career trajectory.

Limited facilities and long wait times

TRICARE beneficiaries may access care directly from the 723 military treatment facilities (MTFs), including 109 MTFs located overseas,⁵⁷ or they may use TRICARE to purchase care from civilian providers in the U.S.⁵⁸ However, only eight MTFs offer the full range of fertility services, including IVF,⁵⁹ leading to limited access to care and long wait times. Specifically, related barriers include:

- › **Geographic limitations on access to care:** Access to IVF in the U.S. is already limited by geography, with one study finding that nearly 40% of reproductive age women live in areas with zero or one ART clinic.⁶⁰ For servicemembers, the eight MTFs offering the full range of fertility health care services are distributed across the country in Maryland, Hawai'i, North Carolina, Washington, Texas, California, Virginia and Ohio.⁶¹ Some of these MTFs contract with civilian providers to provide care, which increases the travel costs and time needed to access care for servicemembers. Many servicemembers may be stationed in locations that make these eight MTFs or civilian ART clinics entirely inaccessible, especially while on active duty.
- › **Limited availability of appropriate specialists:** For veterans, accessing care may also be difficult because not all VA-affiliated fertility centers provide a full range of options. The age of the individual and specific conditions causing infertility can determine which clinics can provide appropriate services.
- › **Excessive wait times:** Wait times are common and often run up to one year, which is significant, since the rate of live births decreases with age.⁶² After waiting for a year on a waitlist, one member of the Air Force had to take significant time off from work because the nearest MTF was three hours away.⁶³ Additionally, changes in location through deployment or changes of station can also cause disruption, delay, or cancellations.⁶⁴ One service member described the ART care team at one facility as “so over-regulated and overwhelmed that they must attempt to force everyone into cycles, they can't accommodate your schedule, and they don't do cutting-edge procedures.”⁶⁵ This service member eventually sought IVF services from a civilian clinic, costing them over \$30,000 in out-of-pocket fees.⁶⁶
- › **Interruptions in access to care while transitioning to veterans' benefits:** In addition to the significant waiting period patients experience in the military and VA health care systems, the transition from receiving care as a servicemember insured under TRICARE to receiving veterans' benefits under VHA, is not seamless and continuity of care is not guaranteed. For example, one Coast Guard veteran reported that she was forced to wait 10 months after her retirement before she was able to access care with a fertility specialist again.⁶⁷

Incorrect diagnoses and inadequate referrals

Both servicemembers and veterans have repeatedly reported receiving inadequate information and care at military and veterans' healthcare facilities. Such barriers include:

- › **Failure to refer:** One Navy servicemember reported that her request for a referral to see a fertility specialist was denied because she had not reached a threshold

“

The VA placed me on clomid for a year without trying to determine what could be the cause. When it didn't work, they wanted to do exploratory surgery. I said no and went to a respected fertility clinic who found on the first day the causes[...]. I became pregnant within a couple of months.”

– Air Force Officer, Veteran^v

“

What bugs me to this day is that she never said, 'You need to go to a different kind of facility.' I was educated! I was the director of Illinois Veterans Affairs. I didn't do my due diligence, so what about those other families?”

– Sen. Tammy Duckworth^{vi}

of three miscarriages—despite having actively tried and failed to conceive for four years.⁶⁸ Another servicemember reported, “I need IVF treatment[,] but the military would not provide it and would not refer me to an outside clinic. I had to find my own clinic and pay out-of-pocket thousands of dollars and drive at least two hours away.”⁶⁹

