No. 26-30203

IN THE

United States Court of Appeals

FOR THE FIFTH CIRCUIT

STATE OF LOUISIANA, by through its Attorney General, LIZ MURRILL; ROSALIE MARKEZICH,

Plaintiffs-Appellants/Cross-Appellees,

v.

FOOD & DRUG ADMINISTRATION; KYLE DIAMANTAS, Acting Commissioner, U.S. Food and Drug Administration; MICHAEL DAVIS, in his official capacity as Acting Director, Center for Drug Evaluation & Research, U.S. Food & Drug Administration; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; ROBERT F. KENNEDY, JR., Secretary, U.S. Department of Health and Human Services,

Defendants-Appellees,

v.

DANCO LABORATORIES, L.L.C.; GENBIOPRO, INCORPORATED,

Intervenors-Appellees/Cross-Appellants.

Appeal from the United States District Court for the Western District of Louisiana

BRIEF OF FORMER MILITARY OFFICIALS, FORMER CIVILIAN NATIONAL SECURITY LEADERS, AND VET VOICE FOUNDATION AS *AMICI CURIAE* IN SUPPORT OF DEFENDANTS-APPELLEES AND INTERVENOR-APPELLEES

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CERTIFICATE OF INTERESTED PERSONS

State of Louisiana, et al. v. U.S. Food and Drug Administration, et al.
No. 26-30203

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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INTRODUCTION AND INTEREST OF *AMICI*[1]

This case implicates military readiness—the ability to recruit, retain, and field a force ready for immediate deployment. Women are essential to that force. For female servicemembers, access to comprehensive reproductive healthcare, including abortion, is critical to maintaining the readiness on which our national security depends.

When access to care is restricted, servicemembers face delays, extended absences, and structural barriers that impair their ability to serve. The nature of military life compounds these burdens. Servicemembers cannot choose where they are stationed, must operate within rigid schedules and chains of command, and cannot easily arrange leave or travel for an in-person appointment. Nationwide abortion restrictions, layered on top of these constraints, make it harder for servicemembers to receive timely care and stay available for duty. These burdens carry systemic consequences: they undermine recruitment, increase attrition, and disrupt unit cohesion.

These are not speculative concerns. Restricted access has direct, measurable effects on unit readiness, personnel availability, and mission execution. Where permitted, telehealth allows servicemembers to obtain care efficiently, reducing

[1] This brief was not authored in whole or part by counsel for a party. No one other than *amici* and their counsel made a monetary contribution to the preparation or submission of the brief. *Amici* received consent from all parties to submit this brief.

disruptions to careers and unit operations. Reinstating the in-person dispensing requirement for mifepristone would impose predictable burdens—travel, delay, absence, attrition—that harm military readiness and national security.

Amici are U.S. military veterans, former civilian national security leaders, and a nonprofit that supports current and former servicemembers. Drawing on their expertise in military recruitment, readiness, medical care, and personnel, they submit this brief to explain how restricting access to mifepristone threatens military readiness and national security.

The Honorable Louis Caldera is the former Secretary of the Army and the former Director of the White House Military Office. He graduated from the U.S. Military Academy and began his military career as an Army officer. In his time as Secretary of the Army, he implemented changes to develop a more versatile and deployable force and led a reversal of recruiting shortfalls.

The Honorable Deborah James is the former Secretary of the Air Force and the former Assistant Secretary of Defense for Reserve Affairs. As Secretary of the Air Force, she led efforts to increase percentages of women and diverse candidates in applicant pools, to open more Air Force roles to women, and to extend the Post-Pregnancy Deployment Deferment from six to twelve months.

U.S. Army Major General (Ret.) Paul Eaton is the former Commanding General, Army Infantry Center and School. He gave 33 years of service to the

military, including as the Commanding General of the command charged with reestablishing Iraqi Security Forces from 2003 to 2004.

U.S. Army Major General (Ret.) Tammy Smith is the former Deputy Commanding General for Sustainment, Eighth U.S. Army, Korea, and the Former Special Assistant to the Assistant Secretary of the Army (Manpower and Reserve Affairs). In the latter role, and throughout her career, General Smith handled personnel policy, including readiness and family issues.

U.S. Army Brigadier General (Ret.) Steven M. Anderson is the former Director, Operations and Logistics Readiness for the U.S. Army. In that role, he led a staff responsible for all Army logistics readiness reporting and ran the Army's Logistics Operations Center.

