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INTRODUCTION

Defendants' consolidated Opposition to Plaintiffs' Motion for Preliminary Injunction and Motion to Dismiss ("Defendants' Opposition and Motion to Dismiss") established that Plaintiffs' equal protection challenge to a Department of Defense ("DoD") policy of precluding HIV-positive individuals from commissioning as officers (the "Commissioning Policy") was non-justiciable and not sustainable as a matter of law. Specifically, the Commissioning Policy represents an exercise of military authority Congress specifically vested in the Executive Branch, and that exercise of authority is non-justiciable under the doctrine set forth in *Mindes v. Seaman*. Even if the case were reviewable, dismissal of Plaintiffs' equal protection challenge would still be necessary because Plaintiffs have failed to assert a claim as a matter of law. This Court's review of Plaintiffs' claim is governed by the deferential rational basis standard, and the Commissioning Policy is reasonably related to ensuring that Service members are medically fit and capable of performing their duties.

Plaintiffs' arguments in opposition to Defendants' motion do nothing to alter either conclusion. As a preliminary matter, Plaintiffs contend that this case concerns all of Defendants' HIV-related policies, but Plaintiffs have established standing to challenge the Commissioning Policy only. Plaintiffs also erroneously argue that the *Mindes* doctrine of non-justiciability categorically does not apply in this case, an argument that finds no support in case law, including in *Mindes* itself. Applying the four factor *Mindes* test, the Court should conclude that this case is non-justiciable.

With respect to the merits of their claim, Plaintiffs encourage this Court to disregard binding Fourth Circuit precedent and be the first court to apply a heightened standard of review to claims alleging HIV-based discrimination, but they offer no valid reason for the Court to do so. Under that deferential standard of review, the Commissioning Policy passes constitutional muster

because it is a reasonable exercise of Defendants' judgment about how best to ensure that Service members are medically sound and ready to serve. Dismissal of this action is therefore warranted.

ARGUMENT

A. Plaintiffs are limited to challenging Defendants' Commissioning Policy, which is the sole alleged cause of harm to Plaintiffs

In their Opposition to the Motion to Dismiss and Reply in Support of Their Motion for Preliminary Injunction ("Opposition"), Plaintiffs continue to erroneously suggest that the Court should read their Complaint expansively in this case. In Plaintiffs' telling, because the Complaint mentions various HIV-related policies, asserts claims on behalf of both an individual Service Member and organization, and purports to bring both as-applied and facial claims, "all HIV-related personnel policies cover[ing] all . . . facets of serving as a person living with HIV" in the military are being challenged. Pls.' Opp'n to the Mot. to Dismiss and Reply in Supp. of Their Mot. for a Prelim. Inj. ("Pls.' Opp'n") at 2, ECF No. 51.

Plaintiffs are incorrect. As Defendants noted in their opening brief, in order to invoke the Court's Article III jurisdiction to hear this case, Plaintiffs must establish standing by demonstrating that (1) they have "suffered an injury in fact that is concrete and particularized, and is actual or imminent"; (2) "the injury is fairly traceable to the challenged action"; and (3) "the injury will likely be redressed by a favorable decision." *See Sierra Club v. Va. Elec. & Power Co.*, 145 F. Supp. 3d 601, 609 (E.D. Va. 2015) (citing *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560-61 (1992)). The only injury identified in the Complaint is that suffered by Plaintiff Harrison, who contends that Defendants' Commissioning Policy discriminates against him by preventing him from being able to commission as an officer due to his HIV status. *See* Compl. ¶ 4, ECF No. 1 ("Sgt. Harrison discovered that outdated military policies regarding people living with HIV would prevent him from being commissioned as an officer and from filling this position based in Arlington,

Virginia.”); ¶ 74 (“Defendants have refused to grant Plaintiff Nick Harrison a commission as an officer serving as an attorney in the Judge Advocate General Corps for the D.C. National Guard based solely on his HIV status.”). Having identified one injury in the Complaint, Plaintiffs are limited to challenging Defendants’ policy—the Commissioning Policy—that is the cause of that alleged harm. *See Lewis v. Casey*, 518 U.S. 344, 358 n.6 (1996) (“[S]tanding is not dispensed in gross. If the right to complain of one administrative deficiency automatically conferred the right to complain of all administrative deficiencies, any citizen aggrieved in one respect could bring the whole structure of state administration before the courts for review. That is of course not the law.”).

Plaintiffs’ reliance on the inclusion of OutServe/SLDN as a Plaintiff does not change the standing analysis. OutServe/SLDN asserts no injury to itself as an organization and instead relies on its representation of the interests of its members, including Plaintiff Harrison. Compl. ¶ 69. But “[t]he possibility of such representational standing . . . does not eliminate or attenuate the constitutional requirement of a case or controversy,” and OutServe/SLDN must still establish that “its members, or any one of them, are suffering immediate or threatened injury as a result of the challenged action of the sort that would make out a justiciable case had the members themselves brought suit.” *See Warth v. Seldin*, 422 U.S. 490, 511 (1975). Yet the Complaint identifies only Plaintiff Harrison as an OutServe/SLDN member who allegedly has been injured by Defendants’ policies. The claims of OutServe/SLDN are therefore limited to challenging only the Commissioning Policy, the same policy that allegedly harmed Harrison.¹

¹ Plaintiffs’ submission of two declarations under seal in support of their Motion for Preliminary Injunction, *see* Mem. in Supp. of Pls.’ Mot. for Prelim. Inj., Ex. F, ECF No. 26-6; Ex. G, ECF No. 26-7, does not expand the scope of claims in this case. Neither individual is a named Plaintiff, nor does either claim to be a member of OutServe/SLDN, which makes them both third parties to this action. In any event, neither individual’s assertion of harm would be sufficient to establish standing even if they were Plaintiffs or OutServe/SLDN members, for reasons explained in the Declaration of Lisa Lute, ECF No. 43-1, and the Declaration of Martha Soper, ECF No. 48.

The fact that the Complaint makes passing references to facial challenges to other policies does not establish Plaintiffs' standing to challenge anything other than the Commissioning Policy, *see* Pls.' Opp'n at 2 ("This case is about more than just commissioning, because the facial challenges to Defendants' HIV-related personnel policies cover all of these facets of serving as a person living with HIV."). Standing is an "irreducible constitutional minimum" requirement, *see Lujan*, 504 U.S. at 560, one from which Plaintiffs are not excused simply because they purport to be bringing a facial challenge. *See, e.g., MacDonald v. Moose*, 710 F.3d 154, 162 (4th Cir. 2013) (applying three-part *Lujan* test to facial due process challenge to anti-sodomy law); *Covenant Media of SC, LLC v. City of N. Charleston*, 493 F.3d 421, 429-30 (4th Cir. 2007) ("Although there is broad latitude given facial challenges in the First Amendment context, a plaintiff must establish that he has standing to challenge each provision of an ordinance by showing that he was injured by application of those provisions." (internal citation and quotation marks omitted)); *Greenville Cty. Repub. Party Exec. Comm. v. Greenville Cty. Election Comm.*, 604 F. App'x 244, 253-54 (4th Cir. 2015) (dismissing for lack of standing facial First Amendment and equal protection challenges to state law requiring supermajority for nominating candidates by party convention or petition). "A party has standing to challenge the constitutionality of a [law] only insofar as it has an adverse impact on his own rights," *Cty. Court of Ulster Cty, v. Allen*, 442 U.S. 140, 154-55 (1979), and Plaintiffs must therefore demonstrate that *they* are being harmed by a policy they claim is facially unconstitutional, just as they must for an as-applied challenge. Because the only adverse impact identified by Plaintiffs in this case is Plaintiff Harrison's inability to become a commissioned officer, the Complaint is limited to challenging that policy only.

Notably, the one policy that Plaintiffs concede is *not* covered by their Complaint is the policy announced in the February 14, 2018 Memorandum, as superseded and modified by DoD

Instruction (“DoDI”) 1332.45.² See Pls.’ Opp’n at 3 (“Plaintiffs are not directly challenging the new [DoDI 1332.45] as a violation of equal protection.”). Yet Plaintiffs’ challenge to this policy is at the heart of their request for a preliminary injunction. See Pls.’ Mot. for Prelim. Inj. at 1-2, ECF No. 26 (“Plaintiffs seek a preliminary injunction to preserve the status quo by suspending implementation of the new [February 14, 2018] Policy as applied to any service member classified as non-deployable based solely on their HIV status.”); Pls.’ [Proposed] Order Gr. Pls.’ Mot. for Prelim. Inj. at 1, ECF No. 25-1 (requesting that the Court enjoin Defendants “from implementing [the February 14, 2018 Memorandum] to separate any service member classified as non-deployable based solely on their HIV status”). Plaintiffs cannot base their request for a preliminary relief on a challenge to a policy (DoDI 1332.45) where that claim is not part of the Complaint in this case. See *E. Tenn. Nat. Gas Co. v. Sage*, 361 F.3d 808, 823 (4th Cir. 2004) (“A preliminary injunction is, of course, appropriate to grant intermediate relief of *the same character* as that which may be granted finally.” (citation and internal quotation marks omitted)); *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d 517, 525 (4th Cir. 2003), *abrogated on other grounds* (“[P]reliminary relief may never be granted that addresses matters which in no circumstances can be dealt with in any final injunction that may be entered.”). Because Plaintiffs’ equal protection challenge in this case is limited to the Commissioning Policy, and because Plaintiffs have expressly stated that their Complaint does not challenge DoDI 1332.45, Plaintiffs’ request for the Court to enjoin preliminarily that policy must be denied.

² Both parties refer extensively to DoDI 1332.45 in their briefing on Plaintiffs’ Motion for a Preliminary Injunction and Defendants’ Motion to Dismiss. For the Court’s convenience, Defendants have attached a copy of the DoDI as Exhibit 1 to the instant filing.

B. Plaintiffs' challenge to the Commissioning Policy is non-justiciable

Defendants' Opposition and Motion to Dismiss set forth the reasons why the judicial review of Commissioning Policy (as well as DoDI 1332.45, as challenged in Plaintiffs' preliminary injunction motion) is foreclosed by the doctrine set forth in *Mindes v. Seaman*, 453 F.2d 197 (5th Cir. 1971), and adopted by the Fourth Circuit in *Williams v. Wilson*, 762 F.2d 357, 359 (4th Cir. 1985). See Defs.' Opp'n to Pls.' Mot. for Prelim. Inj. and Mem. in Supp. of Mot. to Dismiss ("Defs.' Opp'n and Mot. to Dismiss") at 10-14, 20-23, ECF No 43. Specifically, the determination about whether to commission an officer is one involving an inherently military judgment about whether a Service member is fit and qualified to serve in such a position. *Id.* at 20-23. Plaintiffs contend that *Mindes* does not apply to their constitutional claims and that, in any event, application of the four-factor *Mindes* test weighs in favor of justiciability. Plaintiffs are wrong on both counts.

First, Plaintiffs' reliance on *Aikens v. Ingram*, 811 F.3d 643 (4th Cir. 2016), for the proposition that *Mindes* does not apply to constitutional challenges, see Pls.' Opp'n at 4, is significantly misplaced. The court's analysis in *Aikens* concerned not whether *Mindes* applies to constitutional challenges (as opposed to non-constitutional challenges) but rather whether *Mindes* applies only to challenges seeking equitable relief versus those seeking monetary damages. See *Aikens*, 811 F.3d at 647-48 (concluding that *Mindes* applies only where equitable relief is sought). *Aikens* thus has no bearing on whether *Mindes* applies to preclude Plaintiffs' claims in the instant case. Furthermore, Plaintiffs' contention that facial constitutional claims are somehow excluded from the purview of *Mindes* is illogical given that the first of two threshold requirements under *Mindes* involves an assessment of whether a plaintiff has alleged a violation of a constitutional right, federal statute, or military regulation. See *Guerra v. Scruggs*, 942 F.2d 270, 276 (4th Cir. 1991) (citing *Mindes*, 453 F.2d at 201).

The remaining cases cited by Plaintiff similarly provide no support for their broad assertion that *Mindes* cannot apply here because they have asserted a facial challenge. In two of those cases, the courts merely concluded that challenges to the military action was justiciable but made no sweeping findings about the applicability of *Mindes* vis-à-vis facial challenges, *see Watson v. Ark. Nat'l Guard*, 886 F.2d 1004, 1010 (8th Cir. 1989); *Emory v. Sec'y of Navy*, 819 F.2d 291, 294 (D.D.C. 1987), while the third case cited by Plaintiff involved no justiciability analysis at all, *see Doe 1 v. Trump*, 275 F. Supp. 3d 167 (D.D.C. 2017).³ Plaintiffs' contention that *Mindes* categorically does not apply in this case finds no support in Plaintiffs' cited cases and should be rejected.

Second, the four-factor test from *Mindes* supports a finding of non-justiciability in this case.⁴ Plaintiffs' equal protection challenge to the Commissioning Policy, which is subject to rational basis review under Fourth Circuit precedent, is premised on the contention that DoD lacked any conceivable rational basis for the challenged policy. *See* Defs.' Opp'n and Mot. to Dismiss at 23-29; *see also infra*, Part D. Given the deferential standard of review, Plaintiffs' claim is inherently weak. *Cf. Woodard v. Marsh*, 658 F.2d 989, 994 (5th Cir. 1981) (concluding claim

³ Plaintiffs' citation to *Doe 1* is also inapposite because the D.C. Circuit has not adopted *Mindes*. *See Kreis v. Sec'y of Air Force*, 866 F.2d 1508, 1512 (D.C. Cir. 1989).

⁴ Defendants do not challenge Plaintiff Harrison's ability to meet the threshold requirements under *Mindes* with respect to the Commissioning Policy. *See* Defs.' Opp'n and Mot. to Dismiss at 21. But Defendants do challenge Plaintiffs' ability to meet these threshold requirements with respect to their challenge to DoDI 1332.45, to the extent the Court permits Plaintiffs to raise this separate claim in their Motion for Preliminary Injunction. Plaintiffs provide no support for their contention that a court is permitted to discard the threshold inquiries under *Mindes* in the context of examining a party's request for a preliminary injunction. *See* Pls. Opp'n at 7. To the contrary, *Mindes* should apply with equal force in the context of a motion for a preliminary injunction given a court's obligation to determine whether the moving party is likely to succeed on the merits of its claims. *See Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008). Just as a court would assess a party's standing to bring a claim as part of the preliminary injunction analysis, so too should it consider whether the claims brought are justiciable.

was weak for purposes of the *Mindes* analysis where it “would have the court determine whether there was any rational basis for the distinctions made, on the basis of such factors, between himself and the two students who were retained. We think that this is precisely the role that *Mindes* cautions the courts from taking.”). In addition, the potential injury to Plaintiff Harrison if review of the Commissioning Policy is refused would be minimal. Plaintiffs effectively concede in their Opposition that the Court lacks the authority to order DoD to commission Harrison and instead request a retroactive evaluation of Harrison without application of the Commissioning Policy, *see* Pls.’ Opp’n at 5-6, n.2, meaning that DoD still retains the ultimate discretion about whether to grant Harrison a commission and could deny him a commission for reasons unrelated to his HIV status. Nor is Harrison at risk of being discharged from the military due to his HIV status; rather, he is merely unable to have a position in the military he wishes—but is not entitled—to have. The harm to Harrison in the absence of review is thus minimal in this case.

As Defendants made clear in their Opposition and Motion to Dismiss, the third and fourth *Mindes* factors also weigh heavily in favor of a non-justiciability finding. Plaintiffs’ challenge to the Commissioning Policy effectively seeks judicial oversight of the inherently military decision about which individuals are qualified to be commissioned. But Congress has expressly vested this power in the Executive Branch and has further afforded the Executive broad discretion in its exercise. *See* 10 U.S.C. § 532(a) (permitting DoD to consider, among other things, a Service member’s “good moral character” and other “special qualifications” when making a commissioning determination). As the Supreme Court has observed, “[i]t is obvious that the commissioning of officers . . . is a matter of discretion within the province of the President as Commander in Chief” and courts accordingly “have never assumed by any process to control the appointing power either in civilian or military positions.” *Orloff v. Willoughby*, 345 U.S. 83, 90

(1953). Decisions about whether to commission a Service member as an officer is precisely the type of judgment for which courts lack expertise and for which deference to the military is warranted.

Furthermore, the fact that both Congress and DoD have played a role in shaping military HIV policy should make the Court particularly reticent to conclude that the Commissioning Policy is subject to judicial review. Both “legislative and executive judgments in the area of military affairs” are entitled to “a healthy deference,” based on the recognition that the Constitution assigns control over the military to these two coordinate branches but not to the judiciary. *See Rostker v. Goldberg*, 453 U.S. 57, 66-67 (1981); *Gilligan v. Morgan*, 413 U.S. 1, 10 (1973) (“The complex subtle, and professional decisions as to the composition, training, equipping, and control of a military force are essentially professional military judgments, subject *always* to civilian control of the Legislative and Executive Branches. The ultimate responsibility for these decisions is appropriately vested in branches of the government which are periodically subject to electoral accountability.”); *Orloff*, 345 U.S. at 92 (declining to review challenge to commissioning decision because “Congress has authorized the President alone to appoint Army officers . . .”).

In this case, Congress has been engaged in the development of military HIV policy through oversight requests. For example, the National Defense Authorization Act (“NDAA”) for Fiscal Year 2014 required DoD to provide a report to Congress concerning “personnel policies regarding members of the Armed Forces infected with [HIV] or Hepatitis B,” including a description of deployment policies. *See* NDAA for Fiscal Year 2014, Pub. L. No. 113-66 § 572, 127 Stat. 672, 772. DoD provided this report in September 2014, explaining the bases for the policies set forth in DoDI 6490.07. *See* Report to Congressional Defense Committees on Department of Defense Personnel Policies Regarding Members of the Armed Forces with HIV or Hepatitis B (Sept. 2014)

(attached as Exhibit 2). More recently, the House Armed Services Committee, in connection with its consideration of the NDAA for Fiscal Year 2018, Pub. L. No. 115-91, 131 Stat. 1283, asked DoD to provide an update regarding “how current policies reflect the evidence base and medical advances in the field[] of HIV,” with a specific request for DoD to address “[t]he feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer.” *See* H.R. Rep. No. 115-200, at 148-49 (2017). DoD responded to this Congressional inquiry on August 2018 with a fulsome report on its HIV policies, including the Commissioning Policy. *See* Department of Defense Personnel Policies Regarding Members of the Armed Forces Infected with Human Immunodeficiency Virus: Report to the Committees on the Armed Services of the Senate and House of Representatives (Aug. 2018) (attached as Exhibit 3).⁵ Given this ongoing dialogue, DoD is not acting alone in developing its HIV policies but is instead receiving tacit Congressional approval for those policies. The active involvement of both the Legislative and Executive Branches—the two branches of government in which control of military affairs is vested—thus provides additional justification for the conclusion that judicial scrutiny would not be appropriate.⁶

C. Rational basis review applies to Plaintiffs’ equal protection challenge to the Commissioning Policy

⁵ The 2014 and 2018 Congressional Reports are both in the public record. The Court is therefore permitted to take them into consideration when ruling on Defendants’ Motion to Dismiss. *See Blankenship v. Manchin*, 471 F.3d 523, 526 n.1 (4th Cir. 2006).