- › **Inadequate testing:** Several servicemembers and veterans reported inadequate fertility diagnostics. A Coast Guard veteran stated that “if getting pregnant is not successful it is chalked up as ‘unexplained’ infertility.”⁷⁰ In her case, after visiting a specialist, the “unexplained” infertility was revealed to be in part due to mycotoxins (mold) which was never considered by military health care providers.⁷¹
- › **Complex referral system:** For veterans, the complexity of the VA's referral system can pose an additional barrier. VA has historically been inconsistent in how referrals are made and how claims and payments to community care providers are handled.⁷² Reports indicate that veterans struggle to make appointments, experience long delays to access community care, and are often unsure whether VA community care providers are even accepting new patients.⁷³
- › **Referrals to limited service providers:** Some veterans report that referrals were made to providers who did not provide a full range of options or did not have payment agreements with the VA.⁷⁴ This problem is compounded when VA refers patients to religiously-affiliated providers, which do not offer IVF services and also sometimes fail to disclose that IVF is even an option. U.S. Senator Tammy Duckworth has previously shared her experience with such a referral. After eight years of receiving fertility health care at an institution she was referred to by the VA, her doctor told her she was too old to become pregnant.⁷⁵ At the recommendation of a friend, she changed physicians, and learned that the VA-recommended provider's religious directives did not permit fertilizing embryos outside of the body—indeed, they never disclosed to her that the service even existed.⁷⁶ Within 18 months of switching providers, Senator Duckworth became pregnant for the first time. She delivered her first daughter, Abigail, in 2014. Abigail became a big sister to Maile in 2018, when Senator Duckworth became the first sitting U.S. senator to give birth.⁷⁷

Lack of accommodations for medical treatment

Servicemembers may face additional obstacles unique to their service that can imperil the success of their treatment or impede their career advancement opportunities. Such barriers include:

- › **Denial of medical leave and accommodations:** If a servicemember's command officer designates them as “mission essential,” medical leave or time off from work to receive care may not be possible.⁷⁸ But fertility health care is time-sensitive and requires frequent ultrasound monitoring, blood tests, medication, and patient availability for egg retrieval. Because members undergoing treatment are not medically exempt from deployment or arduous duty, performance of servicemembers' duties during an IVF cycle may jeopardize their treatment.⁷⁹
- › **Denial of medical weight abeyance:** Military servicemembers must comply with strict weight requirements as part of their service, and failure to pass their weight or body fat standards can make servicemembers ineligible for promotion or transfer opportunities.⁸⁰ The high levels of estrogen during an IVF cycle can lead to rapid and substantial temporary weight gain for some patients. Nonetheless, medical weight abeyance has been denied to members who requested relief due to receiving fertility health care.⁸¹

- › **No consideration of ongoing treatment in transfer decisions:** Fertility treatment does not have a medical designation that requires priority, so there is no mechanism in place to ensure that superior officers accommodate servicemember's fertility treatment needs when they are transferred to a new location. For example, proximity to a clinic that provides fertility health care is not a consideration. Transfers may also increase the cost of care significantly, since patients must change clinics. One servicemember reported that as a result of three transfers within five years, she was forced to undergo expensive, duplicative tests despite having performed those same tests at her previous clinic.⁸² Moreover, after being transferred from California to Virginia mid-cycle, she lost two embryos in shipment from her previous clinic to her new one because they were packaged incorrectly.⁸³ Such issues could be avoided if fertility treatments were considered in transfer decisions.

This lack of systematic support, combined with the discriminatory eligibility requirements under TRICARE and VHA make access to IVF not only a costly but difficult, often labyrinthine process.

Emerging Threats to IVF Access for Servicemembers, Veterans, and their Dependents

On June 24, 2022, the U.S. Supreme Court issued its decision in *Dobbs v. Jackson Women's Health Organization*, overturning *Roe v. Wade* and with it almost 50 years of precedent protecting the right to abortion.⁸⁴ This was the first time the U.S. Supreme Court has eliminated a fundamental right to personal liberty. Without this federal protection, states moved swiftly to enforce existing laws or enact new laws totally banning or severely restricting abortion access. But *Dobbs'* impact is not limited to abortion—without a recognized legal right to make decisions about pregnancy and access to appropriate medical care, people in the U.S. are even more vulnerable to coercion and neglect than before, whether they seek contraception, fertility care, abortion, routine or emergency obstetric care, or control over the circumstances in which they give birth.

In the aftermath of *Dobbs*, efforts to undermine access to IVF have proliferated, including for servicemembers, veterans, and their dependents. Often, these take the form of legislative efforts to grant embryos legal rights. In the context of IVF, where multiple embryos are created to give patients the best chance of establishing a pregnancy, these efforts would upend IVF's standard of practice by potentially limiting the number of embryos that can be created per cycle. If multiple embryos were created, these efforts would wholly undermine the rights of patients to make decisions about their genetic material.