U.S. Army Brigadier General (Ret.) Robin B. Umberg is a former Chief Nurse and Chief of Professional Services, 3rd Medical Command for the U.S. Army. She served in a variety of staff and command assignments throughout her 36 years of service, including in roles that had responsibility for battlefield readiness, training, and career management for more than 27,000 medical personnel.

U.S. Navy Rear Admiral (LH) (Ret.) Michael S. Baker, M.D., F.A.C.S. is a retired general and trauma surgeon who served in the Medical Corps, U.S. Navy. As a Navy officer, he held roles in operational medicine, combat deployments, medical intelligence, and strategic planning.

U.S. Air Force Major General (Ret.) Patricia A. Rose is a retired senior logistics and operational leader who served more than three decades in the U.S. Air Force. She commanded the 36th Aerial Port Squadron at McChord Air Force Base and later directed joint logistics operations in Southwest Asia in support of Operations Iraqi Freedom and Enduring Freedom. She also served in senior logistics leadership roles at U.S. Pacific Command and Air Force Materiel Command. Throughout her career, she held key positions in logistics, engineering, and security, with responsibility for sustainment, readiness, and force protection across global operations.

Vet Voice Foundation is a Washington, D.C.-based non-profit, non-partisan organization dedicated to strengthening the United States military and supporting the wellbeing of current and former servicemembers. Vet Voice Foundation has a particular interest in ensuring that policies affecting servicemembers and veterans reflect the realities of military life.

ARGUMENT

Military readiness is a paramount national interest. As set forth below, reinstating the in-person dispensing requirement for mifepristone would make it harder for servicemembers to access reproductive healthcare, imposing substantial costs on readiness and national security. Telehealth access, including mail and pharmacy dispensing, allows servicemembers stationed in states that permit it to obtain essential care without extended travel or leave. This keeps personnel available, reduces unit disruption, and supports recruitment and retention.

I. Military Readiness Is Essential, and Women Are Critical to Maintaining It.

National security requires the U.S. military to respond to global threats in real time. Personnel must be trained, available, and ready for deployment. Women are essential to meeting this need. They fill critical roles at every level, represent a significant share of the recruitable population, and contribute directly to force capacity. Ensuring their access to reproductive healthcare, including abortion, is vital to sustaining a mission-ready military.

"Military readiness" is the capacity to "produce, deploy, and sustain military forces that will perform successfully in combat."[2] Without sufficient readiness,

[2] G. James Herrera, Cong. Rsch. Serv., R46559, *The Fundamentals of Military Readiness* 1 (2020), https://sgp.fas.org/crs/natsec/R46559.pdf.

adversaries may perceive diminished capability, increasing the risk of conflict.[3] This readiness is particularly urgent today, given ongoing global conflicts in the Middle East. As of April 2026, the U.S. military had more than 50,000 personnel in the region.[4] The Administration has warned that this is a time of "urgency" and growing threats, and that the military "must be prepared."[5]

Capable personnel are the foundation of military readiness. They must be physically prepared and able to respond to threats quickly. A key part of readiness is the ability "to rapidly mobilize, deploy, and redeploy" troops.[6] "Speed matters," especially when confronting global challenges in real time.[7] Barriers to healthcare, including reproductive healthcare, slow operations down by forcing servicemembers to take extended leave or delaying their return to duty.

While the U.S. military remains among the most powerful in the world, its readiness cannot be assumed. A March 2026 Heritage Foundation study concluded

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[3] Leon Panetta et al., Bipartisan Pol'y Ctr., *The Building Blocks of a Ready Military: People, Funding, Tempo* 18–19 (2017), https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Defense-Military-Readiness.pdf.

[4] Patricia Kime, *13 US Troops Killed, More Than 380 Wounded in Operation Epic Fury*, Military Times (Apr. 8, 2026), https://www.militarytimes.com/news/your-military/2026/04/08/pentagon-data-13-us-troops-killed-346-wounded-in-operation-epic-fury/.

[5] Pete Hegseth, U.S. Sec'y of War, Address to General and Flag Officers at Quantico, Virginia (Sept. 30, 2025), https://www.war.gov/News/Transcripts/Transcript/article/4318689/secretary-of-war-pete-hegseth-addresses-general-and-flag-officers-at-quantico-v/.

[6] Herrera, *supra* note 2, at 7.