⁶ Plaintiffs identify a “long list of challenges to accession, commission, assignment, promotion, and discharge regulations that courts have found to be justiciable.” *See* Pls.’ Opp’n at 10. Two of those cases involved claims that were subject to a higher level of scrutiny and thus presented claims that were stronger in nature than that presented by Plaintiffs here, *see Dillard v. Brown*, 652 F.2d 316, 318 (3d Cir. 1981) (claim for sex discrimination); *Serv. Women’s Action Network v. Mattis*, --- F. Supp. 3d. ---, 2018 WL 2021220, at *1 (N.D. Cal. May 1, 2018) (same), while the remaining two cases also involved claims of sex discrimination and were brought in a jurisdiction that has not adopted the *Mindes* test, *see Doe I*, 275, F. Supp. 23d at 192; *Owens v. Brown*, 455 F. Supp. 291, 300 (D.D.C. 1978).

Plaintiffs' Opposition further errs by encouraging the Court to ignore binding precedent and review the Commissioning Policy under strict scrutiny. *See* Pls.' Opp'n at 14 ("Plaintiffs ask this Court to probe beyond the surface of *Doe* [*v. University of Maryland Medical System Corporation*] in assessing the appropriate level of scrutiny in this case, and invite the Court to [apply a higher standard of review]."). The Fourth Circuit has spoken clearly as to the level of scrutiny that applies to Plaintiffs' claims, so the Court should reject Plaintiffs' invitation to depart from binding precedent.

As Defendants noted in their opening brief, the Fourth Circuit held in *Doe* that "alleged unequal treatment of HIV-positive" individuals is subject to rational basis review. 50 F.3d 1261, 1267 (4th Cir. 1995). Although Plaintiffs may quibble with the reasoning employed by the *Doe* court to reach that conclusion, this Court is bound by that precedent and must apply it unless and until it is overruled by the Fourth Circuit sitting *en banc* or by the Supreme Court. *See United States v. Collins*, 415 F.3d 304, 311 (4th Cir. 2005) ("A decision of a panel of this court becomes the law of the circuit and is binding on other [courts] unless it is overruled by a subsequent *en banc* opinion of this court or a superseding contrary decision of the Supreme Court." (internal quotation marks omitted)); *United States v. Brown*, 74 F. Supp. 2d 648, 652 (N.D. W. Va. 1998) ("[A] district court is bound by the precedent set by its Circuit Court of Appeals, until such precedent is overruled by the appellate court or the United States Supreme Court."). This is true even where the "logical underpinnings" for the Fourth Circuit's decision may have been eroded by time or by other higher court rulings. *See United States v. Danielczyk*, 791 F. Supp. 2d 513, 515-16 (E.D. Va. 2011), *rev'd on other grounds*, 683 F.3d 611 (4th Cir. 2012). Because the Fourth Circuit has held that rational basis review applies to equal protection challenges based on HIV status, this Court has no option but to likewise apply rational basis review.

Even if the Court had the discretion to revisit the Fourth Circuit's holding in *Doe*, the fact that the case was decided in 1995 and is thus, in Plaintiffs' view, outdated provides no reason to apply a heightened standard of review. Indeed, multiple courts since the *Doe* decision have similarly applied rational basis review to claims of HIV-based discrimination. See *Mofield v. Bell*, 3 F. App'x 441, 443 (6th Cir. 2001); *Johnson v. Robinson*, Case No. 15-CV-298-JPG-RJD, 2017 WL 5288190, at *4 (S.D. Ill. Nov. 13, 2017), *appeal filed*, No. 17-3426 (7th Cir. 2017); *Washington v. Albright*, No. 2:11-CV-618-TMH, 2011 WL 4345687, at *2 (M.D. Ala. Aug. 22, 2011), *report & recommendation adopted*, No. 2:11-CV-618-TMH, 2011 WL 4345681 (M.D. Ala. Sept. 16, 2011); *Werts v. Greenwood Cty. Det. Ctr.*, No. CIV. A. 4:08-1852-TLW-TER, 2008 WL 5378251, at *4 (D.S.C. Dec. 23, 2008); *Fox v. Poole*, No. 06-CV-148, 2008 WL 3540619, at *6 (W.D. N.Y. Aug. 12, 2008); *Pitre v. David Wade Corr. Ctr.*, No. Civ. A. 06-1802, 2008 WL 466160, at *5 (W.D. La. Feb. 14, 2008); *Perkins v. Kan. Dep't of Corr.*, No. CIV. A. 97-3460-GTV, 2004 WL 825299, at *9 (D. Kan. Mar. 29, 2004).

All of these decisions were issued well after 1996, the year in which Plaintiffs assert “everything changed” and medical advances “transformed the landscape of HIV treatment and prevention and radically shifted health outcomes for people living with HIV,” see Compl. ¶ 19, and they thus demonstrate a continuing judicial consensus about the appropriate standard of review even as medical progress is made. Most notably, Plaintiffs—in the face of this overwhelming precedent—fail to identify a single case in which a court has applied a level of scrutiny other than rational basis, including cases that have been decided in recent years. Given the uniformity of precedent on this point over the course of the past few decades, the fact that the Fourth Circuit has not had occasion to revisit its ruling in *Doe* since it was issued in 1995 provides no justification to

disregard its holding with respect to the applicable standard of review for HIV-based discrimination claims.

Plaintiffs' remaining disagreements with *Doe* are equally unpersuasive. In particular, Plaintiffs reject the view expressed by the parties and the court in *Doe* that HIV is a disability. *See* Pls.' Opp'n at 12-14. But even if Plaintiffs' view were accepted as true, it would still not provide a basis for applying a heightened standard of review. As Defendants noted in their opening brief, any notion of disability aside, HIV is still an infectious disease, and courts have consistently held that alleged discrimination based on disease and other medical conditions are subject to rational basis review. *See, e.g., United States v. Santiago-Martinez*, 58 F.3d 422, 423 (9th Cir. 1995) (obesity); *Adell v. Hepp*, No. 17-CV-448-JPS, 2017 WL 1393728, at *3 (E.D. Wis. Apr. 18, 2017) (bowel disease); *Brandon v. Carmichael*, No. 15CV2814 WQH (PCL), 2016 WL 8731115, at *4 (S.D. Cal. Oct. 28, 2016), *report & recommendation adopted*, No. 15-CV-2814-WQH-PCL, 2016 WL 7030365 (S.D. Cal. Dec. 2, 2016) (hepatitis); *Mlaska v. Schicker*, No. 15-CV-00918-MJR, 2015 WL 6098733, at *11 (S.D. Ill. Oct. 16, 2015) ("medical conditions" generally). Thus, assuming HIV is not a disability, discrimination claims based on HIV status should still be subject to rational basis review, just like claims alleging discrimination based on other types of diseases and medical conditions.

Even if there were not binding precedent governing the applicable standard of review in this case, the Court would nevertheless want to proceed with caution in considering Plaintiffs' request to find HIV-positive individuals to constitute a suspect class. As the Supreme Court has counseled, "respect for the separation of powers" should make courts "reluctant" to establish new suspect classes, *see City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 441 (1985), and this admonition "has even more force when the intense judicial scrutiny would be applied to the

‘specialized society’ of the military,” *Thomasson v. Perry*, 80 F.3d 915, 928 (4th Cir. 1996) (en banc) (citing *Parker v. Levy*, 417 U.S. 733, 743 (1974)). Where the Fourth Circuit in *Doe* has spoken directly to the appropriate standard of review for allegations of HIV-based discrimination, which is binding on this Court, there is no reason for the Court to deviate from this precedent. Rational basis review accordingly applies to Plaintiffs’ claim.

D. The Commissioning Policy satisfies rational basis review

The Commissioning Policy easily passes constitutional muster under rational basis review. As an initial matter, Plaintiffs have failed in their Complaint and in both of their briefs to explain how the Commissioning Policy was the result of “intentional or purposeful discrimination” against those who are HIV positive. *See Morrison v. Garraghty*, 239 F.3d 648, 654 (4th Cir. 2001) (“To succeed on an equal protection claim, a plaintiff must first demonstrate that he has been treated differently from others with whom he is similarly situated and that the unequal treatment was the result of *intentional or purposeful discrimination.*” (emphasis added)). Their failure to identify any purposeful discrimination by DoD alone means that their equal protection challenge should be dismissed at this threshold stage of the analysis.

Even if Plaintiffs could satisfy this threshold requirement, the Commissioning Policy satisfies rational basis review. Plaintiffs do not—and cannot—contest that DoD has a legitimate interest in ensuring that Service members are medically fit and ready to serve. *See* Defs.’ Opp’n and Mot. to Dismiss at 27. To meet this goal, DoD has established criteria that it applies to all persons under consideration for appointment, enlistment, or induction into the Military Services. *See* DoD Instruction (“DoDI”) 6130.03 § 1.2(c). These criteria include being free of contagious diseases, being free of medical conditions that may require excessive time lost from duty due to treatment or hospitalization, being medically capable of adapting to the military environment

without geographical limitations, and being medically capable of performing duties without aggravation of existing physical conditions. *Id.* DoD has classified HIV as a “systemic condition” that makes an individual incapable of meeting these criteria. *Id.* § 5.23(b).

Although Plaintiffs accuse DoD of failing to take into account medical advancement in the treatment of HIV when making this analysis, *see* Pls.’ Opp’n at 16-17, that is plainly not the case. Indeed, in its August 2018 Congressional Report, DoD acknowledged the “medical consensus that modern medication management of HIV infection produces very positive results.” DoD Congressional Report at 9. Nevertheless, DoD has determined that “in the context of the extraordinary challenges of many aspects of military service, including potential mission needs under highly stressful combat conditions or in extremely austere and dangerous places worldwide, even well-managed HIV infection carries risks of complications and comorbidities.” *Id.* Such risks include “immune system dysregulation, neurocognitive impairments . . . , disrupted medication maintenance and necessary monitoring for potential side-effects, possible military vaccination adverse effects, and potential communicability, including in circumstances of buddy-aid to a seriously injured member in combat and emergency whole blood battlefield transfusions.” *Id.* Thus, even with the significant advances in HIV treatment, the unique demands and challenges of military service have led DoD to determine that it is necessary to generally prohibit HIV-positive persons from being appointed, enlisted, or inducted into the Service. *See Gilligan*, 413 U.S. at 10 (observing that the military makes “complex, subtle, and professional decisions as to the composition, training, equipping, and control of a military force,” which are “essentially professional military judgments”).

It is DoD’s application of this bar on accessing HIV-positive individuals in the context of Service Members who wish to become commissioned officers—the Commissioning Policy—that

precludes Plaintiff Harrison from being commissioned as a JAG officer and thus is the challenged policy in this case. As Defendants have previously explained, commissioning as an officer involves a change in a Service member's status, for which the member must satisfy a new set of criteria. *See* Defs.' Opp'n and Mot. to Dismiss at 29. Because commissioning as an officer involves taking on a new set of duties and leadership responsibilities, DoD has reasonably determined that the HIV accession standards should apply to this process just as they do to individuals who are seeking to enlist for the first time.⁷ *Id.* As DoD explained in its Congressional Report, "in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship." DoD Congressional Report at 23.

Although DoD recognizes that, as a general matter, there are benefits in retaining Service members once they have been fully trained and gain a certain amount of experience, these considerations do not apply in the context of an enlisted Service member seeking to commission as an officer because the commissioned position will involve a new skill set and defined responsibilities. *Id.* DoD accordingly has articulated a reasonable basis for the Commissioning Policy, and it survives rational basis review. *See Wilkins v. Gaddy*, 734 F.3d 344, 348 (4th Cir.

⁷ In their Opposition, Plaintiffs badly misconstrue Defendants' point in this regard, claiming that Defendants have argued that HIV-positive individuals cannot be of good moral character, exercise leadership responsibilities and privileges, administer oaths to enlisted service members, or swear a required oath. *See* Pls.' Opp'n at 17-18. This is not the case. Defendants simply pointed out the statutorily proscribed differences between commissioned officers and other enlisted Service members to illustrate the meaningful difference between the two types of positions generally, which is why DoD applies the same accessions criteria to already-enlisted individuals who are commissioning as they would to individuals who are enlisting for the first time. *See* Defs.' Opp'n and Mot. to Dismiss at 28-29. Defendants' argument in this regard cannot fairly be read in the manner suggested by Plaintiffs.

2013) (“[T]he fit between the enactment and the public purposes behind it need not be mathematically precise. As long as [DoD] has a reasonable basis for adopting the classification, which can include rational speculation unsupported by evidence or empirical data, the [challenged policy] will pass constitutional muster.”).

In their Opposition, Plaintiffs contend that they can overcome rational basis review through factual allegations about current medical treatment for HIV-positive individuals, which they contend that Defendants cannot disprove. *See* Pls.’ Opp’n at 16-17 (asserting that even “when Defendants are legitimately permitted to argue the facts [about medical treatment for HIV-positive individuals], they ultimately will lose those arguments”). But this misapprehends rational basis review; policy choices, such as the Commissioning Policy, are “not subject to courtroom fact-finding and may be based on rational speculation supported by evidence or empirical data.” *FCC v. Beach Commc’ns, Inc.*, 508 U.S. 307, 315 (1993); *see also Giarratano v. Johnson*, 521 F.3d 298, 303 (4th Cir. 2008) (“[T]he State has no obligation to produce evidence to support the rationality of [a classification], which may be based on rational speculation unsupported by any evidence or empirical data.” (internal quotation marks omitted)). Defendants thus need not demonstrate that their policy is the only medically acceptable outcome possible; indeed, Defendants have expressed their general agreement with Plaintiffs’ assertion that modern medicine has made great strides in HIV treatment. *See* DoD Congressional Report at 9. Rather, the Commissioning Policy is simply a reflection of what DoD has determined is the best way to square that medical reality with the reality of military life, with its attendant unique demands and challenges. *See Rostker*, 453 U.S. at 64-65 (noting that there is “perhaps . . . no other area” where the Supreme Court has shown the political branches “greater deference” than when reviewing military personnel matters). DoD’s determination in this regard need only be rationally related to

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this date, I filed the foregoing using the Court's CM/ECF system, which will send a notification of electronic filing (NEF) to the following counsel of record:

ANDREW R. SOMMER
Va. Bar Number 70304
WINSTON & STRAWN LLP
1700 K St., NW
Washington, DC 20006
T: (202) 282-5000
ASommer@winston.com

Counsel for Plaintiffs

_____/s/_____
DENNIS C. BARGHAAN, JR.
Assistant United States Attorney
Office of the United States Attorney
Justin W. Williams U.S. Attorney's Building
2100 Jamieson Avenue
Alexandria, Virginia 22314
Tel: (703) 299-3891
Fax: (703) 299-3983
Email: dennis.barghaan@usdoj.gov

Counsel for Defendants

EXHIBIT 1

Department of Defense Instruction 1332.45



DoD INSTRUCTION 1332.45

RETENTION DETERMINATIONS FOR NON-DEPLOYABLE SERVICE MEMBERS

Originating Component: Office of the Under Secretary of Defense for Personnel and Readiness

Effective: July 30, 2018

Releasability: Cleared for public release. Available on the Directives Division Website at <http://www.esd.whs.mil/DD/>.

Incorporates and Cancels: Office of the Under Secretary of Defense for Personnel and Readiness Memorandum, "DoD Retention Policy for Non-Deployable Service Members," February 14, 2018

Approved by: Robert L. Wilkie, Under Secretary of Defense for Personnel and Readiness

Purpose: In accordance with the authority in DoD Directive 5124.02, this issuance:

- Establishes policy, assigns responsibilities, and provides direction for retention determinations for non-deployable Service members.
- Provides guidance and instructions for reporting deployability data for the Total Force.

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SECTION 1: GENERAL ISSUANCE INFORMATION

1.1. APPLICABILITY. This issuance applies to OSD, the Military Departments, the Office of the Chairman of the Joint Chiefs of Staff and the Joint Staff, the Combatant Commands, the Office of the Inspector General of the Department of Defense, the Defense Agencies, the DoD Field Activities, and all other organizational entities within the DoD (referred to collectively in this issuance as the “DoD Components”).

1.2. POLICY. It is DoD policy that:

a. To maximize the lethality and readiness of the joint force, all Service members are expected to be deployable.

b. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for:

(1) A retention determination by their respective Military Departments.

(2) As appropriate, referral into the Disability Evaluation System (DES) in accordance with DoD Instruction (DoDI) 1332.18 or initiation of processing for administrative separation in accordance with DoDI 1332.14 or DoDI 1332.30. This policy on retention determinations for non-deployable Service members does not supersede the policies and processes concerning referral to the DES or the initiation of administrative separation proceedings found in these issuances.

c. Implementation for this policy is October 1, 2018.

1.3. INFORMATION COLLECTIONS. The Monthly Non-deployable Report, referred to in Paragraph 3.2. of this issuance, has been assigned report control symbol DD-P&R(M)2671 in accordance with the procedures in Volume 1 of DoD Manual 8910.01. The expiration date of this information collection is listed in the DoD Information Collections System at <https://apps.sp.pentagon.mil/sites/dodiic/Pages/default.aspx>.

SECTION 2: RESPONSIBILITIES

2.1. UNDER SECRETARY OF DEFENSE FOR PERSONNEL AND READINESS

(USD(P&R)). The USD(P&R) establishes and oversees policy on retention determinations for non-deployable Service members.

2.2. ASSISTANT SECRETARY OF DEFENSE FOR MANPOWER AND RESERVE AFFAIRS (ASD(M&RA)). Under the authority, direction, and control of the USD(P&R), the ASD(M&RA):

- a. Develops policy on the retention of non-deployable Service members.
- b. Monitors the implementation of this guidance.
- c. Tracks the number of non-deployable Service members and those non-deployable Service members retained in military service and the justification for such retention, in accordance with Section 3 of this issuance.

2.3. ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS. Under the authority, direction, and control of the USD(P&R), the Assistant Secretary of Defense for Health Affairs:

- a. Develops policy recommendations to the USD(P&R) for uniform retention medical standards in coordination with the Secretaries of the Military Departments.
- b. Provides oversight of related medical policies and programs.

2.4. SECRETARIES OF THE MILITARY DEPARTMENTS. The Secretaries of the Military Departments:

- a. Will:
 - (1) Determine the deployability status of Service members.
 - (2) Make retention determinations consistent with this issuance for Service members who have been non-deployable for more than 12 consecutive months.
 - (3) Submit monthly reports identifying the number of non-deployable Service members for all components within their Departments to the Office of the USD(P&R) in accordance with Paragraph 3.2. of this issuance.
 - (4) Monitor compliance with requirements established in DoDI 6025.19 to ensure required evaluations, assessments, and other medically related actions are accomplished to improve individual and overall unit readiness.

b. May:

(1) Retain in service those Service members whose period of non-deployability exceeds the 12 consecutive month limit in Paragraph 1.2. of this issuance if determined to be in the best interest of the Military Service.

(2) Delegate the authority in Paragraph 2.4.(b)(1) of this issuance to retain in service those Service members whose period of non-deployability exceeds the 12 consecutive month limit. Such a delegation must be in writing, and may only be made to Presidentially Appointed, Senate-Confirmed officials; Senior Executive Service members; or general/flag officers serving at the Military Department or Service headquarters.

(3) Initiate administrative separation processing, or referral to the DES, as appropriate, prior to a non-deployable Service member being in a non-deployable status for 12 months when the Military Service determines there is a reasonable expectation that the reason will not be resolved and the Service member will not become deployable.