These efforts are deployed in standalone legislation to establish that life begins at fertilization as well as in legislation that would restrict the way IVF is practiced. More recently, anti-abortion advocates and lawmakers have also introduced legislation that purports to support women struggling with infertility but in actuality blames and shames them for their infertility and would delay or dissuade them from seeking IVF to start or build their family. To learn more about these emerging threats, see [IVF Under Attack: Anti-Reproductive Freedom Fertility Doctrines](#).

Recommendations

Gaps in access and coverage for fertility health care pose substantial barriers, especially for servicemembers and veterans. This is compounded by a significant lack of research and data on the scope of infertility servicemembers and veterans face as well as logistical and systemic barriers to accessing care.

Laws and policies must promote and protect military members' rights to make decisions about their reproductive life, including their rights to health, to benefit from scientific progress, to informed consent, and to equality without discrimination. The following are policy recommendations designed to ensure that this community has equitable access to the fertility health care they need to grow their families.

- › Congress and the administration must ensure that all servicemembers and veterans have insurance coverage for “non-coital” reproductive services such as IUI and IVF, without limitations with regard to whether their infertility is service-connected, whether they have an infertility diagnosis, their marital status, or their sexual orientation. Such insurance coverage must include at least three cycles of IVF.
- › Congress and the administration must protect the right of patients to receive IVF, providers to treat their IVF patients, and insurers to provide IVF coverage.
- › Congress and the administration must also address the high demand for fertility health care, including IUI and IVF, by expanding the Defense Health Administration (DHA)'s and VHA's capacity to ensure a greater number of participating providers across more geographic locations.
- › DHA and VHA must incorporate existing best-practice recommendations for fertility health care as established by the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, and the World Health Organization.
- › DHA and VHA must issue and implement guidance for fertility health care referrals, including disclosure of practice limitations such as religious objections by the provider to certain fertility services.
- › Congress and the administration should take immediate steps to ensure the regular collection and publication of data on infertility incidence and access to fertility health care in the military and among veterans, disaggregated by age, race/ethnicity, sex, sexual orientation, and marital status (including for married same-sex couples), geographical location, and military rank, including:
 - › The number of self-reported cases of infertility
 - › The number of diagnosed infertility cases
 - › The number of infertility diagnoses that are “unexplained”
 - › The number of people diagnosed with infertility and also known to be exposed to toxic chemicals during service-related activities
 - › The extent to which there are data gaps in infertility incidence and access to care for BIPOC servicemembers and veterans
 - › Whether there is a discrepancy between rates of self-reported infertility and rates assessed by diagnostic codes within the system of the Defense Health Administration / the Veterans Health Administration.