[7] Eric Edelman et al., Nat'l Def. Strategy Comm'n, *Providing for the Common Defense: The Assessment and Recommendations of the National Defense Strategy Commission* 33, 66 (2018), https://www.govinfo.gov/content/pkg/GOVPUB-D-PURL-gpo120140/pdf/GOVPUB-D-PURL-gpo120140.pdf.

that the U.S. military "is burdened by readiness levels that are more problematic than they should be" and "is at significant risk of not being able to defend America's vital national interests with assurance."[8]

Readiness depends on recruiting personnel who are prepared to fight when needed.[9] Retention is equally critical. Units with consistent personnel are more effective than those relying on fill-in soldiers.[10] When servicemembers leave, units lose cohesion and operational effectiveness.[11] Despite recent improvements, recruitment and retention remain persistent challenges.[12]

Given these challenges, the military benefits from recruiting and retaining women. Department of Defense leaders have long recruited female servicemembers to "maintain and improve mission readiness."[13] As of 2024, women made up about

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[8] The Heritage Foundation, *2026 Index of U.S. Military Strength* 547, 553 (Robert Peters, Daniel R. Green & Wilson Beaver, eds., 2026), https://static.heritage.org/2026/Military_Index/2026_IndexOfUSMilitaryStrength.pdf.

[9] *See* Panetta, *supra* note 3, at 5; Edelman, *supra* note 7, at xi.

[10] Ben Kesling, *The Military Recruiting Crisis: Even Veterans Don't Want Their Families to Join*, Wall St. J. (June 30, 2023, 00:01 ET), https://www.wsj.com/politics/military-recruiting-crisis-veterans-dont-want-their-children-to-join-510e1a25.

[11] *See id.*

[12] *See* Evan Hydock, *Is the Military Recruiting Crisis Over? Not Quite*., Geo. Sec'y Stud. R. (2025), https://gssr.georgetown.edu/the-forum/topics/defense/is-the-military-recruiting-crisis-over-not-quite/; Aaron Sobczak, *High Attrition Rates and Increased Waivers Muddy Enlistment Numbers*, Responsible Statecraft (Mar. 10, 2025), https://responsiblestatecraft.org/military-attrition-rates-high.

[13] U.S. Gov't Accountability Off., GAO-20-61, *Female Active-Duty Personnel: Guidance and Plans Needed for Recruitment and Retention Efforts* 1–2 (2020) ("GAO Report"), https://www.gao.gov/assets/gao-20-61.pdf.

18% of the active-duty force.[14] Women represent a highly recruitable population with strong potential for advancement.[15]

Since the Women's Armed Services Integration Act of 1948, women have increasingly filled essential roles across the military.[16] Women have long served on the front lines—in combat vessels, aircraft, and other combat roles.[17] In 2013, the federal government rescinded a ground combat exclusion rule, allowing women to serve in direct ground combat to help "remov[e] as many barriers as possible to joining, advancing, and succeeding in the U.S. Armed Forces."[18] Ensuring women's continued participation is critical to sustaining military readiness.

II. Timely Access to Reproductive Healthcare, Including Abortion, Is Essential to Military Readiness.

Restrictions on abortion directly impair military readiness. When servicemembers cannot access reproductive healthcare efficiently, they face

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[14] U.S. Dep't of Defense, 2024 Demographics: Profile of the Military Community 18, https://www.militaryonesource.mil/data-research-and-statistics/military-community-demographics/2024-demographics-profile/.

[15] Steve Beynon, *Surge of Female Enlistments Helped Drive Army Success in Reaching 2024 Recruiting Goal*, Military.com (Jan. 9, 2025, 21:50 ET), https://www.military.com/daily-news/2025/01/09/surge-of-female-enlistments-helped-drive-army-success-reaching-2024-recruiting-goal.html.

[16] Douglas Yeung et al., *Recruiting Policies and Practices for Women in the Military: Views from the Field*, RAND Corp. 1–2 (2017), https://www.rand.org/pubs/research_reports/RR1538.html.

[17] *See* Kristy N. Kamarck, Cong. Rsch. Serv., R42075, Women in Combat: Issues for Congress 6–7 (2016), https://www.congress.gov/crs_external_products/R/PDF/R42075/R42075.25.pdf.

[18] Memorandum from Martin E. Dempsey, Chairman of the Joint Chiefs of Staff & Leon E. Panetta, Sec'y of Def., to Secretaries of the Military Departments 1 (Jan. 24, 2013), https://www.womenvetsusa.org/cmsfiles/docs/rescission-of-1994-direct-ground-combat-definition-&-assignment-rule-secdef-24-jan-2013.pdf?1774215191.

extended absences, delayed treatment, and forced choices between their health and careers—all of which undermine deployability, recruitment, and retention. Telehealth access to mifepristone, including mail or pharmacy dispensing, mitigates these harms. In states that permit such access, servicemembers can obtain abortion without delay, leaving unit effectiveness undisturbed. Louisiana's requested relief, which seeks to reimpose the in-person dispensing requirement for mifepristone, threatens this access and would harm military readiness.