SECTION 3: PROCEDURES FOR TRACKING AND REPORTING SERVICE MEMBERS

3.1. TRACKING.

a. The Military Departments will monitor and track the number of Service members by Military Service that are:

(1) Non-deployable in accordance with the categories established in Paragraphs 3.5. and 3.6. of this issuance.

(2) Deployable with limitations in accordance with Paragraph 3.3. of this issuance.

(3) Deployable but have individual medical readiness (IMR) deficits in accordance with Paragraph 3.7. of this issuance.

(4) In training or in a transient status in accordance with the category defined in Paragraph 3.4. of this issuance.

b. To ensure accurate and consistent accounting across the DoD, Military Services will account for Service members in only one category. If a Service member can be accounted for in more than one category, the Service member will be counted only once and in the category with the highest priority listed in accordance with Paragraph 3.8. of this issuance.

3.2. REPORTING.

a. The Secretaries of the Military Departments will report to the ASD(M&RA) the number of non-deployable personnel (and other categories as provided in this section) for all Military Services, and their respective components, on a monthly basis.

(1) The format for the Monthly Non-deployable Report can be found at <https://prhome.defense.gov/M-RA/Inside-M-RA/MPP/OEPM/>.

(2) Reports are due by the end of each month with data current as the last day of the previous month. For example, the June Non-deployable Report is due by June 30th with non-deployable data as of May 31st.

b. The number of non-deployable Service members is reported by categories, either temporary or permanent, and grouped into medical, legal, or administrative sub-categories. Each sub-category is further broken down to account for the specific reasons or conditions that make a Service member non-deployable.

c. The number of Service members who are deployable with limitations, in accordance with Paragraph 3.3. of this issuance, will be categorized separately on the monthly report. Such Service members are not to be counted in the non-deployable populations.

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d. The number of Service members who require urgent or emergent dental treatment for dental readiness (Dental Class 3), are overdue for annual dental screening (Dental Class 4), or are overdue for a Periodic Health Assessment (PHA) are reported as IMR Deficits in accordance with Paragraph 3.7. of this issuance. Such Service members are not counted in the non-deployable populations.

e. The number of Service members who are in a training or transient status are reported in one of the four categories listed in Paragraph 3.4. of this issuance.

3.3. DEPLOYABLE WITH LIMITATIONS. Service members with a medical condition that requires additional medical screening, or Combatant Command approval prior to deployment outside the continental United States, will be categorized as Deployable with Limitations. This includes, but is not limited to, conditions referred to in DoDI 6490.07.

3.4. TRAINING AND TRANSIENT. The Training and Transient category provides a means to track the human resources necessary to maintain a healthy force, within current end strength constraints. This category contains Service members who are not immediately ready for deployment and fall into one of the following four categories:

a. Initial Entry Training. These Service members are:

(1) Enlisted Service members at recruit training, initial skill training, and other proficiency or developmental training accomplished before moving to the member's first permanent duty assignment. This includes all in-transit time commencing upon entry into active service, through completion of the final course of initial entry training that terminates enlisted trainee status.

(2) Enlisted trainees who enter officer candidate school, officer training school, and Service academy preparatory school following enlistment on active duty. These members will be considered:

(a) Enlisted trainees from initial entry on active duty until commissioning.

(b) Upon commissioning, officer accession students and will remain in the initial entry training category for any subsequent initial entry training, or until they begin travel to their first permanent duty assignment.

(3) Officers at officer basic courses, and all initial skill and proficiency training taken before travel to the Service member's first permanent duty assignment. This includes all in-transit time from entry on active duty until completion of the last initial entry course of instruction.

(4) Reserve Component (RC) Service members (enlisted and officer) who enter the Ready Reserve and are awaiting initial entry training.

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b. Cadets and Midshipman. These are individuals currently attending the U.S. Military Academy, the U.S. Air Force Academy, or the U.S. Naval Academy. In accordance with Section 115 of Title 10, United States Code (U.S.C.), cadets and midshipman are counted in the active duty end strength for their respective Service, but by policy are non-deployable while attending school.

c. All Other Training. These are Service members who are attending training that is 20 weeks or more in length, and is conducted after their initial entry training. Examples include Command and Staff Colleges, Senior Service College, the United States Army Sergeants Major Academy, medical residencies, and all other post-graduate professional education opportunities.

d. Transient. These are Service members who are not available for duty while executing permanent change of station orders at the time of the report. This category does not include military personnel who are:

(1) On temporary duty for training between permanent duty stations, or;

(2) Moving between entry-level courses of instruction, specifically Service members who have departed from one duty station and are in transit but have not yet reported for duty at the next permanent duty station.

3.5. TEMPORARY NON-DEPLOYABLE CATEGORIES.

a. Medical. Service members are considered temporarily non-deployable for one of three reasons:

(1) **Patient.** In accordance with DoDI 1120.11, Service members who are hospitalized and are projected to heal, recover, and return to full duty in less than 12 months are temporarily non-deployable.

(2) **Medical Condition That Limits Dull Duty.** Service members who have temporary profiles or are in limited duty status are counted as temporarily non-deployable. Light duty will not be reported as non-deployable unless the duration exceeds 30 days, with discretion given to the medical officer to extend light duty status for up to 60 days, making light duty no longer than 90 days for conditions expected to recover or stabilize within that time.

(3) **Pregnancy (including post-partum).** Service members who are pregnant or in the post-partum phase are temporarily non-deployable. The post-partum phase ranges from 6 to 12 months after childbirth for female Service members and is determined by individual Service policy.

b. Legal. Service members are considered temporarily non-deployable for one of two reasons:

(1) **Prisoner.** Service members convicted by civilian or military authorities and sentenced to confinement of more than 30 days, but for 6 months or less, are temporarily non-

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deployable. Service members confined for more than 6 months are not included in end strength numbers and will not be included in the monthly non-deployability report.

(2) **Legal Action.** Service members who are under arrest, confined 30 days or less, pending military or civil court action, under investigation, a material witness, on commander directed hold, pending non-judicial punishment action under Section 815 of Title 10, U.S.C., also known as Article 15 of the Uniformed Code of Military Justice (UCMJ), or pending discharge based on action under the UCMJ are temporarily non-deployable.

c. Administrative. These Service members are considered temporarily non-deployable for one of eight reasons:

(1) **Absent Without Leave or Unauthorized Absence.** Service members who are absent without leave, as defined in Section 886 of Title 10, U.S.C., also known as Article 86 of the UCMJ, will be considered as temporarily non-deployable.

(2) **Family Care Plan.** In accordance with DoDI 1342.19, Service members required but failing to have a family care plan in place are temporarily non-deployable.

(3) **Adoption.** Service members who are single parents or one member of a dual military couple and are adopting a child are temporarily non-deployable. They are non-deployable for at least 6 months after the child is placed in the home, or longer dependent on the administrative stabilization period prescribed by the jurisdiction in which the adoption occurred.

(4) **Service Member Under 18.** Service members who are not yet 18 years of age are temporarily non-deployable. The Child Soldier Prevention Act of 2007 prohibits Service members under the age of 18 from taking part in hostilities as a member of governmental armed forces.

(5) **Humanitarian Assignment.** Service members assigned to a location to provide support to a family member are temporarily non-deployable. These Service members typically receive 12 to 24 months stabilization by Military Service policy.

(6) **Service Discretion.** Military Services may designate Service members temporarily non-deployable when the previous categories do not apply. Examples include:

(a) Simultaneous Membership Program or Officer Candidate School.

(b) Education stabilization; mobilization deferral for affiliation after release from Active Component.

(7) **Pending Administrative Separation.** Service members being processed for administrative separation are temporarily non-deployable.

(8) **Unsatisfactory Participants or Administrative Action Pending (RC Only).** Service members who are determined to be unsatisfactory participants, as defined in DoDI 1215.13, are temporarily non-deployable.

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3.6. PERMANENT NON-DEPLOYABLE CATEGORIES.

a. Medical. Service members are considered non-deployable for one of three reasons listed below.

(1) **Permanent Limited Duty.** Service members with a medical condition that permanently prevents deployment are non-deployable. This includes Service members processed through the DES who are not deployable and were retained in the Military Service. In accordance with Section 1214a of Title 10, U.S.C., Service members cannot be involuntarily administratively separated or denied reenlistment due to unsuitability based solely on the medical condition considered in the evaluation unless the request to separate the Service member is approved by the Secretary of Defense. The Military Service may direct the Service member to reenter the DES process to be reconsidered for retirement or separation for disability.

(2) **Enrolled in DES.** In accordance with DoDI 1332.18, Service members currently enrolled in the DES process are non-deployable. That includes those pending separation or retirement after receiving a “not fit for duty” determination through the DES.

(3) **Permanent Profile Non-duty Related Action Needed (RC).** Those RC Service members who have a permanent profile and are pending a decision on a line of duty determination are non-deployable.

b. Administrative. These Service members are considered non-deployable for one of three reasons:

(1) **Sole Survivor, Surviving Family Member, or Deferred from Hostile Fire Zone.** Service members who acquired the status in accordance with DoDI 1315.15 are non-deployable.

(2) **Unable to Carry a Firearm.** Service members who are subject to the provisions of Section 922 of Title 18, U.S.C. are non-deployable.

(3) **Conscientious Objector.** Service members who are granted restriction of military duties in accordance with DoDI 1300.06 are non-deployable.

c. Approved for Retention. This category accounts for Service members who are retained by the Military Department despite being in a non-deployable status for 12 months or longer. Service members who the Military Departments retained in Service and are considered non-deployable for one of two reasons:

(1) **Combat Wounded.** These are Service members whose injuries were the result of hostile action, meet the criteria for awarding of the Purple Heart, and whose injuries were not the result of their own misconduct.

(2) **Other.** These are Service members who are not designated as combat wounded but are non-deployable and retained in the Military Service by the Secretary of the Military Department in accordance with Paragraph 2.4. of this issuance.

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3.7. IMR DEFICITS. These IMR categories are not considered non-deployable conditions. Components are expected to immediately correct all IMR deficits to ensure Service members are medically ready to deploy.

a. Overdue PHA. These Service members are not compliant with the requirement to complete a PHA in accordance with DoDI 6025.19.

b. Dental Readiness (Dental Class 3). Service members who require urgent or emergent dental treatment.

c. Overdue Dental Screening (Dental Class 4). Service members who are not compliant with the requirement to complete a dental screening in accordance with DoDI 6025.19.

d. Additional IMR Categories. In addition to dental categories (Dental Classes 3 and 4) and PHAs, the Military Departments track three additional areas of IMR: immunization status, medical readiness and laboratory studies, and individual medical equipment. In accordance with DoDI 6025.19, Service members who are not current in these areas are considered partially medically ready.

3.8. PRIORITIZATION OF SERVICE MEMBERS BY CATEGORY. This paragraph sets the prioritization for the grouping of Service members into categories to provide consistent reporting among the Military Departments, in accordance with Paragraph 3.1.(b) of this issuance. Service members will be counted only once, in a single category; Service members who may fall into more than one category will be reported in the priorities established in this paragraph. These categories are listed below in descending order of priority.

a. Deployed. This category includes Service members who are currently deployed. These Service members will not be counted in any other category (including deployable with limitations or approved for retention).

b. Deployable with Limitations.

c. Approved for Retention.

(1) Combat wounded – Non-deployable but retained.

(2) Other – Non-deployable but retained.

d. Permanent Non-Deployable.

(1) Medical permanent limited duty.

(2) Administrative.

(a) Sole survivor, surviving family member, or deferred from hostile fire zone.

(b) Unable to carry a firearm (e.g., Lautenberg Amendment).

- (c) Conscientious objector.
- (d) Ex-prisoner of war.
- (3) Medical Enrolled in DES.
- (4) Permanent profile non-duty related action needed (RC).

e. Training and Transient.

- (1) Initial entry training.
- (2) Cadets or Midshipmen.
- (3) All other training.
- (4) Transient (permanent change of station).

f. Temporary Non-Deployable.

- (1) Medical.
 - (a) Patient (assigned to “Individuals Account”).
 - (b) Medical condition that limits full duty.
 - (c) Pregnancy (including post-partum).
- (2) Legal.
 - (a) Prisoner.
 - (b) Legal Action.
- (3) Administrative.
 - (a) Absence without leave.
 - (b) Family Care Plan.
 - (c) Adoption.
 - (d) Service member under 18.
 - (e) Humanitarian assignment.
 - (f) Service Discretion.
 - (g) Pending Administrative Separation.

(h) Unsatisfactory participants or admin action pending (RC).

g. IMR Deficits.

- (1) Overdue PHA.
- (2) Dental readiness (Dental Class 3).
- (3) Overdue dental screening (Dental Class 4).

DoDI 1332.45, July 30, 2018

SECTION 4: RETENTION DETERMINATION

4.1. RETENTION AUTHORITY FOR NON-DEPLOYABLE SERVICE MEMBERS. In accordance with Paragraph 2.4. of this issuance, the Secretaries of the Military Departments have retention authority.

4.2. RETENTION DETERMINATION.

a. The Secretaries of the Military Departments may retain Service members who are non-deployable in excess of 12 consecutive months, on a case-by-case basis, if determined to be in the best interest of the Service, based on:

(1) The Service member's ability to perform appropriate military duties commensurate with his or her office, grade, rank, or skill.

(2) The likelihood that the Service member will resolve the condition or reason that is the underlying cause of his or her non-deployable status.

b. The Secretaries of the Military Departments may approve retention for Service members who are non-deployable in excess of 12 consecutive months for up to:

(1) The length of time remaining on a Service member's enlistment contract; or

(2) Three years for officers, including warrant officers, and those enlisted members serving on indefinite contracts.

(3) Upon expiration of the retention period, the Secretary of the Military Department concerned may renew retention for a Service member on a case-by-case basis for periods stated in this paragraph.

c. The Secretaries of the Military Departments may establish procedures for Service members who are or will be non-deployable for 12 months or longer due to an administrative reason to request retention consideration.

d. Approval of the retention for Service members who are non-deployable for 12 months or longer will only be made for individual Service members, not an entire cohort or skill set of Service members.

e. Except as required by DoDI 1332.18, the Secretaries of the Military Departments may request from the Secretary of Defense the authority to automatically exempt Service members serving in specified positions from the requirement for a retention determinations pursuant to Paragraph 2.4.b.

f. When appropriate, Service members not recommended for further retention will be considered for processing for administrative separation in accordance with DoDI 1332.14 or DoDI 1332.30, or referral for disability separation in accordance with DoDI 1332.18.

DoDI 1332.45, July 30, 2018

4.3. SPECIAL CATEGORIES.

a. Pregnant and post-partum Service members, as a group, are exempt from Paragraph 2.4.a., for pregnancy-related health conditions during pregnancy through the post-partum period.

b. The Secretaries of the Military Departments have the authority to retain combat wounded Service members who have been evaluated through the DES and whose reason for non-deployability is a direct result of their combat wounds, if requested by the Service member.

(1) Disapproval of retention for non-deployable combat wounded Service members, who wish to be retained and whose reason for non-deployability is a direct result of their combat wounds, may not be delegated.

(2) Retention will be authorized in accordance with Paragraph 4.2.b.

c. Unless found unfit for duty through the DES, Service members serving in specified positions approved by the Secretary of Defense pursuant to Paragraph 4.2.e. are exempt from requiring a retention determination based solely on being in a non-deployable status for 12 months or longer. Upon reassignment, these Service members will again require a retention determination in accordance with Paragraph 4.2.a.

d. Unless sooner discharged or retired under another provision of law, or discharged due to misconduct or sub-standard performance, the Secretaries of the Military Departments may retain those Service members who are, or will be, non-deployable for 12 months or longer due to administrative reasons and who have attained such years of creditable service so as to be within 3 years of qualifying for:

(1) Regular retirement (or in the case of enlisted members of the Navy or Marine Corps, transfer to the Fleet Reserve or Fleet Marine Corps Reserve, as the case may be) pursuant to Sections 3911, 3914, 6323, 6330, 8911, or 8914 of Title 10, U.S.C.; or

(2) Non-regular retirement (but for age) pursuant to Sections 12731 and 12735 of Title 10, U.S.C., if, in the case of RC members other than RC members within 3 years of qualifying for regular retirement, they have attained at least 17 years of qualifying creditable service as computed in accordance with Section 12732 of Title 10, U.S.C., and continue to attain qualifying creditable service as computed under attains Section 12732 of Title 10, U.S.C. to become eligible for non-regular retirement within the 3-year period.

SECTION 5: AUTHORITIES FOR SEPARATIONS AND RETIREMENTS

5.1. In accordance with Paragraph 1.2. of this issuance, a Service member who has been non-deployable for an administrative reason (not medical or legal) for more than 12 consecutive months, will be processed for administrative separation in accordance with DoDI 1332.14 or DoDI 1332.30. Military Services should ensure expeditious administrative separation proceedings in accordance with Military Department and Military Service policies.

5.2. A Service member who has been non-deployable due to a physical disability that makes him or her potentially unfit for the duties of his or her office, grade, rank, or rating for more than 12 consecutive months will be referred into the DES in accordance with DoDI 1332.18.

GLOSSARY

G.1. ACRONYMS.

ASD(M&RA)	Assistant Secretary of Defense for Manpower and Reserve Affairs
DES	Disability Evaluation System
DoDI	DoD instruction
IMR	individual medical readiness
PHA	periodic health assessment
RC	Reserve Component
UCMJ	Uniformed Code of Military Justice
U.S.C.	United States Code
USD(P&R)	Under Secretary of Defense for Personnel and Readiness.

G.2. DEFINITIONS. Unless otherwise noted, these terms and their definitions are for the purpose of this issuance.

active duty. Defined in the DoD Dictionary of Military and Associated Terms.

active service. Defined in Section 101(d)(3) of Title 10, U.S.C.

active status. Defined in Section 101(d)(4) of Title 10, U.S.C.

combat wounded. Service members whose injuries were the result of hostile action, who meet the criteria for awarding of the Purple Heart, and whose injuries were not the result of their own misconduct.

deployable. A Service member who does not have a Service-determined reason that precludes him or her from deployment.

deployment. The movement of personnel into and out of an operational area or in support of operations. Deployment encompasses all activities from origin or home station through destination, specifically including inter-theater, and intra-theater movement legs, staging, and holding areas.

Military Departments. The Departments of the Army, Navy, and Air Force.

Military Service Headquarters. Headquarters, United States Army; Headquarters, United States Navy; Headquarters, United States Air Force; and Headquarters, United States Marine

Corps.

Military Services. The United States Army, the United States Navy, the United States Air Force, and the United States Marine Corps.

military specialty. A military occupational specialty in the Army and the Marine Corps; an Air Force specialty code in the Air Force; or a rating or Navy enlisted classification in the Navy.

non-deployable. A Service member who has a Service-determined reason that precludes him or her from deployment.

permanently non-deployable. A Service member who has a reason that precludes them from deployment, and there is a Service expectation that the reason will not be resolved and the Service member will never be deployable.

profile. A document used to communicate to commanders the individual medical restrictions for Soldiers and Airmen.

Ready Reserve. Defined in the DoD Dictionary of Military and Associated Terms.

reason code. The term used to define non-deployable categories.

separation. A general term that includes discharge, release from active duty, release from custody and control of the Military Services, transfer to the Individual Ready Reserve, and similar changes in Active and Reserve status.

temporarily non-deployable. A Service member who has a reason or reasons that precludes him or her from deployment, and there is a Service expectation that the reason or reasons will be resolved and the Service member will be deployable.