Endnotes

- 1 *Infertility Prevalence Estimates 1990-2021*, WORLD HEALTH ORG. (April 3, 2023), <https://www.who.int/publications/i/item/978920068315>.
- 2 *Key Statistics from the National Survey of Family Growth*, CTNS. FOR DISEASE CONTROL & PREVENTION, https://www.cdc.gov/nchs/nsgf/key_statistics/i-keystat.htm#impaired (last visited Sept. 12, 2025).
- 3 Colleen Nugent & Anjani Chandra, *Infertility and Impaired Fecundity in Women and Men in the United States, 2015-2019*, National Health Statistics Reports (April 24, 2024), <https://www.cdc.gov/nchs/data/nhsr/nhsr202.pdf>.
- 4 See generally Monique Tello, *Racism and Discrimination in Health Care: Providers and Patients*, HARVARD HEALTH PUBLISHING: HARVARD HEALTH BLOG (Jan. 16, 2017, 9:30 AM), <https://www.health.harvard.edu/blog/racism-discrimination-health-care-providers-patients-2017011611015>; David R. Williams & Toni D. Rucker, *Understanding and Addressing Racial Disparities in Health Care*, 21 HEALTH CARE FIN. REV. 75 (2000), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4194634/>; Ursula E. Bauer & Marcus Plescia, *Addressing the Disparities in the Health of American Indian and Alaska Native People: The Importance of Improved Public Health Data*, 104 AM. J. PUB. HEALTH S255 (2014), <https://pmc.ncbi.nlm.nih.gov/articles/PMC4035867/>.
- 5 Anjani Chandra et al., *Infertility and Impaired Fecundity in the United States, 1982-2010: Data from the National Survey of Family Growth* (Aug. 14, 2013), <https://www.cdc.gov/nchs/data/nhsr/nhsr067.pdf>; Melissa Wellons et al., *Racial Differences in Self-reported Infertility and Risk Factors for Infertility in a Cohort of Black and White Women: The CARDIA Women's Study*, 90 FERTILITY & STERILITY 1640 (2008), <https://pmc.ncbi.nlm.nih.gov/articles/PMC2592196/>.
- 6 E.A. Weedon et al., *The Prevalence of Infertility in American Indian/Alaska Natives and Other Racial/Ethnic Groups: National Survey of Family Growth (NSFG)*, 107 FERTILITY & STERILITY e44 (2017), [https://www.fertstert.org/article/S0015-0282\(17\)30166-8/fulltext](https://www.fertstert.org/article/S0015-0282(17)30166-8/fulltext).
- 7 *Demographics of the U.S. Military*, COUNCIL ON FOREIGN RELATIONS, <https://www.cfr.org/backgrounder/demographics-us-military>.
- 8 U.S. Department of Defense, *2023 Demographics: Profile of the Military Community* (2023), <https://download.militaryonesource.mil/12038/MOS/Reports/2023-demographics-report.pdf>.
- 9 U.S. DEP'T OF VETERANS AFFAIRS, *Serving Her Country: Exploring The Characteristics of Women Veterans*, <https://www.data.va.gov/stories/s/Women-Veterans-in-2023/wci3-yrsv/>.