A. Limited access to reproductive healthcare impedes the deployability, recruitment, and retention of servicemembers.

Access to abortion affects physical preparedness. When abortion is not readily accessible, servicemembers may have to take extended leave and travel long distances. Those disruptions hinder a servicemember's ability to serve and ripple through unit operations. Units that are not fully staffed cannot respond quickly, and units relying on fill-in soldiers are less effective.[19] Delayed or denied care can also cause serious health consequences that require additional leave or separation from the military, further eroding readiness.[20] Where permitted, telehealth access to mifepristone mitigates these ripple effects. *See infra* Section II.C.

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[19] Kesling, *supra* note 10.

[20] *See* Daniel Grossman et al., *Care Post-Roe: Documenting Cases of Poor-Quality Care Since the* Dobbs *Decision,* Advancing New Standards in Repro. Health 11–14, 19 (2024), https://www.ansirh.org/sites/default/files/2024-09/ANSIRH%20Care%20Post-Roe%20Report%209.04.24_FINAL%20EMBARGOED_0.pdf.

Government officials have recognized that barriers to reproductive healthcare weaken readiness by hurting recruitment and retention. After *Dobbs*, then-Pentagon Under Secretary of Defense for Personnel and Readiness Gilbert R. Cisneros, Jr. warned that abortion barriers could drive attrition, noting that "some service members may choose to leave the military altogether" because they cannot get care.[21] At a Congressional hearing on servicemembers' reproductive health and readiness, Representative Jackie Speier cautioned that abortion restrictions "creat[e] a real incentive for women not to serve."[22]

Servicemembers themselves report the same impact. In 2023, active-duty servicemembers confirmed that barriers to reproductive access "are impacting their willingness to continue to serve in the military," creating a "retention and morale issue."[23] Active-duty members testified before Congress that restricted access "degrades morale," "affects retention," and could discourage new recruits from joining the military altogether.[24]

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[21] Alex Horton & Rachel Roubein, *Abortion Ruling Will Worsen Military Personnel Crisis, Pentagon Says*, Wash. Post (July 29, 2022, at 17:17 ET), https://www.washingtonpost.com/national-security/2022/07/29/military-abortion-recruiting/.

[22] *Service Members' Reproductive Health and Readiness: Hearing Before the Subcomm. on Mil. Pers. of the H. Comm. on Armed Servs.*, 117th Cong. 17 (2022) ("Hearing"), https://www.congress.gov/117/chrg/CHRG-117hhrg51197/CHRG-117hhrg51197.pdf.

[23] Trevor Hunnicutt, *Restrictive Abortion Laws Hurting US Military, White House Says*, Reuters (July 17, 2023, at 18:23 ET), https://www.reuters.com/world/us/restrictive-abortion-laws-hurting-morale-retention-us-military-w-house-2023-07-17/.

[24] Hearing, *supra* note 22, at 22 (testimonies of Sharon Arana & Theresa Mozzillo).

Accessible reproductive healthcare directly supports retention. Women are more likely than men to leave military service, and the ability to control whether and when to have children contributes to women's higher departure rates.[25] Reproductive healthcare access also affects retention for all servicemembers, including men.[26] When a servicemember's spouse or dependent cannot access care, the servicemember may take extended leave or depart from the military entirely.[27] The effects of limiting access to reproductive healthcare extend beyond individual servicemembers to their families and, ultimately, to the military as a whole.

B. Federal policies already restrict abortion access for servicemembers and veterans, making further restrictions even more burdensome for servicemembers' ability to access timely care.

Abortion access for servicemembers is already limited by federal statute and policy. These restrictions make it all the more important that servicemembers not be forced to navigate additional barriers, like a nationwide in-person dispensing requirement for mifepristone.

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[25] *See* GAO Report, *supra* note 13, at 2, 11, 29; *see also* Douglas Lindsay, *The Military Is Growing Again but Capacity, Not Recruiting, Is the Real Test*, Military.com (Jan. 27, 2026, at 10:00 ET), https://www.military.com/feature/2026/01/26/military-growing-again-capacity-not-recruiting-real-test.html (citing stable family support as a consideration for retention across the military).

[26] *See* Hearing, *supra* note 22, at 22 (testimony of Theresa Mozzillo).

[27] Notwithstanding federal restrictions on providing abortion to servicemembers, the federal government can extend, and indeed has previously extended, some reproductive healthcare benefits to recipients of TRICARE—government-managed health insurance for military servicemembers and veterans—and their dependents. *See infra* Section II.B (describing travel allowances offered under the Biden Administration). Those benefits would be enjoyed by female dependents of male policyholders, in addition to female policyholders serving in the military.