DoDI 1332.45, July 30, 2018

REFERENCES

- DoD Directive 5124.02, “Under Secretary of Defense for Personnel and Readiness (USD(P&R)),” June 23, 2008
- DoD Instruction 1120.11, “Programming and Accounting for Active Component (AC) Military Manpower,” March 17, 2015
- DoD Instruction 1215.13, “Ready Reserve Member Participation Policy” May 5, 2015
- DoD Instruction 1300.06, “Conscientious Objectors,” July 12, 2017
- DoD Instruction 1315.15, “Special Separation Policies for Survivorship,” May 19, 2017
- DoD Instruction 1332.14, “Enlisted Administrative Separations,” January 27, 2014, as amended
- DoD Instruction 1332.18, “Disability Evaluation System (DES),” August 5, 2014, as amended
- DoD Instruction 1332.30, “Commissioned Officer Administrative Separations,” May 11, 2018
- DoD Instruction 1342.19, “Family Care Plans,” May 7, 2010, as amended
- DoD Instruction 6025.19, “Individual Medical Readiness (IMR),” June 9, 2014
- DoD Instruction 6490.07. “Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees” February 5, 2010
- DoD Manual 8910.01, Volume 1, “DoD Information Collections Manual: Procedures for DoD Internal Information Collections,” June 30, 2014, as amended
- Office of the Chairman of the Joint Chiefs of Staff, “DoD Dictionary of Military and Associated Terms,” current edition
- The Child Soldier Prevention Act of 2007, 110th Congress, S.1175
- United States Code, Title 10
- United States Code, Title 18

EXHIBIT 2

***Report to Congressional Defense Committees on
Department of Defense Personnel Policies
Regarding Members of the Armed Forces with HIV
or Hepatitis B (Sept. 2014)***



UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

**PERSONNEL AND
READINESS**

SEP 22 2014

The Honorable Carl Levin
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report responds to section 572 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

The DoD and the Military Services have policies in place to address the management of individuals with these conditions. The policies were established with an understanding of these diseases and the impact on the individual and the risk to other individuals. Health care providers in the Military Health System have appropriate training to manage the acute and long-term health needs of individuals with these conditions. The enclosed report reviews the policies for accession, retention, deployment, discharge, and adverse actions. The review found that the policies for management of DoD personnel with HIV or HBV are evidence-based, medically accurate, reflect standard of care medical practices, and have been reviewed regularly and updated as practices, guidelines, and standard of care have evolved.

Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Sincerely,


Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable James M. Inhofe
Ranking Member



UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

**PERSONNEL AND
READINESS**

SEP 22 2014

The Honorable Barbara A. Mikulski
Chairwoman
Committee on Appropriations
United States Senate
Washington, DC 20510

Dear Madam Chairwoman:

This report responds to section 572 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

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Sincerely,


Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Richard C. Shelby
Vice Chairman



UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

PERSONNEL AND
READINESS

The Honorable Howard P. "Buck" McKeon
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

SEP 22 2014

Dear Mr. Chairman:

This report responds to section 572 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

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Sincerely,


Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member



**UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000**

**PERSONNEL AND
READINESS**

SEP 22 2014

The Honorable Harold Rogers
Chairman
Committee on Appropriations
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report responds to section 572 of the National Defense Authorization Act for Fiscal Year 2014 (Public Law 113-66) which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

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Thank you for your interest in the health and well-being of our Service members, veterans, and their families. A similar letter has been sent to the Chairpersons of the other congressional defense committees.

Sincerely,


Jessica L. Wright

Enclosure:
As stated

cc:
The Honorable Nita M. Lowey
Ranking Member

**Report to Congressional Defense Committees on Department of
Defense Personnel Policies Regarding Members of the Armed
Forces with HIV or Hepatitis B**



2014

The estimated cost of report for the
Department of Defense is approximately
\$5100.00

This includes \$4,500.00 in expenses and
\$600.00 in DoD labor.

Generated on July 30, 2014

EXECUTIVE SUMMARY

INTRODUCTION: This report responds to section 572 the National Defense Authorization Act (NDAA) for Fiscal Year 2014 (Public Law 113-66), which requires the Secretary of Defense to submit a report on Department of Defense (DoD) personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV) and hepatitis B (HBV).

DATA COLLECTION: DoD and Service policies were reviewed to develop this report.

POLICIES PERTAINING to HIV and HBV:

1. Individuals under consideration for appointment, enlistment, or induction into the Military Services with evidence of HIV or HBV infection do not meet accession standards, which require healthy recruits free of communicable diseases or medical conditions that may require excessive time lost for treatment or probably will result in separation for medical unfitness. Recruits must also be capable of functioning in the demanding military environment without aggravation of existing medical conditions.
2. Service members already serving who have laboratory evidence of HIV or HBV infection:
 - Are referred for appropriate treatment and managed in the same manner as a Service member with other chronic or progressive illnesses. If determined to be unfit for duty, the Service member will be separated or retired.
 - May not deploy without a waiver and the approval of the Combatant Commander. The factors considered ensure the Service member will be able to perform duties.
 - May not be subjected to adverse personnel action solely due to infection status. However, a Service member with laboratory evidence of HIV infection who disobeys an order to inform current or potential sexual partners of their infected status or to engage in safe sex practices may be subject to disciplinary action.

DISCUSSION: This review found that current DoD HIV and HBV policies are:

1. Established to maintain military readiness and based on international, national and federal guidelines, and professional organization recommendations for prevention, identification and treatment of HIV and HBV.
2. Evidence-based, medically accurate and reviewed regularly by subject matter experts.
3. Established to ensure applicants can complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military without jeopardizing their health, the health of their unit, or the health of the inhabitants of the lands where our forces are deployed.
4. In support of retention of DoD personnel already serving unless there is evidence of deteriorating health or other factors that make the individual unable or unfit to perform their duties.

5. Implemented to ensure that infection with HIV or HBV will not be the basis for adverse personnel actions.

CONCLUSION: The policies for management of DoD personnel with HIV or HBV are evidence-based, medically accurate, and are reviewed regularly and updated as practices, guidelines, and standards of care evolve.

INTRODUCTION:

Section 572 of NDAA for FY 2014, which was signed into law on December 26, 2013, required the Secretary of Defense to submit a report on DoD personnel policies regarding members of the Armed Forces infected with HIV or HBV to the congressional defense committees not later than 180 days after enactment of the act. The statute states: “The report shall include the following:

(1) A description of policies addressing the enlistment or commissioning of individuals with these conditions and retention policies, deployment policies, discharge policies, and disciplinary policies regarding individuals with these conditions.

(2) An assessment of these policies, including an assessment of whether the policies reflect an evidence-based, medically accurate understanding of how these conditions are contracted, how these conditions can be transmitted to other individuals, and the risk of transmission.”

An interim report dated April 30, 2014 was sent to the chairpersons of the defense committees.

DATA COLLECTION:

The Assistant Secretary of Defense for Health Affairs (ASD(HA)) requested each of the Military Departments to provide a summary addressing the requirements in section 572 of the NDAA for FY 2014. The ASD(HA) reviewed DoD-level policies for enlistment or commissioning, retention, deployment, discharge and discipline of individuals infected with HIV or HBV. This report combines the Service data with the DoD assessment to provide a summary addressing the two requirements in the NDAA language.

POLICIES PERTAINING TO HIV AND HBV:

1. Enlistment or Commissioning

Standards for enlistment or commissioning of individuals into the Armed Services are stated in DoDI 6130.03, “Medical Standards for Appointment, Enlistment, or Induction in The Military Services.” Paragraph 4 states “It is DoD policy to ensure that individuals under consideration for appointment, enlistment, or induction into the Military Services are:

- (1) Free of contagious diseases that probably will endanger the health of other personnel.
- (2) Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
- (3) Medically capable of satisfactorily completing required training.
- (4) Medically adaptable to the military environment without the necessity of geographical area limitations.
- (5) Medically capable of performing duties without aggravation of existing physical defects or medical conditions.”

Applicants with the following specific medical conditions do not meet accession standards:

- Presence of HIV or serologic evidence of infection or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing, or
- Current acute or chronic hepatitis carrier state, hepatitis in the preceding 6 months or persistence of symptoms after 6 months, or objective evidence of impairment of liver function

In accordance with DoDI 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs will be tested for laboratory evidence of HIV within 72 hours of arrival to the program and denied entry to the program if such test is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV not later than during their commissioning physical examination, and denied a commission if they test positive.

Service accession policies are in compliance with DoDI 6130.03 and DoDI 6485.01.

2. Retention

Once a Service member has been trained, the goal is to retain members who acquire HIV or HBV who are still capable of performing their duties in the rigorous military environment and to deploy wherever the military serves. If any member incurs a medical condition that limits their ability to continue performing their military occupation, the Department's Disability Evaluation System (DES) provides for the member to have a fair and full review to determine fitness for duty (see paragraph 4 below for a discussion of DES).

The screening policies for HIV and HBV identify Service members who have been infected since accession into the military. In the Army and Air Force, HBV screening for Service members is performed if clinically indicated. SECNAVINST 5300.30E currently requires all AD personnel to receive, in addition to accession testing, an HBV test every 25 months. However, since it has been determined that there is no medical or force readiness indication for such frequent testing, the Secretary of the Navy has issued a temporary deferral from this requirement. Navy is currently revising SECNAVINST 5300.30E to remove this needlessly stringent requirement. Additional screening will be in accordance with the US Preventive Task Force Recommendation Statement, "Screening for Hepatitis B Virus Infection in Non-pregnant Adolescents and Adults," and as medically indicated.

DoDI 6485.01 requires all Service members to be screened periodically for laboratory evidence of HIV infection.

- AD and Reserve Component (RC) Selected Reserve (SELRES) personnel are screened every 2 years unless more frequent screenings are clinically indicated.

- Members of the SELRES are screened at least once every 2 years. RC personnel are screened when called to a period of AD greater than 30 days if they have not received an HIV test within the last 2 years.¹

Testing for laboratory evidence of HIV for pre- and post-deployment is conducted in accordance with DoDI 6025.19, "Individual Medical Readiness" and DoDI 6490.03, "Deployment Health." (The requirements for screening in DoDI 6025.19 and DoDI 6490.03 are listed under the deployments section.)

The U.S. Preventive Services Task Force (USPSTF) makes recommendations for screening for HIV that are patient specific. In addition, the 2013 recommendations noted that there are no definitive data supporting specific screening intervals. These recommendations are reviewed by the subject matter experts when reviewing DoD policy for currency. It is important to note that DoD policy is population based screening based upon unique operational military requirements. For example, the safety of the U.S. military blood supply is a primary factor in determining the policy for screening. The DoD screening policy supports early detection and treatment. The USPSTF 2013 recommendations also noted that there is direct evidence of the benefits of early antiretroviral therapy for HIV infected persons and its effectiveness in preventing HIV transmission.

An AD Service member with laboratory evidence of HIV or HBV infection is evaluated and managed in the same manner as a Service member with other chronic or progressive illnesses. A treatment plan is established, any indicated treatment is initiated. The member may be allowed to continue to serve in a manner that ensures ongoing access to appropriate medical care provided that she or he is fit for duty. Infected RC members who are fit for duty are also managed in the same manner as those with chronic or progressive illnesses and their medical condition is monitored periodically.

3. Deployment

DoDI 6025.19 requires that an HIV test result, completed within the last 24 months, be on file prior to deployment.

DoDI 6490.03 requires pre-deployment serum specimens and HIV testing (or as required by HIV threat or country requirements) for all deployments greater than 30 days to areas outside the contiguous United States (OCONUS) with non-fixed Military Treatment Facilities (MTFs). The combatant command (COCOM) Commander, Service component commander, or commander exercising operational control determines requirements for serum testing and HIV testing for all OCONUS deployments less than 30 days; OCONUS deployments to areas with fixed U.S. MTFs; and deployments within the contiguous United States (CONUS). When required, pre-deployment HIV tests must have been collected within 2 years of deployment (or more recently, based on country entry requirements). HIV serum samples that are not more than 12 months old

¹"RC personnel" includes all members of the RC not in the SELRES. For example, a member in the Individual Ready Reserve is not routinely screened; however, the member is screened when ordered to AD for more than 30 days.

stored in the DoD Serum Repository may satisfy the pre-deployment specimen requirement. DoDI 6490.03 requires notification of Service members if a pre- or post-deployment serum sample will be tested for HIV.

In accordance with DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," Service members with the following medical conditions may not deploy unless a waiver is granted:

- Known blood-borne diseases that may be transmitted to others in a deployed environment.
- Presence of HIV seropositivity with the presence of progressive clinical illness or immunological deficiency.

The Combatant Command surgeon must be consulted in all instances of HIV seropositivity and active HBV infection for consideration of a medical clearance for deployment. The Combatant Commander is the final approval authority for waivers.

AR 40-501, "Standards of Medical Fitness," directs that HIV infected members will not be deployed to a combat theater of operations. However, waivers may be granted to HIV infected individuals to serve in OCONUS duty assignments. AR 40-501 is currently under revision and will address the availability of medical care in OCONUS for members with HIV or HBV who are granted a waiver. The revised policy will direct that medical services available in the assignment area must provide the same standard of care as in CONUS.

In 2012, based on advances in medical treatment which have significantly simplified the disease management of individuals with HIV, the Navy updated its policies to allow individuals with HIV, who have had appropriate evaluation and medical clearance, to operationally deploy aboard select naval vessels. These personnel are considered to have controlled HIV infection as manifested by an unimpaired immune system, no current viremia, an established history of compliance with medical treatment, and a history of professional attitude. This policy is based on the following considerations:

- There is no demonstrated risk of transmission of infection in normal daily activities.
- An investment in training of these individuals has been made.
- The previous policy of denying deployments was making this subset of personnel less competitive in achieving career milestones or warrior qualifications.

The Air Force (AF) policy states that HIV-infected Service members cannot deploy or be stationed OCONUS without a waiver. The AF is continuing to develop guidance for non-permanent change of station (PCS) extended duty tours and/or travel to areas with increasing military operations tempo (such as United States Africa Command or United States Pacific Command).

4. Discharge From Duty or Retirement

A Service member infected with HIV or HBV is not retired or separated solely on the basis of being infected. However, an infected member whose condition deteriorates and interferes with the successful performance of their military occupation may be referred to the Disability Evaluation System (DES) for a physical disability evaluation, which provides for a fair and full review to determine fitness for duty.

DoDI 1332.18, "Physical Disability Evaluation," DoD Manual 1332.18, Vol 1, "Disability Evaluation System Manual: General Information and Legacy DES (LDES) Time Standards," and DoD Manual 1332.18, Vol 2: Disability Evaluation System Manual: Integrated Disability Evaluation System (IDES)" establish policy for determining fitness for duty and for retiring or separating Service members due to physical disability. A medical evaluation is the first step in the disability evaluation process. A Medical Evaluation Board (MEB) documents a Service member's medical conditions and full clinical information. A summary of clinical information includes a medical history, appropriate physical examination, indicated medical tests and their results, medical and surgical consultations as necessary, diagnoses, ongoing or recommended treatment, and prognosis. The medical evaluation documents the medical status and duty limitations of Service members (subject to Service departmental regulations).

If the Service member cannot perform the duties of her or his military occupational specialty, the MEB refers the case to the DES. Criteria for referral of Service members into the DES include:

- Have one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of their office, grade, rank, or rating including those duties remaining on a Reserve obligation for more than 1 year after diagnosis;
- Have a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or
- Have a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.

In all cases, competent medical authorities will refer into the DES eligible Service members who meet the criteria within 1 year of diagnosis.

A Service member is considered unfit when the evidence establishes that the member, due to physical disability, is unable to reasonably perform the duties of her or his office, grade, rank, or rating to include duties during a remaining period of Reserve obligation. For members determined unfit due to duty-related medical impairments, the PEB determines their entitlement to benefits under Chapter 61 of 10 U.S.C. Members found unfit are separated or retired in accordance with the guidance in DoDI 1332.18.

A revision of DoDI 1332.18 and the supporting Manuals were published on 5 August 2014. As a result, the Military Services will need to review Service policies for disability evaluation to ensure compliance with the revised DoD policy.

5. Adverse Personnel Action

HIV or HBV infection may not be the sole cause for adverse personnel actions. DoDI 6485.01 directs that information obtained as a result of an epidemiologic assessment interview will not be used to support any adverse personnel action against the Service member.

The Services use a strategy of aggressive disease surveillance and health education programs to help control the transmission of HIV or HBV. An infected Service member receives training on the prevention of further transmission of HIV or HBV infection to others and the potential legal consequences of exposing others to HIV infection. All Services hold HIV infected members accountable under the Uniform Code of Military Justice (UCMJ) if they ignore orders to warn and protect others whose health might be jeopardized by sexual contact or other types of high risk exposures. Commanders may recommend that personnel who violate such guidance be considered for involuntary discharge or separation.

DISCUSSION:

International, national and federal guidelines and professional organization recommendations are considered in the development of DoD and Service policies and during the periodic reviews and updates. These guidelines and recommendations are evidence-based, and take into consideration the epidemiology and pathophysiology of how HIV and HBV are contracted and transmitted. DoD policies for HIV and HBV are consistent with the current guidelines and recommendations of the Centers for Disease Control and Prevention. Service policies are in compliance with the DoD policies. The health information and privacy of infected Service members are protected by DoD privacy policies and programs, with which the Services are also in compliance.

The Heads of the DoD Components must ensure that each issuance for which they are the office of primary responsibility is reviewed annually. The policy must be certified as current or revised, changed, or cancelled as appropriate. The DoD policy on HIV in military Service members was revised most recently on June 7, 2013 and was reviewed in June 2014 for currency.

All Department of the Army (DA) administrative publications must be no more than 5 years old. All DA Publications more than 5 years old must be updated to reflect current policies and procedures. The Army reported that their personnel policies are reviewed every 5 years at a minimum to ensure currency and that they reflect standard of care practices. AR40-501 is being revised in light of the advances in care and treatment for HIV, and normal life expectancy for those with adequate access to care and compliance with treatment recommendations. Army reports, for example, that a current policy that prevents the assignment of HIV infected soldiers to military-sponsored educational programs that would result in an additional service obligation is being reconsidered.

The Navy reported that its guidance for evaluation, diagnosis, and management options for HIV and HBV undergoes frequent and significant updates as medical capabilities, technologies, and evidence based practices evolve. Navy policy incorporates best practices to maintain a fit and ready force capable of carrying out the Navy's mission in its unique operational milieu.

Therefore, policies undergo review and revision to ensure maximum readiness at least every five years. When specific issues arise, policies are amended as needed on a case by case basis.

Recognizing the similarities in the transmission of, and risk factors for HIV and HBV infection, Department of the Navy medical, manpower and personnel policies reflect current knowledge of the natural history of these infections, the risks to the infected individual incident to continued military service, the risk of transmission of these viruses to non-infected personnel, the effect of infected personnel on commands and the mission, and the safety of military blood supplies.

The AF Medical Service reported that their HIV and HBV policies are assessed every two years to ensure they accurately reflect current evidence-based practice. Air Force Instruction 48-135, "Human Immunodeficiency Virus Program," was rewritten in 2014 in consultation with the Air Force Medical Service Infectious Disease physician and HIV point of contact at San Antonio Military Medical Center to ensure clinical accuracy. Similarly, HBV policies are reviewed by both Infectious Disease and Gastroenterology subject matter experts to ensure accuracy and adherence to up to date evidence-based practices.