- 10 For more information, see Center for Reproductive Rights, *IVF: A Critical Method For Building Families* (May 9, 2025), <https://reproductiverights.org/ivf-fact-sheet-2025/>.
- 11 Press Release, American Society for Reproductive Medicine, *US IVF Usage Increases in 2023, Leads To Over 95,000 Babies Born* (Apr. 23, 2025), <https://www.asrm.org/news-and-events/asrm-news/press-releasesbulletins/us-ivf-usage-increases-in-2023-leads-to-over-95000-babies-born/>.
- 12 National Institute of Health, Eunice Kennedy Shriver National Institute of Child Health and Human Development, *Assisted Reproductive Technology (ART)*, <https://www.nichd.nih.gov/health/topics/infertility/conditioninfo/treatments/art#transfer>.
- 13 Press Release, American Society for Reproductive Medicine, *US IVF Usage Increases in 2023, Leads To Over 95,000 Babies Born* (Apr. 23, 2025), <https://www.asrm.org/news-and-events/asrm-news/press-releasesbulletins/us-ivf-usage-increases-in-2023-leads-to-over-95000-babies-born/>.
- 14 U.S. Department of Health and Human Services, *Fact Sheet: In Vitro Fertilization (IVF) Use Across the United States* (May 13, 2024), <https://www.hhs.gov/about/news/2024/03/13/fact-sheet-in-vitro-fertilization-ivf-useacross-united-states.html>.
- 15 SOC'Y FOR ASSISTED REPROD. TECH., *Final National Summary Report for 2022* (2022), https://www.sartcorsonline.com/rptCSR_PublicMultiYear.aspx#patient-cumulative (last visited Sept. 12, 2025) (Select "Patient's Own Eggs," "Live Births Per Intended Egg Retrieval (First Embryo Transfer)," and "1st Transfer").
- 16 *Id.*; Audrey Gaskins et al., *Predicted Probabilities of Live Birth Following Assisted Reproductive Technology Using United States National Surveillance Data from 2016 to 2018*, Am. J. of Obstetrics and Gynecology (2023), <https://pubmed.ncbi.nlm.nih.gov/36702210/>.
- 17 Amy Klein, *IVF is Expensive. Here's How to Bring Down the Cost*, N.Y. TIMES (Apr. 18, 2020), <https://www.nytimes.com/article/ivf-treatment-costs-guide.html>; see also Megan Leonhardt, *Women are Traveling Far and Wide for Affordable IVF – Here's Why It's So Expensive*, CNBC (Aug. 13, 2019), <https://www.cnbc.com/2019/08/13/women-are-traveling-far-and-wide-for-affordable-ivf.html>.
- 18 Emily S. Jungheim, *In Vitro Fertilization Insurance Coverage and Chances of a Live Birth*, 317 J. AM. MED. ASS'N. 1273 (2017), <https://jamanetwork.com/journals/jama/fullarticle/2613146>.
- 19 Bronwyn Bedrick et al., *Factors Associated with Early In Vitro Fertilization Treatment Discontinuation*, 112 FERTILITY & STERILITY 105 (2019), [https://www.fertstert.org/article/S0015-0282\(19\)30250-X/fulltext](https://www.fertstert.org/article/S0015-0282(19)30250-X/fulltext).

- 20 Christina Caron, *Getting Pregnant with IUI: What You Need to Know*, N.Y. TIMES (Apr. 18, 2020), <https://www.nytimes.com/article/getting-pregnant-iui.html>.
- 21 *Id.*
- 22 *Harvard Mental Health Letter: The Psychological Impact of Infertility and its Treatment*, HARVARD HEALTH PUBLISHING (May 2009), https://www.health.harvard.edu/press_releases/psychological-impact-of-infertility.
- 23 Heather Stringer, *No Insurance Required: Psychologists Who Treat the Trauma of Infertility*, 48 AM. PSYCHOL. ASS'N 70 (2017), <https://www.apa.org/monitor/2017/07-08/trauma-infertility>.
- 24 SERVICE WOMEN'S ACTION NETWORK, *Access to Reproductive Health Care: The Experiences of Military Women* (2018), (on file with the Service Women's Action Network) (hereinafter SWAN report).
- 25 Steve Beynon, *Surge of Female Enlistments Helped Drive Army Success in Reaching 2024 Recruiting Goal* (Jan. 9, 2025), <https://www.military.com/daily-news/2025/01/09/surge-of-female-enlistments-helped-drive-army-success-reaching-2024-recruiting-goal.html>.
- 26 Jodie Katon, *Self-Reported Infertility Among Male and Female Veterans Serving During Operation Enduring Freedom/Operation Iraqi Freedom*, 23 J. WOMEN'S HEALTH (LARCHMOUNT) 175 (Feb. 2014) (finding that 15.8% of female and 13.8% of male veterans reported experiencing infertility), <https://pubmed.ncbi.nlm.nih.gov/24261648/>.
- 27 Sarah O. Meadows et al., *The Women's Reproductive Health Survey (WRHS) of Active-Duty Service Members* (Sep. 13, 2022), https://www.rand.org/pubs/research_reports/RR1031-1.html.
- 28 *Id.*
- 29 DEPARTMENT OF DEFENSE, Medical Surveillance Monthly report, *Update: Infertility Among Active Component Service Women* (May 2025), <https://health.mil/Reference-Center/Reports/2025/05/01/MSMR-Vol-32-No-5-May-2025>.
- 30 *Id.*
- 31 Sarah O. Meadows et al., *The Women's Reproductive Health Survey (WRHS) of Active-Duty Service Members* (Sep. 13, 2022), https://www.rand.org/pubs/research_reports/RR1031-1.html.
- 32 SWAN Report, *supra* at 25; *Key Statistics from the National Survey of Family Growth*, Ctrs. for Disease Control and Prevention, https://www.cdc.gov/nchs/nsfg/key_statistics/i-keystat.htm#impaired (last visited Sept. 29, 2025).
- 33 KRISTY N. KARMACK, CONG. RESEARCH SERV., *Diversity, Inclusion, and Equal Opportunity in the Armed Services: Background and Issues for Congress* (2019), <https://sgp.fas.org/crs/natsec/R44321.pdf>.
- 34 U.S. Department of Defense, *2023 Demographics: Profile of the Military Community* (2023), <https://download.militaryonesource.mil/12038/MOS/Reports/2023-demographics-report.pdf>; Molly Clever & David R. Segal, *The Demographics of Military Children and Families*, 23 THE FUTURE OF CHILDREN 13 (2013), <https://www.semanticscholar.org/paper/The-Demographics-of-Military-Children-and-Families-Clever-Segal/c567b17bc58e83e93e68e28f1cfe270473593a48?p2df>; Jennifer Schultz, *Veterans by the Numbers*, NAT'L CONFERENCE OF STATE LEGISLATURES: BLOG (Nov. 10, 2017), <https://www.ncsl.org/state-legislatures-news/details/veterans-by-the-numbers>.
- 35 Ginny L. Ryan, *Investigator-Initiated Research 13-294 — Human Services Research & Development Study: Impact of Sexual Assault and Combat-Related Trauma on Fertility in Veterans*, U.S. DEP'T OF VETERANS AFFAIRS, https://www.hsrdr.research.va.gov/research/abstracts.cfm?Project_ID=2141704065.
- 36 *See, e.g.* Karen Jowers, *Do Military Women Have Higher Rates of Infertility than Civilians?*, MILITARY TIMES (Dec. 14, 2018), <https://www.militarytimes.com/pay-benefits/2018/12/14/do-military-women-have-higher-rates-of-infertility-than-civilians/>; *Military Women: On the Hook for Infertility?*, CTR. FOR REPROD. MED. & ADVANCED REPROD. TECHS., <https://ivfminnesota.com/military-women/>.
- 37 Joseph Pizzorno, *Environmental Toxins and Infertility*, 17 INTEGRATIVE MED. 8, 8-10 (2018), <https://pubmed.ncbi.nlm.nih.gov/articles/PMC6396757/>.
- 38 SWAN Report, *supra* note 25.
- 39 Ginny L. Ryan et al., *Voluntary and Involuntary Childlessness in Female Veterans: Associations with Sexual Assault*, 102 FERTILITY & STERILITY 539, 542, 544 (2014), [https://www.fertstert.org/article/S0015-0282\(14\)00402-6/fulltext](https://www.fertstert.org/article/S0015-0282(14)00402-6/fulltext).
- 40 Kristin L. Rooney & Alice D. Domar, *The Relationship Between Stress and Infertility*, 20 DIALOGUES IN CLINICAL NEUROSCIENCE 41 (2018), <https://pubmed.ncbi.nlm.nih.gov/articles/PMC6016043/>.
- 41 Kristin Mattocks et al., *Infertility Care Among OEF/OIF/OND Women Veterans in the Department of Veterans Affairs*, 53 MED. CARE S68 (2015), <https://pubmed.ncbi.nlm.nih.gov/articles/PMC4410265/> (“Women Veterans who received an infertility diagnosis were also more likely to have a mental health diagnosis than women without an infertility diagnosis, including depression . . . PTSD . . . and bipolar disorder . . .”).