To prevent hepatitis B, DoD began vaccinating all new recruits in 2002. Tri-service vaccination policy is contained in Army Regulation 40-562, *BUMEDINST 6230.15B, AFI 48-110, "Immunizations and Chemoprophylaxis for the Prevention of Infectious Diseases." Current policy continues vaccination of basic trainees and other accessions (unless sero-immune) during initial entry training. The hepatitis B vaccine is also provided for susceptible personnel who are at risk of potential exposure to blood-borne pathogens. For military purposes, this includes occupational specialties involving health care workers, emergency medical technicians, mortuary affairs personnel, search and rescue specialists, correctional facility staff, and designated special operations forces. Members deploying for more than 30 days to areas of high hepatitis B Service members who may have been exposed to Hepatitis B are evaluated and receive post-exposure prophylaxis, if appropriate.

There is no vaccine currently available to prevent HIV infection, but the Army is engaged in clinical research. Post-exposure prophylaxis is available and is provided for Service members, as appropriate, based upon the nature and timing of the exposure.

In summary, this review found that current DoD and Service policies for accession, retention, deployment, discharge, and discipline of DoD personnel with HIV or HBV:

- are based on international, national and federal guidelines, and professional organization recommendations for prevention, identification, and treatment of HIV and HBV;
- are evidence based and medically accurate in accordance with how HIV and HBV are contracted and transmitted;
- are reviewed regularly by subject matter experts at the DoD and Service level, and are updated as guidelines and recommendations evolve or new medical information becomes available;
- are consistent with national guidelines, consistently implemented across DoD, and that Service policies are in compliance with DoD-level policies;

- support retention of DoD personnel unless there is evidence of deteriorating health or other factors that make the individual unable or unfit to perform their duties;
- direct that infection with HIV or HBV will not be the sole basis for adverse actions; and
- protect the privacy of an infected individual.

Service policies reflect frequent changes and updates as medical capabilities, technologies, and evidence-based practices have evolved. The AF, which has the most recently revised policies for HIV and HBV, believes its current policies are appropriate, reflect the most current evidence-based practice, and are medically accurate based on how these conditions are contracted and transmitted. The Army and the Navy are currently revising the policies governing the management of Service members infected with HIV or HBV.

CONCLUSIONS:

DoD accession policies are consistent with the need of the military Services to recruit healthy personnel who are able to participate in demanding military training and capable of deploying to harsh and austere environments without deterioration in their health.

For those who become infected with HIV or HBV after accession, DoD policy is evidence-based and in accordance with state-of-the-art clinical guidelines. The emphasis is upon retention if the medical condition is stable with appropriate treatment.

A waiver is required for Service members with HIV or HBV infection to deploy. As with other medical conditions requiring a waiver, many factors that the Service member will encounter during the deployment are considered to determine whether it is likely the medical condition will limit the Service member's performance or cause the medical condition to deteriorate.

Service members with medical illnesses or conditions that might limit their ability to perform military duties (including HIV or HBV infection) may be evaluated for either duty limitations or medical discharge.

Adverse personnel actions based solely on HIV or other infection are precluded by DoD and Service policy. However, as with any direct order, a Service member, who violates the order to inform sexual partners of their HIV or HBV status or fails to use safe sexual practices, may be subject to disciplinary action.

The policies for management of DoD personnel with HIV or HBV are evidence-based, medically accurate, reflect standard of care medical practices, and have been reviewed regularly and updated as practices, guidelines, and standard of care have evolved.

EXHIBIT 3

*Department of Defense Personnel Policies
Regarding Members of the Armed Forces Infected
with Human Immunodeficiency Virus: Report to
the Committees on the Armed Services of the Senate
and House of Representatives (Aug. 2018)*



PERSONNEL AND
READINESS

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

AUG 27 2018

The Honorable John McCain
Chairman
Committee on Armed Services
United States Senate
Washington, DC 20510

Dear Mr. Chairman:

This report is in response to House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act for Fiscal Year 2018, which requests that the Department of Defense submit a report on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV).

The enclosed report includes the following: (1) a description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition; (2) an update on the status of the Department of the Army's HIV policy; (3) an assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted, how this condition can be transmitted to other individuals, the risk of transmission, and treatment regimens available; and (4) the feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

Thank you for your continued support of our Service members. A similar letter is being sent to the Chairman of the House Committee on Armed Services.

Sincerely,

Stephanie Barna
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Jack Reed
Ranking Member



PERSONNEL AND
READINESS

OFFICE OF THE UNDER SECRETARY OF DEFENSE
4000 DEFENSE PENTAGON
WASHINGTON, DC 20301-4000

AUG 27 2018

The Honorable William M. "Mac" Thornberry
Chairman
Committee on Armed Services
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This report is in response to House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act for Fiscal Year 2018, which requests that the Department of Defense submit a report on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV).

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Sincerely,

Stephanie Barna
Performing the Duties of the Under Secretary of
Defense for Personnel and Readiness

Enclosure:
As stated

cc:
The Honorable Adam Smith
Ranking Member

Department of Defense Personnel Policies Regarding Members of the Armed Forces Infected with Human Immunodeficiency Virus:

Report to the Committees on the Armed Services of the Senate and House of Representatives



August 2018

The estimated cost of this report or study for the Department of Defense is approximately \$18,000 for the 2018 Fiscal Year. This includes \$100 in expenses and \$18,000 in DoD labor.
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EXECUTIVE SUMMARY

INTRODUCTION: House Report 115-200, pages 148-149, accompanying H.R. 2810, the National Defense Authorization Act (NDAA) for Fiscal Year (FY) 2018, requested that the Department of Defense (DoD) submit a report to the Committees on Armed Services of the Senate and House of Representatives on its personnel policies regarding members of the Armed Forces infected with human immunodeficiency virus (HIV). Specifically, the Committee requested DoD provide the following in its report:

- (1) A description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition.
- (2) An update on the status of the Department of the Army's HIV policy, which was under review during the issuance of a 2014 report.
- (3) An assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted; how this condition can be transmitted to other individuals; the risk of transmission; and treatment regimens available.
- (4) The feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

DATA COLLECTION: This report follows the Department's interim response submitted to the Committees on Armed Services of the Senate and House of Representatives on March 19, 2018, and includes DoD- and Service-level policies and assessments addressing the requirements specified in House Report 115-200. Service-level information was obtained from each of the Military Departments at the request of the Office of the Assistant Secretary of Defense for Health Affairs (OASD(HA)).

PERSONNEL POLICIES PERTAINING TO HIV:

1. Enlistment and Commissioning (i.e., Accession): Grounded in statutory requirements for accessions of able-bodied and physically qualified individuals, recently reissued Department of Defense Instruction (DoDI) 6130.03, "Medical Standards for Appointment, Enlistment, or Induction into the Military Services," May 6, 2018, establishes DoD policy to ensure that individuals considered for appointment, enlistment, or induction into the Military Services are:

- Free of contagious diseases that may endanger the health of other personnel.
- Free of medical conditions or physical defects that may reasonably be expected to require excessive time lost from duty for necessary treatment or hospitalization, or may result in separation from the Military Service for medical unfitness.
- Medically capable of satisfactorily completing required training and initial period of contracted service.

- Medically adaptable to the military environment without geographical area limitations.
- Medically capable of performing duties without aggravating existing physical defects or medical conditions.

That instruction also establishes a specific policy to allow applicants who do not meet the specified physical and medical standards to be considered for a medical waiver. The instruction addresses 29 body systems, and lists for each of those a number of conditions that do not meet medical accession standards. Under the heading “Systemic Conditions,” there are 19 such conditions, including presence of HIV infection. Thus, HIV infection is a disqualifying medical condition for entry into the military service. Both prior service and non-prior service applicants undergo screening for HIV prior to entrance. As with all other disqualifying medical conditions, applicants may be considered for a medical waiver.

2. Retention and Discharge: DoD and Service policies restrict involuntary separation of a Service member solely due to being HIV positive. Service members who acquire HIV after joining the military are ensured access to appropriate medical care: DoD policy requires they receive counseling and treatment consistent with the standard of care, evidence-based HIV clinical practice standards, and medical management guidelines. HIV positive Service members receive a referral for medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses. Service members with HIV may continue their service as long as they are able to perform their military duties, taking into account the nature of their position. If they develop a disability, HIV-positive Service members undergo evaluation of fitness for continued service by the same process as those who are HIV-negative. Active duty (AD) and Reserve Component (RC) Service members with laboratory evidence of HIV infection who are determined to be unfit for further duty undergo separation or retirement. Military Departments and Combatant Commands (CCMD) limit assignments of HIV-infected individuals based on expert medical review, determination regarding the individual’s fitness for duty, and the nature and location of the duties performed, in accordance with operational requirements.

3. Deployment: DoD policy establishing deployment-limiting medical conditions sets the minimum standard for all deploying and deployed DoD personnel. Military Department policy guidance, Service-specific readiness requirements, or Combatant Commander needs may involve additional restrictions. HIV antibody positive status is a deployment-limiting medical condition precluding contingency deployment.

DoDI 6490.07, “Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees,” Enclosure 3, dated February 5, 2010, provides that individuals with a diagnosis of “human immunodeficiency virus (HIV) antibody positive with the presence of progressive [HIV related] clinical illness or immunological deficiency” shall not deploy unless a waiver is granted. All Service policies preclude HIV positive Service members from deploying to combat areas or in support of contingency operations due to the potential lack of access to needed medical care or medications in austere environments, as well as the military risks inherent in the mission assigned that could lead to illness exacerbation and compromise unit readiness and mission completion. For purposes of this report, a contingency deployment is one that is outside the continental United States (OCONUS), more than 30 days in duration, and in a

location with medical support from only non-fixed (temporary) military medical treatment facilities. A contingency deployment also includes the relocation of forces and materiel to an operational area in a situation requiring military operations in response to natural disasters, terrorists, or as otherwise directed.

All Services currently permit HIV positive Service members to deploy for purposes other than combat or a contingency operation, or to be assigned for duty in certain overseas locations, subject to receipt of a waiver. In view of this, members with HIV infection may be considered deployable with limitations. A waiver may be recommended on a case-by-case basis after review of the individual Service member's health and consideration of factors including the climate, altitude, rations, housing, nature of the duty assignment proposed, and medical services available in the location to which deployment or assignment is proposed. Further, the condition must not pose a significant risk of substantial harm to the individual or others, taking into account the condition of the deployed environment. The following table outlines the Service-specific policies for grant of a waiver to permit an HIV positive Service member to deploy for other than combat or a contingency, or to be assigned for duty in an overseas location:

Army	Waivable?	Yes
	By Whom?	Combatant Commander
	Under what conditions?	Soldier is determined to be fit and free of HIV-related illness.
	Host nation rules apply?	Yes, but deployments may be permitted <i>only</i> to Europe and Korea.
Navy/ Marine Corps	Waivable?	Yes
	By Whom?	<u>Sailors</u> : Treating HIV Evaluation and Treatment Unit (HETU), Navy Bloodborne Infection Management Center, PERS-82, and receiving command. <u>Marines</u> : Deputy Commandant. Manpower & Reserve Affairs and receiving command.
	Under what conditions?	Agreement by all organizations/officials listed above and receiving command (including the CCMD, as appropriate). Sailors/Marines who have no viremia (i.e., there is no virus present in the bloodstream), do have an established history of medical compliance, and possess a professional attitude, may be considered on a case-by-case basis for large ship platform tours and OCONUS deployment/assignment.
	Host nation rules apply?	Yes
Air Force	Waivable?	Yes
	By Whom?	Air Force Medical Support Agency, with favorable coordination from receiving commander and CCMD approval.
	Under what conditions?	No HIV-related illness.
	Host nation rules apply?	Yes

DoD has recently issued a new policy, DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018, for implementation October 1, 2018. The overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for a retention determination by their respective Military Department, and, as appropriate, referral into the Disability Evaluation System (DES) or initiation of processing for administration separation, with the normal policies and procedures, including due process procedures, of those systems continuing to apply. The Military Departments will determine the deployability status of Service members and will make retention determinations for Service members who have been non-deployable for more than 12 consecutive months. They may retain such members if determined to be in the best interest of the Military Service. Under this DoDI, "non-deployable" and "deployable with limitations" are two separate categories; the retention determination process applying to the former but not the latter. The Military Departments have authority to determine the specific dividing line between the two categories most appropriate for the operational circumstances applicable to their respective Services.

4. Disciplinary: DoD policy provides that a HIV positive status is not a punishable offense and cannot be used as a sole basis for disciplinary action against an individual. DoD policy also prohibits the use of information obtained as a result of an epidemiologic assessment interview to support any adverse personnel action against a Service member. However, Service members with laboratory evidence of HIV infection may be subject to disciplinary action if they disobey an order to inform current or potential sexual partners of their infected status or do not engage in safe sex practices.

ARMY POLICY STATUS UPDATE: Initiated in 2015, a working group has reviewed Army Regulation (AR) 600-110, last updated in April 2014, to assess any need for changes to reflect an evidence-based, medically accurate understanding of HIV infectivity, transmission, and treatment. This process is expected to be completed in the near future.

MEDICAL ASSESSMENT OF PERSONNEL POLICIES: Currently, no vaccine exists to prevent HIV infection, and no treatment exists to cure it. Broad consensus regarding published medical evidence supports the notion that people living with HIV on antiretroviral therapy (ART) who have an undetectable viral load in their blood, have a "negligible risk" of sexually transmitting HIV. Depending on the ART drugs used, it may take as long as six months for an individual's viral load to reach an undetectable level. Thus, with the advent of ART, HIV infection has evolved from a once terminal condition to a chronic illness requiring regular management and strict adherence to treatment protocol. As a result, the Department's policies have evolved over time. They currently focus not only on minimizing risks of HIV exposure, but also on providing evidence-based care and support for Service members living with HIV, with the goal to maintain a Service member's fitness for duty, optimize retention and quality of life, and help avoid disease progression of HIV-positive Service members into potential disability. Recognizing the risk factors for HIV infection and transmission, DoD- and Service-level personnel policies intend to reflect current knowledge of: how HIV is contracted and transmitted to HIV-naïve individuals; the ability of an HIV-positive individual to continue service without exacerbating his or her condition or risking the military mission; the effect of

infected personnel on commands; and the safety of military blood supplies. Medical literature pertaining to HIV medicine rapidly evolves. Subject matter experts across the Military Services are aware of and have access to all available contemporary medical literature, practice guidelines, medications, and treatment modalities based on emerging and published evidence-based studies or expert opinion.

FEASIBILITY OF ALLOWING ENLISTED SERVICE MEMBERS TO BECOME COMMISSIONED OFFICERS AND RESTRICTIONS DIFFERENT FOR OFFICERS:

DoD policy has long maintained a difference between accession medical standards and retention medical standards. The rationale for this difference is that once a member has been fully trained and has experience in performing the duties of his or her position, whether as an enlisted member or officer, the needs of the Service incline decidedly toward allowing the member to continue to perform those duties and return the investment the Service has made in the member. At the accession stage, the needs of the Service incline toward selecting members in whom to make the training and mentoring investment who minimize any risk of inability due to medical conditions to complete an initial period of service and potentially a longer military commitment.

Longstanding DoD policy under DoDI 6130.03 has also held that in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship. The needs of the Service do not necessarily favor an officer applicant with prior enlisted service compared to one without such service, in minimizing any risk of inability to perform satisfactorily in the commissioned officer position due to medical conditions. Yet, it is appropriate to note that a review of two individual officer candidates, one with and one without prior enlisted service, requesting a medical waiver for the same condition, the candidate with prior service may well have the advantage of a record of successful military service in the enlisted ranks. However, regarding which set of standards to apply to the initial medical screening, the accession medical standards are the more appropriate standards for all applicants, including applicants for enlistment or commissioning. This is long-established DoD policy for all medical conditions; there is no special or different rule for individuals with HIV infection.

DISCUSSION: The Department has a responsibility to ensure the health and well-being of Service members, and through its policies, aims to minimize the risk of Service members' exposure to HIV, while ensuring that those infected with HIV have access to appropriate care and management of their illness and are able to continue service. Military unique considerations; the rapidly evolving nature of medical evidence and understanding pertaining to the nature of HIV transmission, infectivity, associated risks, and treatment; evolving mission requirements; and Service member needs pertaining to health information privacy protections, as well as opportunities for career advancement, are key factors that influence personnel policy pertaining to HIV-infected members of the Armed Forces. Current DoD- and Service-level personnel policies pertaining to HIV-infected members of the Armed Forces:

- Are established to maintain military readiness and optimize lethality of the Armed Forces.

- Are instituted to ensure military applicants can successfully complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military, including combat against enemy forces, without jeopardizing their health, the health of their unit, or the military mission, as well as to respect host Nation laws where our forces are deployed.
- Support retention of Service members infected with HIV, unless there is evidence of deteriorating health or other factors that render the individuals unable or unfit to perform their duties.
- Require the same procedures for medically evaluating Service members who develop disability due to chronic illness to determine fitness for continued service, regardless of whether the Service member is HIV-positive.
- Aim to ensure that, except for assignment limitations, HIV-infected personnel are treated no differently than other Service members.
- Ensure that a Service member infected with HIV but able to fully perform duties is not retired or involuntarily separated solely based on being infected.
- Direct the protection of health information and privacy of HIV-infected personnel.
- Reflect existing evidence and adhere to current nationally-accepted, evidence-based guidelines, and assess evolving medical evidence and scientific understanding of the nature and risk of HIV transmission, available treatment regimens, and the latest HIV management approaches and practices.
- Stipulate clinical management to be consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

CONCLUSIONS: DoD- and Service-level personnel policies pertaining to members of the Armed Forces infected with HIV are evidence-based in accordance with current clinical guidelines and are reviewed and updated to align with evolving medical capabilities, technologies, evidence-based practices, and current scientific understanding of the nature of HIV infection, transmission, and management. Maintaining the health of military personnel is essential for force readiness. It is a strategic objective of the Military Health System (MHS) to sustain the health of Service members and restore the health and return to duty of Service members who become ill or injured, whenever possible. Once a Service member completes training, the goal is to retain members who acquire HIV and who are still capable of performing their duties in the rigorous military environment. Personnel policies aim to balance the need of the Services (e.g., readiness, resilience, deployability, mission accomplishment, retention) with the needs of Service members infected with HIV (e.g., access to quality care, counseling, support and educational services, privacy protections, option to continue service, if desired). As such, existing DoD- and Service-level personnel policies intend to maximize the lethality, readiness, and operational effectiveness of the Armed Forces, as well as help ensure the health and well-being of Service members, while mitigating the risk of HIV transmission.