- 42 See, e.g. U.S. Department of Defense, Department of Defense Releases Fiscal Year 2019 Annual Report on Sexual Assault in the Military (Apr. 30, 2020), <https://www.war.gov/News/Releases/Release/Article/2170913/departement-of-defense-releases-fiscal-year-2019-annual-report-on-sexual-assault/>; Dave Philipps, ‘*This is Unacceptable.*’ *Military Reports a Surge of Sexual Assaults in the Ranks*, N.Y. TIMES (May 2, 2019), <https://www.nytimes.com/2019/05/02/us/military-sexual-assault.html>; Patricia Kime, *Despite Efforts, Sexual Assaults Up Nearly 40% in US Military*, MILITARY.COM (May 2, 2019), <https://www.military.com/daily-news/2019/05/02/despite-efforts-sexual-assaults-nearly-40-us-military.html>.
- 43 Miriam Reisman, *PTSD Treatment for Veterans: What’s Working, What’s New, and What’s Next*, 41 PHARMACY & THERAPEUTICS 623 (2016), <https://pmc.ncbi.nlm.nih.gov/articles/PMC5047000/>.
- 44 U.S. Department of Defense, Implementing Guidance Memorandum: Policy for Assisted Reproductive Services for the Benefit of Seriously or Severely Ill/Injured (Category II or III) Active Duty Service Members (ADSMs) 3 (2012), https://www.sart.org/globalassets/asrm/asrm-content/news-and-publications/news-and-research/press-releases-and-bulletins/pdf/dod_policy_guidance.pdf
- 45 *Id.*
- 46 Joseph Clark, *DOD Amends Assisted Reproductive Services Policy for Seriously, Severely Ill or Injured Active Duty Service Members*, DOD NEWS (Mar. 11, 2024), <https://www.defense.gov/News/News-Stories/Article/Article/3702693/dod-amends-assisted-reproductive-services-policy-for-seriously-severely-ill-or/>.
- 47 *Id.* (“In other words, there may be a total of six attempts to accomplish three completed IVF cycles. Further, if the injured Service Member has used initiated IVF cycles, subsequently remarries and desires this benefit with the new spouse, the number of cycles available is dependent on prior cycles used.”).
- 48 Lori Gawron et al., *Impact of Deployment on Reproductive Health in U.S. Active-Duty Servicewomen and Veterans*, 36 SEMINARS IN REPROD. MED. 361 (2018), doi:10.1055/s-0039-1678749.
- 49 *About VHA*, U.S. DEP’T OF VETERANS AFFAIRS, <https://www.va.gov/health/aboutvha.asp> (last updated Jul. 14, 2019) (last visited Apr. 2, 2020).
- 50 38 CFR § 17.38(c)(2).
- 51 Continuing Appropriations and Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2017, and Zika Response and Preparedness Act, Pub. L. No. 114-223 § 260, <https://www.congress.gov/bill/114th-congress/house-bill/5325>; Fertility Counseling and Treatment for Certain Veterans and Spouses, 38 C.F.R. § 1762 (2019), <https://www.federalregister.gov/documents/2019/03/07/2019-04096/fertility-counseling-and-treatment-for-certain-veterans-and-spouses>.
- 52 The Department of Veterans Affairs notes: “For the purposes of this section, “a service-connected disability that results in the inability of the veteran to procreate without the use of fertility treatment” means, for a male veteran, a service-connected injury or illness that prevents the successful delivery of sperm to an egg; and, for a female veteran with ovarian function and a patent uterine cavity, a service-connected injury or illness that prevents the egg from being successfully fertilized by a sperm. This definition parallels requirements in DoD policy guidance for an active duty service member who is seriously or severely ill/injured (Category II or III) to receive fertility counseling and treatment using ART.” 82 Fed. Reg. 6273 (January 19, 2017).
- 53 REPORT TO CONGRESS: EFFORTS TO TREAT INFERTILITY OF MILITARY FAMILIES, OFFICE OF THE SEC’Y OF DEFENSE 1, 8 (2015).
- 54 EMILY K. LANE, CONG. RESEARCH SERV., IF11504, INFERTILITY IN THE MILITARY (2020), <https://crsreports.congress.gov/product/pdf/IF/IF11504>
- 55 SERVICE WOMEN’S ACTION NETWORK, SURVEY DATA, *supra* note 40.
- 56 *Id.*
- 57 BRYCE H. P. MENDEZ, CONG. RESEARCH SERV., IF10530, DEFENSE PRIMER: MILITARY HEALTH SYSTEM (2020), <https://fas.org/sgp/crs/natsec/IF10530.pdf> [hereinafter DEFENSE PRIMER].
- 58 *All Provider Directories*, TRICARE (last visited May 30, 2019), <https://www.tricare.mil/FindDoctor/AllProviderDirectories/NonNetwork>.
- 59 Covered Services, TRICARE (last visited March 12, 2026), <https://tricare.mil/CoveredServices/IsIt-Covered/AssistedReproductiveServices>
- 60 John A. Harris, *Geographic Access to Assisted Reproductive Technology Health Care in the United States: A Population-Based Cross-Sectional Study*, 107 FERTILITY & STERILITY 1023 (2017), <https://doi.org/10.1016/j.fertnstert.2017.02.101>.
- 61 *Supra* note 59.
- 62 *IVF Success Rates: The Impact of Female Age*, FERTILITYIQ (last accessed May 19, 2020), <https://www.fertilityiq.com/ivf-in-vitro-fertilization/ivf-success-rates#the-impact-of-female-age>.
- 63 SERVICE WOMEN’S ACTION NETWORK, SURVEY DATA, *supra* note 40.
- 64 REPORT TO CONGRESS, *supra* note 55, at 7.