INTRODUCTION:

In House Report 115-200, page 148-149, to accompany H.R. 2810, NDAA for FY 2018 (Public Law 115-91), the Committee on Armed Services of the House of Representatives requested that the DoD submit a report to the Committees on the Armed Services of the Senate and House of Representatives on its personnel policies regarding members of the Armed Forces infected with HIV. Specifically, the Committee requested that DoD provide the following in its report:

- (1) A description of policies addressing the enlistment or commissioning, retention, deployment, discharge, and disciplinary policies regarding individuals with this condition.
- (2) An update on the status of the Department of the Army's HIV policy, which was under review during the issuance of a 2014 report.
- (3) An assessment of these policies, with reference to medical experts and literature, which includes how the policies reflect an evidence-based, medically accurate understanding of how this condition is contracted; how this condition can be transmitted to other individuals; the risk of transmission; and treatment regimens available.
- (4) The feasibility of allowing an individual who is currently serving as an enlisted member of the Armed Forces to become a commissioned officer of the Armed Forces, and what restrictions are different for an officer.

The Committee indicated that the Department's previous report, submitted to Congress in response to section 572 of the NDAA for FY 2014, did outline the current DoD policies; however, it failed to include how current policies reflect the evidence base and medical advances in the field of HIV. The Committee also stated the report fell short in describing the criteria guiding the implementation of these policies throughout different branches and among commanding officers.

DATA COLLECTION: This report follows the Department's interim response submitted to the Committees on Armed Services of the Senate and House of Representatives on March 19, 2018, and includes DoD- and Service-level policies and assessments addressing the requirements specified in House Report 115-200. Service-level information was obtained from each of the Military Departments at the request of the OASD(HA).

PERSONNEL POLICIES PERTAINING TO HIV:

1. Accession (Enlistment or Commissioning)

Accession standards require healthy recruits who are free of communicable diseases or medical conditions that will likely endanger the health of other personnel, require excessive time lost from duty for necessary treatment or hospitalization, or likely result in separation from service due to medical unfitness. DoDI 1304.26, "Qualification Standards for Enlistment, Appointment,

and Induction,” provides basic entrance qualification standards “designed to ensure that individuals under consideration for enlistment, appointment, or induction are able to perform military duties successfully, and to select those who are the most trainable and adaptable to Service life.” Recruits must also be capable of functioning in the demanding military environment without aggravation of existing medical conditions. DoDI 6130.03, “Medical Standards for Appointment, Enlistment, or Induction in the Military Services,” states that individuals under consideration for appointment, enlistment, or induction into the Military Services must be:

- Free of contagious diseases that probably will endanger the health of other personnel.
- Free of medical conditions or physical defects that may require excessive time lost from duty for necessary treatment or hospitalization, or probably will result in separation from the Service for medical unfitness.
- Medically capable of satisfactorily completing required training.
- Medically adaptable to the military environment without the necessity of geographical limitations.
- Medically capable of performing duties without aggravation of existing physical defects or medical conditions.

DoDI 6130.03 also establishes a specific policy to allow applicants who do not meet the specified physical and medical standards to be considered for a medical waiver. This instruction addresses 29 body systems and lists for each a number of conditions that do not meet medical accession standards. Under the heading “Systemic Conditions,” there are 19 such conditions, including presence of HIV infection. DoDI 6485.01, “Human Immunodeficiency Virus (HIV) in Military Service Members,” June 7, 2013, reiterates that individuals with laboratory evidence of HIV infection are denied eligibility for appointment, enlistment, pre-appointment, or initial entry training for military service pursuant to DoDI 6130.03. All applicants for appointment, enlistment, or individuals being inducted into the Military Services are screened for laboratory evidence of HIV infection. Applicants do not meet accession standards if they present with HIV or serologic evidence of infection, or false-positive screening test(s) with ambiguous results on confirmatory immunologic testing. Thus, HIV infection is a disqualifying medical condition for military service, and persons infected with HIV are neither enlisted nor commissioned into military service. As with all other disqualifying medical conditions, applicants may be considered for a medical waiver pursuant to DoDI 6130.03.

Additionally, DoDI 6485.01 requires applicants to the U.S. Service Academies, the Uniformed Services University of the Health Sciences, and other officer candidate programs undergo testing for laboratory evidence of HIV within 72 hours of arrival to the program, and denies entry to the program if the test result is positive. Reserve Officer Training Corps program cadets and midshipmen must be tested for laboratory evidence of HIV no later than during their commissioning physical examination, and are denied a commission if they test positive.

Applicants for active and reserve enlisted service undergo HIV testing typically at U.S. Military Entrance Processing Command Military Entrance Processing Stations (MEPS) or other authorized locations. Applicants not tested at the MEPS undergo testing as part of the physical examination conducted prior to accession.

Service accession policies comply with DoDI 6130.03 and DoDI 6485.01. Applicable Service policies are set forth in the following: AR 600-110 and AR 40-501 for the Army; Secretary of the Navy Instruction (SECNAVINST) 5300.30E for the Navy and Marine Corps; and Air Force Instruction (AFI) 48-123 for the Air Force.

DoD medical accession standards are reviewed periodically by the Accession Medical Standards Working Group (AMSWG), which evaluates and recommends updates to maintain the currency and validity of those standards. The AMSWG is co-chaired by representatives from the Office of the Assistant Secretary of Defense for Manpower and Reserve Affairs (M&RA) and OASD(HA). It includes a voting representative from each of the five Military Services, with additional support from the following DoD components/offices: Joint Staff Surgeon; Surgeons General of the Army, Navy, and Air Force; medical officers of the Coast Guard and National Guard Bureau; and personnel chiefs of the Army, Navy, Air Force, Marine Corps, Joint Staff, and National Guard Bureau. Among the functions of the AMSWG are to perform evidence-based assessments of the accession standards and provide direction in research initiatives for the Accession Medical Standards Research Activity, including evidence-based research in support of medical standards assessments.

Supported by the work of the medical and personnel experts of the AMSWG, the DoDI 6130.03 disqualification for accession for HIV infection does not reflect disagreement with the medical consensus that modern medication management of HIV infection produces very positive results. However, in the context of the extraordinary challenges of many aspects of military service, including potential mission needs under highly stressful combat conditions or in extremely austere and dangerous places worldwide, even well-managed HIV infection carries risks of complications and comorbidities, possibly with latent effects, immune system dysregulation, neurocognitive impairments (NCI) (discussed further below), disrupted medication maintenance and necessary monitoring for potential side-effects, possible military vaccination adverse effects, and potential communicability, including in circumstances of buddy-aid to a seriously injured member in combat and emergency whole blood battlefield transfusions. In view of these risks, the needs of the Service incline toward maintaining the longstanding medical standard disallowing accession of HIV infected individuals.

2. Retention/Discharge

Once a Service member completes initial training, the policy is to retain members who acquire HIV and are still capable of performing their duties in the rigorous military environment. Clinical management of an AD Service member and an RC Service member on AD for a period of more than 30 days with laboratory evidence of HIV infection is conducted consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

DoDI 6485.01 specifically addresses HIV in Service members, and prescribes procedures for the identification, surveillance, and management of members of the Military Services infected with HIV and for prevention activities to control transmission of HIV. An AD Service member with laboratory evidence of HIV infection is referred for appropriate treatment and a medical evaluation of fitness for continued service in the same manner as a Service member with other chronic or progressive illnesses, in accordance with DoDI 1332.18, "Disability Evaluation System." AD Service members with laboratory evidence of HIV infection determined to be fit for duty are allowed to serve in a manner that ensures access to appropriate medical care.

A RC Service member with laboratory evidence of HIV infection is referred for a medical evaluation of fitness for continued service in accordance with Service regulations, and in the same manner as an RC Service member with other chronic or progressive illnesses. Eligibility for AD for a period of more than 30 days is denied to those RC Service members with laboratory evidence of HIV infection (except under conditions of mobilization and on the decision of the Secretary of the Military Department concerned). RC Service members, either who are not on AD for a period of more than 30 days or who are not on full-time National Guard duty, and who show laboratory evidence of HIV infection, are transferred involuntarily to the Standby Reserve only if they cannot be used in the Selected Reserve.

In accordance with DoDI 6485.01, the privacy of a Service member with laboratory evidence of HIV infection is protected consistent with DoD 5400.11-R, "Department of Defense Privacy Program" and DoD 6025.18-R, "DoD Health Information Privacy Regulation."

A Service member infected with HIV but able to fully perform their duties is not retired or separated solely based on being infected. However, Service members, including those infected with HIV, whose condition deteriorates or otherwise interferes with their ability to perform their military occupation successfully, may be referred to the DES. The DES provides for the member to have a fair and full review to determine fitness for duty. The following DoD issuances establish policy for determining fitness for duty, and for retiring or separating Service members due to physical disability: Department of Defense Manual (DoDM) 1332.18, Vol 1, "Disability Evaluation System (DES) Manual: General Information and Legacy DES (LDES) Time Standards;" DoDM 1332.18, Vol 2, "Disability Evaluation System (DES) Manual: Integrated Disability Evaluation System (IDES);" and DoDM 1332.18, Vol 3, "Disability Evaluation System (DES) Manual: Quality Assurance Program (QAP)."

A medical evaluation is the first step in the disability evaluation process. A Medical Evaluation Board (MEB) documents a Service member's medical conditions and full clinical information. A summary of clinical information includes a medical history; appropriate physical examination; indicated medical tests and their results; medical and surgical consultations as necessary; diagnoses; ongoing or recommended treatment; and prognosis. The medical evaluation documents the medical status and duty limitations of Service members (subject to Service departmental regulations).

If the Service member cannot perform the duties of her or his military occupational specialty (MOS), the MEB refers the case to the DES. Criteria for referral of Service members into the DES include:

- Having one or more medical conditions that may, individually or collectively, prevent the Service member from reasonably performing the duties of his or her office, grade, rank, or rating, including those duties remaining on a Reserve obligation for more than one year after diagnosis;
- Having a medical condition that represents an obvious medical risk to the health of the member or to the health or safety of other members; or
- Having a medical condition that imposes unreasonable requirements on the military to maintain or protect the Service member.

A Service member is considered unfit when the evidence establishes that the member, due to physical disability, is unable to perform the duties of her or his office, grade, rank, or rating reasonably, to include duties during a remaining period of Reserve obligation. AD and RC Service members with laboratory evidence of HIV infection who, because of their disease progression, are determined to be unfit for further duty are medically separated or retired pursuant to DoDI 1332.18.

Service retention and discharge policies comply with the retention and discharge DoD policies described above.

Retention/Discharge - Army:

AR 600-110 stipulates that individuals confirmed to be HIV infected will be treated with dignity and understanding. Guidance for dealing with the psychosocial aspects of the disease may be obtained from command medical authorities and chaplains. Every effort will be made to ensure that, except for their assignment limitations, HIV infected personnel are treated no differently than other Soldiers. Commanders must ensure that information about the HIV infected Soldier's medical condition is provided only to those whose duties require knowledge of that information.

In AR 600-110, there is no medical reason for HIV-infected Soldiers' duties to change solely because of their infection (except in certain instances for health care providers). In instances where a Soldier performs duties as a member of a flight crew, or other position requiring a high degree of alertness or stability (for example, explosive ordnance disposal), a case-by-case determination is made by a MEB as to the Soldier's fitness to perform his or her duties. In the case of HIV-infected health care providers, their duties may be restricted if they present a risk of transmitting HIV to their patients. An expert medical review committee designated by the deputy commander for clinical services makes this determination. This committee makes recommendations on a case-by-case basis to the Medical and Dental Activity/United States Army Medical Center (MEDCEN)/Dental Activity commander per AR 40-68, "Clinical Quality Management," regarding the restriction of duties of HIV infected health care providers. The restriction may only apply until the risk is eliminated. In all other instances, HIV infected

Soldiers are utilized in their primary MOS, per normal utilization criteria contained in Army personnel regulations and the assignment limitations specified in AR 600-110.

Infectious disease specialists medically evaluate HIV-infected Soldiers at a participating MEDCEN supporting the health service region to determine their infection status. HIV infected Soldiers who meet medical retention standards outlined in AR 40-501, and who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations (every six months or as directed), are not involuntarily separated solely based on HIV status.

HIV-infected RC Soldiers who wish to continue to serve in the RC must prove fitness for duty per medical retention standards of AR 40–501 and be found fit for duty. RC Soldiers are required to obtain the fit for duty medical examination from the civilian medical community at no expense to the Government. The required medical procedures are provided to the Soldier to give to his or her physician. This examination must be repeated at least annually after the initial evaluation. Medical follow-up and evaluation are conducted every six months and as directed by the infectious disease physician for all HIV infected Soldiers.

Except for those identified during the accession testing program, HIV infected AD Soldiers able to perform duties fully who do not demonstrate progressive clinical illness or immunological deficiency during periodic evaluations are not involuntarily separated solely because they are HIV infected. HIV infected Soldiers who demonstrate rapidly progressive clinical illness or immunological deficiency may not meet medical retention standards under AR 40–501, and are evaluated for physical disability processing under AR 635–40, “Disability Evaluation for Retention, Retirement, or Separation.” AR 600-110 specifies procedures for officers (paragraph 6-13) and for enlisted personnel (paragraph 6-14). In accordance with AR 40-501, HIV-infected Soldiers who demonstrate progressive clinical illness or immunological deficiency are referred to a MEB. For Active Army Soldiers and RC Soldiers on AD for more than 30 days (except for training under 10 U.S.C. § 10148), a MEB must be accomplished and, if appropriate, the Soldier must be referred to a Physical Evaluation Board (PEB) under AR 635–40. For RC Soldiers not on AD for more than 30 days or on AD for training under 10 U.S.C. § 10148, referral to a PEB will be determined under AR 635–40. Records of official medical diagnoses provided by civilian medical providers concerning the presence of progressive clinical illness or immunological deficiency in RC Soldiers may be used as a basis for administrative action under, for example, AR 135–133, “Ready Reserve Screening, Qualification Records System, and Change of Address Reporting,” AR 135–175, “Separation of Officers,” AR 135–178, “Enlisted Administrative Separations,” or AR 140–10, “Assignments, Attachments, Details, and Transfers,” as appropriate. Additionally:

- Soldiers identified as HIV infected within 180 days of initial entry on AD are separated under the provisions of AR 635–200 for failure to meet accession medical fitness standards.
- HIV infected Army National Guard (ARNG) Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards are processed under AR 40–501 and

National Guard Regulation (NGR) 600–200, “Enlisted Personnel Management,” or NGR 635–101, “Efficiency and Physical Fitness Boards,” as appropriate.

- HIV infected United States Army Reserve Soldiers who demonstrate progressive clinical illness or immunological deficiency, as determined by medical authorities, and who do not meet medical retention standards under AR 40–501 are processed in accordance with AR 135–178 (enlisted) or AR 135–175 (officer).

The Army National Guard implements guidance as prescribed by the AR 600-110 and AR 40-501 with regard to HIV positive personnel. AR 600-110 is administered by the G1 (Army Personnel) section; however, Army National Guard – Office of the Chief Surgeon (ARNG-CSG) has oversight with regard to monitoring the implementation of laboratory testing and re-testing of HIV positive Soldiers). HIV positive Soldiers are retained in current MOS/Area of Concentration, as long as medical fitness standards are maintained in accordance with AR 40-501. ARNG-CSG relies highly on the input of Army Directives, the U.S. Army Public Health Center, and the Centers for Disease Control and Prevention (CDC) when considering medical retentions.

Retention/Discharge - Navy and Marine Corps:

If an AC Sailor or Marine tests HIV antibody positive during routine screening, he or she is directed by the Chief, Bureau of Medicine and Surgery to an appropriate medical facility for evaluation and determination of fitness for duty, like all Service members with a chronic medical condition, in accordance with SECNAVINST 1850.4E, “Navy Disability Evaluation Manual,” and Chapter 18 of Naval Medical Command (NAVMED) P-117, “Manual of the Medical Department,” which pertains to DES. Members with HIV undergo additional evaluation in accordance with DoDI 6485.01. If found fit for full duty (i.e., physically qualified to remain on AD), they are referred, evaluated, treated, and followed by an HETU, and are subsequently retained, deployed, and returned to their unit for duty. Further, they are eligible for reenlistment following normal reenlistment procedures. RC Sailors undergo evaluation by their civilian providers, and are also evaluated for fitness for duty in the same manner as all RC members with a chronic medical condition. Marine Corps Order (MCO) 1300.8, “Marine Corps Personnel Assignment Policy,” is in accordance with SECNAVINST 5300.30E regarding the referral for medical evaluation for continued service, appropriate treatment, and determination of fitness for duty.

In SECNAVINST 5300.30E, if a Sailor or Marine is found unfit for continued service, he or she is processed for medical separation through the physical disability system and discharged. Sailors and Marines who have tested HIV positive also have the option to undergo voluntary separation, and are afforded the option of requesting a voluntary discharge under honorable conditions, unless there are other factors involved. Retention or discharge decisions are based on the determination of competent medical authority regarding fitness of service. SECNAVINST 5300.30E is currently under revision.

MCO 1900.16 Chapter 1, “Separation and Retirement Manual,” refers to SECNAVINST 5300.30E for voluntary separation of Marines who have tested positive for HIV. In MCO 1001R.1L, “Reserve Administration Manual,” Reserve Marines identified as HIV positive and

who, although deemed medically fit for duty, are unable to fill an appropriate billet within the Selected Reserve and are placed in the Standby Reserve-Inactive Status List. Under this status, such Marines are not eligible to participate, receive pay or retirement point credit, are not eligible for promotion consideration, and are not accountable for purposes of end strength or controlled grades.

SECNAVINST 5300.30E and DoDI 6485.01 permit members of the Marine Corps Ready Reserve who are HIV positive to continue to serve within the Marine Corps Reserve, barring any medically assessed unfitting conditions, such as immunologic deficiency, neurological deficiency, progressive clinical or laboratory abnormalities associated with HIV, or diagnosis of Acquired Immune Deficiency Syndrome (AIDS)-defining conditions.

Retention/Discharge - Air Force:

AFI 44-178, "Human Immunodeficiency Virus Program," instructs that "members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, may not be separated solely on the basis of laboratory evidence of HIV infection." AFI 48-123 stipulates that HIV is potentially a cause for denying continued service and requires a retention decision through a MEB or similar review."

AFI 44-178 guides the management of AD Service members with HIV and screening protocol routinely employed by the Air Force. In accordance with AFI 44-178, all AD Airmen with asymptomatic HIV are seen annually at the Air Force HIV Medical Evaluation Unit (MEU) in San Antonio. The MEU completes a narrative summary (NARSUM) for each Airman with HIV infection, which is forwarded to the Air Force Personnel Center (AFPC) for adjudication regarding retention.

In an effort to treat every Airman equitably and with dignity and respect, the Air Force refers Airmen with asymptomatic HIV infection into the DES in the same manner and process as any other Airman with a chronic medical condition. As outlined above, current Air Force policy requires that all Airmen with HIV have a NARSUM reviewed annually by AFPC. AFPC is the only entity that can assign Airmen an Assignment Limitation Code-C (ALC-C), which restricts permanent and temporary duty assignments to areas where appropriate medical care is available to the HIV-positive Service member. The intent of the ALC-C is to protect such members from being placed in environments where adequate medical care is not available. The benefit of assigning an ALC-C is that it ensures visibility at all levels that an Airman will require a waiver for OCONUS assignment or deployment.

3. Deployment

DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," includes HIV antibody positive diagnosis with the presence of progressive clinical illness or immunological deficiency as a medical condition that usually precludes contingency deployment. In all instances of HIV seropositivity, the policy requires that the cognizant CCMD surgeon be consulted before medical clearance for deployment. The Combatant Commander is the final approval authority for waivers. The medical standards in DoDI 6490.07 are mandatory for contingency deployments, and permissible for any other deployment, based on the commander's decision.

Medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable. DoD personnel with existing medical conditions may deploy based upon a medical assessment, if the following conditions are met:

- (1) The condition is not of such a nature or duration that an unexpected worsening or physical trauma is likely to have a grave medical outcome or negative impact on mission execution.
- (2) The condition is stable and reasonably anticipated by the pre-deployment medical evaluator not to worsen during the deployment in light of physical, physiological, psychological, and nutritional effects of the duties and location.
- (3) Any required, ongoing health care or medications anticipated to be needed for the duration of the deployment are available in theater within the MHS. Medication must have no special handling, storage, or other requirements (e.g., refrigeration, cold chain, or electrical power requirements). Medication must be well tolerated within harsh environmental conditions (e.g., heat or cold stress, sunlight) and should not cause significant side effects in the setting of moderate dehydration.
- (4) There is no need for routine evacuation out of theater for continuing diagnostics or other evaluations. (All such evaluations should be accomplished before deployment.)

DoDI 6490.07 sets the minimum standard for all deploying and deployed DoD personnel. Military Department policy guidance, Service-specific readiness needs, or CCMD requirements may involve additional deployment restrictions. Additionally, DoDI 6485.01 instructs compliance with host-nation requirements for screening and related matters for Service members. As outlined below, all Services currently permit HIV positive Service members to deploy for purposes other than combat or a contingency operation, or be assigned for duty in certain overseas locations, subject to receipt of a waiver. In view of this, members with HIV infection may be considered deployable with limitations.

Deployment - Army:

AR 40-501, paragraph 5-14, "Medical fitness standards for deployment and certain geographical areas," states a general rule that "all Soldiers considered medically qualified for continued military status and medically qualified to serve in all or certain areas of the continental United States (CONUS) are medically qualified to serve in similar or corresponding areas outside the continental United States (OCONUS)." However, the policy acknowledges, "because of certain medical conditions, some Soldiers may require administrative consideration when assignment to combat areas or certain geographical areas is contemplated. Such consideration of their medical conditions would ensure these Soldiers are used within their functional capabilities without undue hazard to their health and well-being as well as ensure they do not produce a hazard to the health or well-being of other Soldiers."

AR 40-501, paragraph 5-14, lists medical conditions requiring careful review prior to recommending whether the Soldier can deploy to duty in a combat zone or austere isolated area

where medical treatment may not be readily available. In accordance with AR 40-501, HIV infected Soldiers are not permitted to deploy into the combat theater of operations. Additionally, in accordance with AR 600-110 and AR 614-30, "Overseas Service," Soldiers confirmed to be HIV infected while stationed overseas are reassigned to the United States.

However, if found fit by a PEB, HIV infected Soldiers may be considered for overseas deployment to Europe or Korea (host Nation permitting), in accordance with AR 40-501. HIV infected AD Soldiers, including Active Guard and Reserve, are otherwise limited to duty within the United States (including Alaska, Guam, Hawaii, Puerto Rico, and the U.S. Virgin Islands). In the United States (including Alaska, Hawaii, Guam, Puerto Rico, and the U.S. Virgin Islands), HIV infected Soldiers are not assigned to:

- Any table of organization and equipment or modified table of organization and equipment unit. Installation commanders may reassign any HIV infected Soldier in such units to table of distribution and allowances (TDA) units on their installation, provided the Soldier has completed a normal tour in that unit (a normal tour for these purposes is three years from reporting date to the unit). After completion of a normal tour, reassignment to TDA units may be made, provided assignment can be made according to normal personnel management and assignment criteria in AR 614-100, "Officer Assignment Policies, Details, and Transfers," and AR 614-200, "Enlisted Assignments and Utilization Management." Reassignment must be to an authorized position for the Soldier's grade and primary or secondary MOS. Installation commanders unable to make appropriate reassignments report the names of HIV infected Soldiers to the Commander, Human Resource Command (HRC), Army Human Resource Command (AHRC)-EPD-I (enlisted), or Total Army Personnel Command (TAPC)-OPD-M (officer).
- Military-sponsored educational programs, regardless of length, but which would result in an additional service obligation. These programs include, but are not limited to, advanced civilian schooling, professional residency, fellowships, training with industry, and equivalent educational programs, regardless of whether the training is conducted in civilian or military organizations. HIV infected Soldiers assigned to these programs are disenrolled at the end of the academic term in which HIV infection is confirmed and may be reassigned without regard to Permanent Change of Station restrictions. Any financial support received by the Soldier may be retained through the end of the current term of enrollment and will not be subject to any recoupment. In addition, any additional service obligation incurred as a result of attendance at military sponsored educational programs is waived. Not included in this restriction are military schools required for career progression in a Soldier's MOS, branch, or functional area (such as, Noncommissioned Officer Education System schools, Captains Career Course, or intermediate level education).
- U.S. Army Recruiting Command, Cadet Command, MEPS, ARNG full time recruiting force, or ARNG full time attrition/retention force, if a Soldier's medical condition requires frequent medical follow-up (as determined by medical authorities), and if the Soldier's projected duty station is geographically isolated from an Army military treatment facility capable of providing that follow-up. These organizations report HIV-

infected Soldiers who cannot be assigned under this policy to the Commander, HRC, AHRC-EPD-I (enlisted) or TAPC-OPD-M (officer), for assignment instructions.

AR 600-110 stipulates that commanders may not change the assignment or use of HIV-infected Soldiers solely because of their infection, unless required by that regulation or the Soldier's medical condition. Grouping all HIV infected Soldiers within a command into the same subordinate unit, duty area, or living area is prohibited unless no other unrestricted units, positions, or accommodations are available.

HIV infected Service members may transfer to the Active Army from another Armed Force (inter-Service transfer), if they meet medical retention standards in AR 40-501. However, Service members who are HIV infected may not be transferred to the Army from another Armed Force, if they are required to meet accession medical standards in AR 40-501, except as specifically permitted in the Accession Testing Program, as described in AR 600-110.

Deployment - Navy/Marine Corps:

Deployment determinations for HIV-infected Service members are based on guidance articulated in DoDI 6490.07 and in CCMD Area of Responsibility specific Force Health Protection policies. SECNAVINST 5300.30E permits certain personnel on a case-by-case basis to be considered for OCONUS or large ship platform tours, in consultation with the treating HETU, Navy Bloodborne Infection Management Center, and PERS-82 (Temporary Disability Retirement List] (for Sailors), or the United States Marine Corps M&RA (for Marines). These cases apply to personnel with controlled HIV disease (as manifested by a reconstituted immune system, no viremia, an established history of medical compliance, and a history of professional attitude). This placement requires the receiving command's acceptance. These personnel are not considered for overseas individual augmentee tours, given the austere environments in which they potentially could be placed. This policy is based on the following considerations:

- There is no demonstrated risk of transmission of disease in normal daily activities.
- An investment in training of these members has been made.
- The previous policy of denying deployments has made this subset of personnel less competitive in achieving career milestones or warrior qualifications.

MCO 1300.8 is in accordance with SECNAVINST 5300.30E regarding assignment of HIV infected personnel.

Deployment - Air Force:

AFI 48-123 indicates, "conditions, which may seriously compromise the near-term well-being if an individual were to deploy, are disqualifying for mobility status or deployment duty." In accordance with DoDI 6490.07, AFI 48-123 also indicates, "medical evaluators must consider climate, altitude, rations, housing, duty assignment, and medical services available in theater when deciding whether an individual with a specific medical condition is deployable." However, AFI 48-123 also states, "in general, a member must be able to perform duty in austere environment with no special food, billeting, medical or equipment support for up to 179 days."

DoD has recently issued a new policy, DoDI 1332.45, “Retention Determinations for Non-Deployable Service Members,” July 30, 2018, for implementation October 1, 2018. The overarching policy is that to maximize the lethality and readiness of the Joint Force, all Service members are expected to be deployable. Service members who are considered non-deployable for more than 12 consecutive months will be evaluated for a retention determination by their respective Military Department, and, as appropriate, referral into the DES or initiation of processing for administration separation, with the normal policies and procedures, including due process procedures, of those systems continuing to apply. The Military Departments will determine the deployability status of Service members and will make retention determinations for Service members who have been non-deployable for more than 12 consecutive months. They may retain such members if determined to be in the best interest of the Military Service. Under this DoDI, “non-deployable” and “deployable with limitations” are two separate categories; the retention determination process applying to the former but not the latter. The Military Departments have authority to determine the specific dividing line between the two categories most appropriate for the operational circumstances applicable to their respective Services.

4. Disciplinary

In and of itself, being HIV positive is not a punishable offense and cannot be used as a basis for disciplinary action against the individual. DoDI 6485.01 directs that information obtained during or primarily as a result of an epidemiologic assessment interview, (which is defined in DoDI 6485.01 as the “questioning of a Service member who has been confirmed by DoD to have laboratory evidence of HIV infection for purposes of medical treatment or counseling or for epidemiologic or statistical purposes”), cannot be used to support any adverse personnel action against the Service member, in accordance with section 705(c) of Public Law 99-661, “National Defense Authorization Act for Fiscal Year 1987,” November 14, 1986. DoDI 6485.01 defines “adverse personnel action” as “a court-martial, non-judicial punishment, involuntary separation for other than medical reasons, administrative or punitive reduction in grade, denial of promotion, an unfavorable entry in a personnel record (other than an accurate entry concerning an action that is not an adverse personnel action), or a bar to reenlistment other than for medical reasons.”

DoDI 6485.01 also requires aggressive disease surveillance and implementation of health education programs for Service members. A Service member with laboratory evidence of HIV infection receives training on how to prevent further transmission of HIV infection to others, and the legal consequences of exposing others to HIV infection. In compliance with this policy, the Services provide counseling and training to Service members with HIV infection regarding the prevention of disease transmission to others and the legal consequences of intentional exposure to others, or failure to disclose status to sexual partners or blood donation centers.

However, infected Service members retained on AD who fail to comply with the directives given during preventive medicine counseling are subject to appropriate disciplinary actions for their disregard or disobedience. All Services hold HIV infected members accountable under the Uniform Code of Military Justice if they ignore orders to warn and protect others whose health might be jeopardized by sexual contact or other types of high-risk exposures. Commanders may recommend that personnel who violate such guidance be considered for involuntary discharge or separation.

STATUS UPDATE ON THE DEPARTMENT OF THE ARMY'S HIV POLICY:

Initiated in 2015, a working group has reviewed AR 600-110, last updated in April 2014, to assess any need for changes to reflect an evidence-based, medically accurate understanding of HIV infectivity, transmission, and treatment. This process is expected to be completed in the near future.

MEDICAL ASSESSMENT OF POLICIES:

Currently, no vaccine exists to prevent HIV infection, and no treatment exists to cure it. As such, the Department takes every effort to protect the health and well-being of Service members to minimize the risk of exposure to HIV through regular HIV screening and surveillance efforts. DoDI 6485.01 requires that the Secretaries of the Military Departments report HIV test results to the Defense Medical Surveillance System, pursuant to Department of Defense Directive (DoDD) 6490.02E, "Comprehensive Health Surveillance," and directs health care personnel providing medical care to follow the recommendations issued by the CDC for preventing HIV transmission in health-care settings.

DoD health surveillance policy also requires that medical surveillance systems continuously capture data on occupational and environmental exposures to potential and actual health hazards, and link with medical surveillance data to monitor the health of DoD's population and identify potential risks to health. Thus, this policy enables timely implementation of interventions to prevent, treat, or control disease and injury, and reinforces the provision of optimal medical care.

Impact of Antiretroviral Therapy on Disease Management

Viral suppression and AIDS are two ends of the spectrum of HIV infection. Virally-suppressed HIV infection usually requires an individual to take ART, alternatively referred to as combination Antiretroviral Therapy, regularly and to see an infectious disease specialist annually. ART consists of a combination of antiretroviral (ARV) drugs to suppress the HIV virus to undetectable levels and stop HIV disease progression. AIDS is usually the result of long-term non-adherence with medications and can be associated with impairment and disability (e.g., opportunistic infections, cancer, weakness).

There is broad consensus on evidence published in the medical literature to support the notion that people living with HIV on ART with an undetectable viral load in their blood have a "negligible risk" of sexually transmitting HIV. Depending on the ART drugs used, it may take as long as six months for the viral load to become undetectable. "Continued and reliable HIV suppression requires selection of appropriate agents and excellent adherence to treatment. HIV viral suppression should be monitored to assure both personal health and public health benefits."¹

However, it is important to emphasize that despite undetectable viral loads, HIV transmission still can occur. According to the U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis, "exposure to a source patient with an undetectable serum viral load does not eliminate the possibility of HIV transmission or the need for (post-exposure prophylaxis) PEP and follow-up testing. While the risk of transmission from an occupational exposure to a source patient with an undetectable serum viral load is thought to be very low, PEP

should still be offered. Plasma viral load (e.g., HIV RNA [ribonucleic acid]) reflects only the level of cell-free virus in the peripheral blood; persistence of HIV in latently infected cells, despite patient treatment with ARV drugs, has been demonstrated, and such cells might transmit infection even in the absence of viremia. HIV transmission from exposure to a source person who had an undetectable viral load has been described in cases of sexual and mother-to-child transmissions.”² It is also important to underscore that an “undetectable” viral load that confers a “negligible risk” of HIV transmission has no application in the setting of blood transfusion or needlestick (occupational) exposures.

Thus, with the advent of ART, HIV infection has evolved from a once terminal condition to a chronic illness requiring regular management and strict adherence to treatment protocol. As a result, the Department’s policies have evolved over time. They currently focus not only on minimizing risks of HIV exposure for HIV-naïve individuals, but also on providing evidence-based care and support for Service members living with HIV, with the goal to retain and maintain a Service member’s fitness for duty, optimize quality of life, as well as avoid any disability that might arise as a result of HIV infectivity.

Recent Findings Signifying Impairments Despite Viral Suppression and Asymptomatic HIV: Potential Impact on Future Policy

Despite virological suppression, long-term treated patients may experience memory difficulties, mental slowing, attention deficits, and other neurological impairment symptoms. Moreover, neurocognitive damage can occur without HIV-infected individuals experiencing related symptoms or interference in their daily functioning. The impact of HIV-associated neurocognitive disorder and asymptomatic NCI on fitness for duty, including resilience and readiness, is currently unknown.

According to a Department of Defense Infectious Disease Clinical Research Program cross-sectional study of 200 HIV-infected and 50 HIV-uninfected military beneficiaries including AD members, retirees, or dependents, HIV positive patients diagnosed and managed early during the course of HIV infection had a low prevalence of NCI. This is comparable to matched HIV-uninfected persons.³ Based on these data, the early recognition and management of HIV infection may be important in limiting NCI.

Yet effective ART resulting in viral suppression and asymptomatic infection does not imply absence of HIV-associated injury or impairment. Some HIV-infected, virally suppressed patients on ART will develop illnesses associated with premature aging (e.g., cardiovascular disease, osteoporosis). As the HIV-positive population ages, there is greater recognition that cerebrovascular disease risk factors such as hypertension, diabetes, and hypercholesterolemia are becoming risk factors for cognitive impairment in HIV-positive patients on ART.⁴

Common neurocognitive symptoms experienced by HIV-infected patients potentially include changes in memory, concentration, attention, and motor skills, may present challenges for accurate diagnoses and assessments of functional capacity, and often require prolonged observation or reporting.^{5,6} Some patients may experience a fluctuating course of NCI over time, including symptom normalization; however, it is unknown whether these changes reflect

biologic alterations induced by responses to (or failures) of ART, or occur independently of viral load and changes to ART regimens.⁷ Despite effective systemic viral suppression among HIV-positive individuals on ART, scientific studies have indicated that a small subset of individuals show neurocognitive deterioration with evidence of persistent laboratory and neuroimaging abnormalities in the central nervous system.⁸ A longitudinal cohort observation study found that numerous patients with asymptomatic NCI, even with a suppressed plasma viral load, eventually developed symptomatic NCI.⁹ The impact of these potential NCIs on a Service member's readiness, resilience, and/or retention is currently unknown.

As the HIV-positive population on ART ages, there is greater recognition that cerebrovascular disease risk factors such as hypertension, diabetes, and hypercholesterolemia may become risk factors for cognitive impairment.¹⁰ The future impact of HIV as a chronic disease on readiness, resiliency, and retention, as well as treatment and management approaches, are a part of ongoing DoD health surveillance efforts.

As stipulated in DoDD 6490.02E, DoD requires comprehensive, continuous and consistent health surveillance to enable continuous capture of individual and population data, including health status, occupational exposures, disease, and medical interventions (such as immunizations, treatments and medications), in order to implement early intervention and disease control strategies and reinforce provision of optimal medical care. As such, the policy enables DoD to be well-positioned to update policies and practices to appropriately identify and manage HIV infection among Service members as the HIV-positive population on ART ages.

Military-Unique Considerations

According to the Military Infectious Diseases Research Program (MIDRP), HIV “remains a significant threat to Service members deployed overseas, and is a major source of regional instability in areas of US force protection.”¹¹ Additionally, the MIDRP also recognized that infectious diseases can also impose “a significant burden on the medical logistical system for people requiring treatment” and “loss of personnel to infectious diseases reduces operational readiness and effectiveness by requiring replacement troops.” Therefore, the MIDRP indicates, preventing disease is “a force multiplier by keeping people healthy and by enhancing readiness,” and DoD must protect its forces from diseases that may compromise its ability to complete missions and to prevent troops from acquiring illnesses. As such, preventing disease through limiting risk of exposure to infectious disease is a key component to enhance military readiness and effectiveness.

It is important to note that DoD HIV screening policy is population-based, and accounts for unique operational military requirements. For example, protecting the safety of the U.S. military blood supply or health of potential donors and recipients (i.e., Service members) is of critical importance to DoD and therefore a central issue. Combat-related injuries, especially during mass casualty situations, require large supplies of blood for transfusions. The need for screening the blood supply is therefore critical. In certain cases, “battlefield transfusions” may be required to resuscitate casualties in life-threatening situations when the inventory of U.S. Food and Drug Administration (FDA)-compliant blood products is depleted in combat zones due to austere operating conditions and irregular resupply. In these cases, the U.S. Army Institute of Surgical

Research Joint Trauma System Clinical Practice Guideline on Fresh Whole Blood indicates that Service members may receive an emergency transfusion of fresh whole blood in life-saving or limb-sparing situations.¹² This Joint Trauma System Clinical Practice Guideline also indicates that even though fresh whole blood undergoes rapid testing for HIV to the greatest extent possible prior to transfusion, the potential risk for HIV transmission remains in battlefield circumstances. HIV infection is among a number of medical conditions that preclude blood donation. Early CDC data demonstrate that the highest risk of transmission of HIV infection is via blood transfusion (92.50 percent transmission rate, or 9250/10000 exposures).¹³ Even though this data included cases involving transmission of very high viral loads as well as lower levels of viremia, it is conceivable that a unit of whole blood (as utilized used in a “walking blood bank” scenario) would pose a very high risk of transmission of HIV infection, even if from an HIV-infected Service member with an undetectable viral load.¹⁴ To the extent possible, DoD adheres to FDA blood-borne pathogen screening guidelines requiring all donated blood products be tested for HIV types I and II.¹⁵ DoD ensures the safety of the blood supply through policies of the Armed Services Blood Program Office and the accreditation requirements of the American Association of Blood Banks. However, in emergency battlefield circumstances it is impossible to eliminate all risk of communicability through blood transfusion.