- 65 SERVICE WOMEN’S ACTION NETWORK, ACCESS TO REPRODUCTIVE HEALTH CARE: THE EXPERIENCES OF MILITARY WOMEN (2018), *supra* note 29.
- 66 *Id.*
- 67 E-Mail from Kerry Karwan, Retired Lieutenant Commander, U.S. Coast Guard, to Freya Riedlin, Fed. Policy Counsel, Ctr. for Reprod. Rights (June 10, 2020 10:43am). On file at Ctr for Reprod. Rights.
- 68 SERVICE WOMEN’S ACTION NETWORK, SURVEY DATA, *supra* note 40.
- 69 *Id.*
- 70 E-Mail from Kerry Karwan, *supra* note 68.
- 71 *Id.*
- 72 Carrie M. Farmer et al., *Balancing Demand and Supply for Veterans’ Health Care: A Summary of Three RAND Assessments Conducted Under the Veterans Choice Act*, 20 RAND HEALTH Q. 12 (2016), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158276/>
- 73 CARRIE M. FARMER & TERRI TANIELIAN, ENSURING ACCESS TO TIMELY, HIGH-QUALITY HEALTH CARE FOR VETERANS: INSIGHTS FROM RAND RESEARCH (2019) (testimony submitted to the Senate Committee on Veterans’ Affairs).
- 74 SERVICE WOMEN’S ACTION NETWORK, SURVEY DATA, *supra* note 40.
- 75 Rebecca Johnson, *Senator Tammy Duckworth on the Attack that Took Her Legs—and Having a Baby at 50*, VOGUE (September 12, 2018), https://www.vogue.com/article/tammy-duckworth-interview-vogue-october-2018-issue?mbid=social_on-site_twitter.
- 76 *Id.*
- 77 Emmarie Huetteman, *Make Room for Baby: After Giving Birth, Duckworth Presses Senate To Bend Rules*, KFF Health News (Apr. 11, 2018), <https://kffhealthnews.org/news/make-room-for-moms-after-giving-birth-duckworth-presses-senate-to-bend-rules/>.
- 78 REPORT TO CONGRESS, *supra* note 55.
- 79 E-Mail from Kerry Karwan, Retired Lieutenant Commander, U.S. Coast Guard, to Freya Riedlin, Fed. Policy Counsel, Ctr. for Reprod. Rights (Feb. 3, 2020 1:33 PM EST) (attaching fact sheet with information on military fertility issues and IVF use among service members).
- 80 *See, e.g.* Stew Smith, *Army Weight Control Program*, MILITARY.COM, <https://www.military.com/military-fitness/army-fitness-requirements/weight-control-program> (last visited July 16, 2020).
- 81 E-Mail from Kerry Karwan, *supra* note 79.
- 82 E-Mail from Kerry Karwan, *supra* note 68.
- 83 *Id.*
- 84 *Dobbs v. Jackson Women’s Health Organization*, 142 S. Ct. 2228 (2022), https://www.supremecourt.gov/opinions/21pdf/19-1392_6j37.pdf.

Quote Endnotes

- ⁱ SERVICE WOMEN’S ACTION NETWORK, SURVEY DATA (2018) (on file with the Service Women’s Action Network).
- ⁱⁱ *Id.*
- ⁱⁱⁱ *Id.*
- ^{iv} *Id.*
- ^v *Id.*
- ^{vi} Rebecca Johnson, *Senator Tammy Duckworth on the Attack that Took Her Legs—and Having a Baby at 50*, VOGUE (September 12, 2018), https://www.vogue.com/article/tammy-duckworth-interview-vogue-october-2018-issue?mbid=social_on-site_twitter.