Service Policies

Service policies accurately reflect current medical literature and expert opinion (consensus standards) regarding transmission and treatment of HIV. The U.S. Air Force (USAF) management of Airmen with HIV is highly structured and achieves viral load suppression in over 90 percent of patients. AFI 44-178 is the underpinning of the USAF’s HIV management success. AR 600-110, “Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus,” and Headquarters, Department of the Army medical and personnel policies on HIV reflect current knowledge of the natural progression of HIV infection; the risks to the infected individual incident to military service; the risk of transmission of the disease to non-infected personnel; the overall impact of infected personnel in Army units and on readiness posture; and the safety of military blood supplies. The Assistant Secretary of the Navy (M&RA) established SECNAVINST 5300.30E to reflect current knowledge of the natural history of HIV; the risks to the infected individual incident to military service; the risk of transmission of HIV to non-infected personnel; the effect of infected personnel on commands; and the safety of military blood supplies. The Services are currently reviewing and updating several policies, to include SECNAVINST 5300.30E, AFI 44-178, AR 600-110, to reflect changes as medical capabilities, technologies, and evidence-based practices have evolved.

Medical literature pertaining to HIV medicine rapidly evolves. MHS subject matter experts are aware of and have access to all available contemporary medical literature, practice guidelines, medications, and treatment modalities based on emerging and published evidence-based studies or expert opinion, referenced in, but not limited to the following:

- “National HIV/AIDS Strategy for the United States.” U.S. Department of Health & Human Services. Available at <https://www.hiv.gov>.
- Panel on Antiretroviral Guidelines for Adults and Adolescents. Guidelines for the Use of Antiretroviral Agents in Adults and Adolescents Living with HIV. Department of Health

and Human Services. Available at:

<http://aidsinfo.nih.gov/contentfiles/lvguidelines/AdultandAdolescentGL.pdf>.

- Primary Care Guidelines for the Management of Persons Infected with HIV, issued by expert panel of the HIV Medicine Association of the Infectious Diseases Society of America. Update issued in: Aberg JA, Gallant JE, Ghanem KG, et al. Primary care guidelines for the management of persons infected with HIV: 2013 update by the HIV medicine association of the Infectious Diseases Society of America. Clin Infect Dis. 2014;58(1):e1-34. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/24235263/>.
- CDC. “Integrated prevention services for HIV infection, viral hepatitis, sexually transmitted diseases, and tuberculosis for persons who use drugs illicitly: summary guidance from CDC and the U.S. Department of Health and Human Services.” MMWR Recomm Rep. 2012;61(RR-5):1-40. Available at: <https://www.cdc.gov/mmwr/preview/mmwrhtml/rr6105a1.htm>.

FEASIBILITY OF ALLOWING ENLISTED MEMBERS TO BECOME COMMISSIONED OFFICERS OF THE ARMED FORCES AND RESTRICTIONS DIFFERENT FOR OFFICERS:

DoD policy has long maintained a difference between accession medical standards and retention medical standards. The rationale for the difference is that once a member has been fully trained to perform, and has experience in performing the duties of his or her position, whether as an enlisted member or officer, the needs of the Service incline decidedly toward allowing the member to continue to perform those duties and return the investment the Service has made in the member. At the accession stage, the needs of the Service incline toward selecting members in whom to make the training and mentoring investment, who minimize any risk of inability due to medical conditions to complete an initial period of service and potentially a longer military commitment. Longstanding DoD policy under DoDI 6130.03 has also held that in the case of an enlisted member seeking appointment as a commissioned officer, the accession standards are the appropriate ones to apply because it is a new position, involving a whole new set of duties and responsibilities and new training and mentorship. The needs of the Service do not necessarily favor an officer applicant with prior enlisted service, compared to one without such service, when it comes to minimizing any risk of inability due to medical conditions to perform satisfactorily in the commissioned officer position. However, it is appropriate to note that a review of two individual officer candidates, one with and one without prior enlisted service, requesting a medical waiver for the same condition, the candidate with prior service may well have the advantage of a record of successful military service in the enlisted ranks. However, regarding which set of standards to apply to the initial medical screening, the accession medical standards are the more appropriate standards for all applicants, including applicants for enlistment or commissioning. This is long-established DoD policy for all medical conditions; there is no special or different rule for individuals with HIV infection.

DISCUSSION:

The Department has a responsibility to ensure the health and well-being of Service members, and through its policies, aims to minimize the risk of Service members’ exposure to HIV, while ensuring that those infected with HIV have access to appropriate care and management of their illness and are able to continue service. Military unique considerations; the rapidly evolving

nature of medical evidence and understanding pertaining to the nature of HIV transmission, infectivity, associated risks, and treatment; evolving mission requirements; and Service member needs pertaining to health information privacy protections, as well as opportunities for career advancement, are key factors that influence personnel policy pertaining to HIV-infected members of the Armed Forces.

Current DoD- and Service-level personnel policies pertaining to HIV-infected members of the Armed Forces:

- Are established to maintain military readiness and optimize lethality of the Armed Forces.
- Are instituted to ensure military applicants can successfully complete rigorous military training and deploy to austere environments to accomplish the demanding missions of the military, without jeopardizing their health, the health of their unit, or the military mission, as well as to respect host Nation laws where our forces are deployed.
- Support retention of Service members infected with HIV, unless there is evidence of deteriorating health or other factors that render the individuals unable or unfit to perform their duties.
- Require the same procedures for medically evaluating Service members who develop disability due to chronic illness to determine fitness for continued service, regardless of whether the Service member is HIV-positive.
- Aim to ensure that, except for assignment limitations, HIV-infected personnel are treated no differently than other Service members.
- Ensure that a Service member infected with HIV is not retired or involuntarily separated solely based on being infected.
- Recognize that in the unique circumstances of military combat operations, there remain significant risks that individuals with even well-controlled HIV infection may suffer adverse health effects and create additional mission risks for the military command.
- Direct the protection of health information and privacy of HIV-infected personnel.
- Reflect existing evidence and adhere to current nationally accepted, evidence-based guidelines, and assess evolving medical evidence and scientific understanding of the nature and risk of HIV transmission, available treatment regimens, and the latest HIV management approaches and practices.
- Stipulate clinical management to be consistent with standard of care, evidence-based HIV clinical practice standards, and medical management guidelines.

CONCLUSIONS:

DoD personnel policy for HIV-positive Service members is evidence-based, in accordance with state-of-the-art clinical guidelines, reviewed for currency, and updated accordingly as medical capabilities, technologies, and evidence-based practices evolve.

DoD accession policies align with the military's requirements to recruit healthy personnel who are able to complete demanding military training and to deploy to austere environments without exacerbating their health or compromising operational effectiveness and mission accomplishment.

For those who acquire HIV after accession, DoD policy emphasizes retention if the medical condition is stable with appropriate treatment and the Service member is found fit for duty. Service members with laboratory evidence of HIV infection who are able to perform the duties of their office, grade, rank and/or rating, cannot be separated solely based on laboratory evidence of HIV infection. Service members with medical illnesses or conditions that might limit their ability to perform military duties (including HIV infection) may undergo evaluation for either duty limitations or medical discharge.

A waiver is required for HIV-positive Service members to deploy; medical evaluators must consider climate, altitude, rations, housing, duty assignment, and available medical services in theater when deciding whether an individual is deployable. However, current Service policies do not permit HIV-infected Service members to deploy to combat theaters of operation or in support of other contingency operations, given the austere environment, potential exacerbation of illness and lack of access to needed medical care, as well as risk of compromising unit readiness and successful mission completion. Army policy currently allows deployment to Europe and Korea for HIV-infected soldiers found fit by a PEB (host Nation permitting). Navy policy currently permits case-by-case consideration for non-combat OCONUS or large ship platform tours for HIV-infected personnel with controlled HIV disease (as manifested by a reconstituted immune system, no viremia, an established history of medical compliance).

DoD policy prohibits adverse personnel actions based solely on HIV status, assuming ability to perform duties fully. However, as with any direct order, a Service member who violates the order to inform sexual partners of their HIV status or fails to use safe sexual practices, as instructed during face-to-face consultation, may be subject to disciplinary action.

Maintaining the health of military personnel is essential for force readiness. It is a strategic objective of the MHS to sustain the health of Service members, restore the health, and return to duty of Service members who become ill or injured, if possible. Once Service members complete training, the goal is to retain members who acquire HIV who are still capable of performing their duties in the rigorous military environment. Personnel policies aim to balance the need of the Services (e.g., readiness, resilience, deployability, mission accomplishment, retention) with the needs of Service members infected with HIV (access to quality care, counseling, support and educational services, privacy protections, and option to continue service, if desired). Existing personnel policies intend to maximize the lethality, readiness, and operational effectiveness of the Armed Forces, as well as to help ensure the health and well-being of Service members, while mitigating the risk of HIV transmission.

ACRONYMS:	
AD	active duty
AFI	Air Force Instruction
AFPC	Air Force Personnel Center
AHRC	Army Human Resource Command
AIDS	Acquired Immune Deficiency Syndrome
ALC-C	Assignment Limitation Code-C
AMSWG	Accession Medical Standards Working Group
AR	Army Regulation
ARNG	Army National Guard
ARNG-CSG	Army National Guard – Office of the Chief Surgeon
ART	antiretroviral therapy
ARV	antiretroviral
CCMD	Combatant Command
CDC	Centers for Disease Control and Prevention
CONUS	continental United States
DES	Disability Evaluation System
DoD	Department of Defense
DoDD	Department of Defense Directive
DoDI	Department of Defense Instruction
DoDM	Department of Defense Manual
FDA	U.S. Food and Drug Administration
FY	Fiscal Year
HETU	HIV Evaluation and Treatment
HIV	human immunodeficiency virus
HRC	Human Resource Command
IDES	Integrated Disability Evaluation System
IMR	individual medical readiness
LDES	Legacy Disability Evaluation System
M&RA	Manpower and Reserve Affairs
MCO	Marine Corps Order

MEB	Medical Evaluation Board
MEDCEN	United States Army Medical Center
MEPS	Military Entrance Processing Stations
MEU	Medical Evaluation Unit
MHS	Military Health System
MIDRP	Military Infectious Diseases Research Program
MOS	military occupational specialty
MQA	medical quality assurance
NARSUM	narrative summary
NAVMED	Naval Medical Command
NCI	neurocognitive impairment
NDAA	National Defense Authorization Act
NGR	National Guard Regulation
OASD(HA)	Office of the Assistant Secretary of Defense for Health Affairs
OCONUS	outside the continental United States
PEB	Physical Evaluation Board
QAP	Quality Assurance Program
RC	Reserve Component
SECNAVINST	Secretary of the Navy Instruction
TAPC	Total Army Personnel Command
TDA	table of distribution and allowances
USAF	U.S. Air Force

REFERENCED POLICIES:

1. DoD Issuances:

- DoD 5400.11-R, "Department of Defense Privacy Program," May 14, 2007
- DoD 6025.18-R, "DoD Health Information Privacy Regulation," January 2003
- DoDD 6490.02E, "Comprehensive Health Surveillance," February 8, 2012, as amended
- DoDI 1304.26, "Qualification Standards for Enlistment, Appointment, and Induction," March 23, 2015, as amended
- DoDI 1332.18, "Disability Evaluation System (DES)," August 5, 2014
- DoDI 1332.45, "Retention Determinations for Non-Deployable Service Members," July 30, 2018
- DoDI 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," February 17, 2011, as amended
- DoDI 6025.19, "Individual Medical Readiness (IMR)," June 9, 2014
- DoDI 6130.03, "Medical Standards for Appointment, Enlistment, or Induction in the Military Services," April 28, 2010, as amended
- DoDI 6485.01, "Human Immunodeficiency Virus (HIV) in Military Service Members," June 7, 2013
- DoDI 6490.03, "Deployment Health," August 11, 2006, as amended
- DoDI 6490.07, "Deployment-Limiting Medical Conditions for Service Members and DoD Civilian Employees," February 5, 2010
- DoDM 1332.18, Volume 1, "Disability Evaluation System (DES) Manual: General Information and Legacy Disability Evaluation System (LDES) Time Standards," August 5, 2014
- DoDM 1332.18, Volume 2, "Disability Evaluation System (DES) Manual: Integrated Disability Evaluation System (IDES)," August 5, 2014
- DoDM 1332.18, Volume 3, "Disability Evaluation System (DES) Manual: Quality Assurance Program (QAP)," November 21, 2014
- DoDM 6025.13, "Medical Quality Assurance (MQA) and Clinical Quality Management in the Military Health System (MHS)," October 29, 2013

2. Department of the Army:

- AR 40-501, "Standards of Medical Fitness," June 14, 2017
- AR 40-68, "Clinical Quality Management," Rapid Action Revision Issue Date: May 22, 2009
- AR 135-133, "Ready Reserve Screening, Qualification Records System, and Change of Address Reporting," December 22, 2016
- AR 135-175, "Separation of Officers," November 29, 2017
- AR 135-178, "Enlisted Administrative Separations," November 7, 2017
- AR 140-10, "Assignments, Attachments, Details, and Transfers," August 15, 2005
- AR 140-50, "Officer Candidate School, Army Reserve," October 15, 1999
- AR 350-51, "United States Army Officer Candidate School," June 11, 2001
- AR 600-8-24, "Officer Transfers and Discharges," Rapid Action Revision Issue Date: September 13, 2011

- AR 600-110, “Identification, Surveillance, and Administration of Personnel Infected with Human Immunodeficiency Virus,” April 22, 2014
 - AR 614-30, “Overseas Service,” December 22, 2016
 - AR 614-100, “Officer Assignment Policies, Details, and Transfers,” January 10, 2006
 - AR 614-200, “Enlisted Assignments and Utilization Management,” November 29, 2017
 - AR 635-40, “Disability Evaluation for Retention, Retirement, or Separation,” January 19, 2017
 - AR 635–200, “Active Duty Enlisted Administrative Separations,” December 19, 2016
3. Departments of the Army and the Air Force National Guard Bureau:
- NGR 351-5, “State Military Academies,” Incl Change 1, December 16, 1985
 - NGR 600-200, “Enlisted Personnel Management,” July 31, 2009
 - NGR 635-101, “Efficiency and Physical Fitness Boards,” August 15, 1977
4. Department of the Navy and United States Marine Corps:
- SECNAVINST 1850.4E, “Department of the Navy (DON) Disability Evaluation Manual,” April 30, 2002
 - SECNAVINST 5300.30E, “Management of Human Immunodeficiency Virus, Hepatitis B Virus and Hepatitis C Virus Infection in the Navy and Marine Corps,” August 13, 2012
 - NAVMED P-117, “Manual of the Medical Department (MANMED): Chapter 18: Medical Evaluation Boards,” January 10, 2005
5. Department of the Air Force:
- AFI 44-178, “Human Immunodeficiency Virus Program,” March 4, 2014; Certified Current June 28, 2016
 - AFI 48-123, “Medical Examinations Standards,” November 5, 2013
 - AFI 48-123 – Air Force Medical Command Supplement (AFMCSUP), “Medical Examinations Standards,” October 23, 2014
6. United States Marine Corps-Specific Policies:
- MCO 1300.8, “Marine Corps Personnel Assignment Policy,” September 18, 2014
 - MCO 1900.16 CH 1, “Separation and Retirement Manual,” August 7, 2015
 - MCO 1001R.1L, “Marine Corps Reserve Administration Manual,” December 23, 2015

ADDITIONAL REFERENCES

¹ Prevention Access Campaign. Risk of Sexual Transmission of HIV from a Person Living with HIV Who Has An Undetectable Viral Load: Messaging Primer and Consensus Statement. Issued July 21, 2016. Endorsements updated January 8, 2018. Available at:

<https://www.preventionaccess.org/consensus>

² Kuhar DT, Henderson DK, Struble KA, Heneine W, Thomas V, Cheever LW et al. Updated U.S. Public Health Service Guidelines for the Management of Occupational Exposures to Human Immunodeficiency Virus and Recommendations for Postexposure Prophylaxis. *Infect Control Hosp Epidemiol*. 2013; 34(9):875-892. Available at:

<https://www.ncbi.nlm.nih.gov/pubmed/23917901>.

³ Crum-Cianflone NF, Moore DJ, Letendre S et al. Low prevalence of neurocognitive impairment in early diagnosed and managed HIV-infected persons. *Neurology*. 2013;80:371–379. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/23303852>.

⁴ Sacktor N. Changing clinical phenotypes of HIV-associated neurocognitive disorders. *J Neurovirol*. 2018;24(2):141-145. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28752495>.

⁵ Price RW. HIV-associated neurocognitive disorders: Epidemiology, clinical manifestations, and diagnosis. UpToDate. Literature review current through May 2018. This topic last updated February 14, 2017. Available at: <https://www.uptodate.com/contents/hiv-associated-neurocognitive-disorders-epidemiology-clinical-manifestations-and-diagnosis>.

⁶ De Souza EM, Buoniconti CS, Valim FC, Moura AS. Risk factors for neurocognitive impairment in HIV-infected patients and comparison of different screening tools. *Dementia & Neuropsychologia*. 2016;10(1):42-46. Available at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5674913/>.

⁷ Antinori A, Arendt G, Becker JT, et al. Updated research nosology for HIV-associated neurocognitive disorders. *Neurology*. 2007;69(18):1789-1799. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4472366/>.

⁸ Sacktor N. Changing clinical phenotypes of HIV-associated neurocognitive disorders. *J Neurovirol*. 2018;24(2):141-145. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28752495>.

⁹ Grant I, Franklin DR Jr, Deutsch R, Woods SP, et al. Asymptomatic HIV-associated neurocognitive impairment increases risk for symptomatic decline. *Neurology*. 2014;82:2055–2062. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4118496/pdf/NEUROLOGY2013549501.pdf>.

¹⁰ Sacktor N. Changing clinical phenotypes of HIV-associated neurocognitive disorders. *J Neurovirol*. 2018;24(2):141-145. Available at: <https://www.ncbi.nlm.nih.gov/pubmed/28752495>.

¹¹ U.S. Army Medical Research and Materiel Command. Military Infectious Diseases Research Program (MIDRP). Background and Environment. Available at:
http://mrmc.amedd.army.mil/index.cfm?pageid=medical_r_and_d.midrp.overview

¹² U.S. Army Institute of Surgical Research: Joint Trauma System Clinical Practice Guideline: Fresh Whole Blood (FWB) Transfusion. 2012. Available at:
http://www.usaisr.amedd.army.mil/cpgs/Fresh_Whole_Blood_Transfusion_24_Oct_12.pdf

¹³ Patel P, Borkowf CB, Brooks JT. Et al. Estimating per-act HIV transmission risk: a systematic review. *AIDS*. 2014. doi: 10.1097/QAD.0000000000000298. Available at:
<https://www.ncbi.nlm.nih.gov/pubmed/24809629>.

¹⁴ Patel P, Borkowf CB, Brooks JT. Et al. Estimating per-act HIV transmission risk: a systematic review. *AIDS*. 2014. doi: 10.1097/QAD.0000000000000298. Available at:
<https://www.ncbi.nlm.nih.gov/pubmed/24809629>.

¹⁵ U.S. Department of Health and Human Services, Food and Drug Administration: CFR- Code of Federal Regulations Title 21. Available at
<https://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm?CFRPart=1271&showFR=1>