Federal law bars the Department of Defense from using funds to provide abortions "except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of . . . rape or incest."[28] Unless those exceptions apply, "[n]o medical treatment facility or other facility of the Department of Defense may be used to" provide an abortion.[29] In practice, servicemembers seeking non-covered abortions must pay out-of-pocket and travel to non-military providers. These restrictions already burden servicemembers significantly. Telehealth abortion access, where permitted, eases these financial and logistical burdens by cutting the costs of traveling to an in-person clinic.

In January 2025, President Trump issued an Executive Order purporting to reinforce the Hyde Amendment.[30] The order revoked Biden-era executive orders protecting abortion access and directed agencies to develop guidance enforcing the Hyde Amendment.[31]

After the Executive Order, federal agencies made two significant policy changes affecting servicemembers and veterans. First, in early 2025, the Department of Defense rescinded regulations authorizing transportation allowances for

[28] 10 U.S.C. § 1093(a).
[29] *Id.* § 1093(b).
[30] Exec. Order No. 14182, Enforcing the Hyde Amendment, 90 Fed. Reg. 8751, 8751 (Jan. 24, 2025).
[31] *Id.*

servicemembers to travel for reproductive healthcare, making such travel, which is already burdensome, even more difficult.[32] Second, in December 2025, the Department of Veterans Affairs stopped providing abortions to veterans and their dependents—even in cases involving serious health risks, rape, or incest.[33]

Federal law and policy already significantly burden access to abortion for servicemembers, veterans, and their families. Telehealth access to mifepristone in states that permit it is therefore a key channel that allows servicemembers to obtain timely care despite federal restrictions. Reinstating the in-person dispensing requirement would disrupt that channel, compounding the burdens described above.

C. State restrictions on abortion impose additional barriers on servicemembers and veterans seeking reproductive healthcare nationwide.

Beyond federal restrictions, servicemembers and veterans face significant obstacles to accessing reproductive healthcare at the state level, leaving telehealth as an increasingly critical remaining pathway to timely care.

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[32] Memorandum from Sarah W. Moore, Deputy Dir., Def. Travel Mgmt. Off., Dep't of Def. to Military Advisory Panel (Jan. 29, 2025), https://media.defense.gov/2025/jan/29/2003634768/-1/-1/0/utd_for_map_04-25(s)_remove-travel-for-non-covered-reproductive-health-care-services.pdf.

[33] *See* Julianne McShane, *Department of Veterans Affairs Quietly Implements Abortion Ban*, MS Now (Dec. 23, 2025, at 11:30 ET), https://www.ms.now/news/abortion-ban-veterans-affairs-va; *see also* Serra Sippel & Janessa Goldbeck, *Army Veterans Deserve Access to Abortion. The Senate Just Denied Them*., MS Now (Mar. 26, 2026, at 12:04 ET), https://www.ms.now/opinion/va-abortion-access-senate-vote.

Since *Dobbs*, abortion access has been severely curtailed in many states. As of this writing, 25 states significantly restrict abortion.[34] These restrictions have compounding effects—not just for women in those states, but for women nationwide seeking reproductive healthcare. In states where abortion remains available, clinics are overwhelmed with patients, including those traveling from out of state.[35] Clinic closures have further reduced provider availability,[36] meaning that even servicemembers stationed in states where abortion is legal may have to travel far or wait longer to receive in-person care—burdens that telehealth access to mifepristone, where permitted, avoids entirely.

These nationwide access challenges compound the unique burdens of military service.[37] Servicemembers who need in-person abortion care must often report their pregnancy up the chain of command, obtain commander approval to travel, and navigate unpredictable deployments to locations not of their choosing.[38] These

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[34] *See Interactive Map: US Abortion Policies*, Guttmacher Inst. (last visited July 17, 2026), https://states.guttmacher.org/policies/.

[35] *See* Alyssa Goldberg, *People Are Flocking Out-of-State for Abortion Care. Clinics Are Fighting to Keep Up*, USA Today (Mar. 18, 2025, at 11:59 ET), https://www.usatoday.com/story/life/health-wellness/2025/03/05/abortion-clinic-fund-travel-sustainability/80697629007/.

[36] *See* Off. Sen. Elizabeth Warren et al., *The "Defund" Disaster: How the Republican Attack on Planned Parenthood Is Hurting Patients and Raising Americans' Health Care Costs* 1 (2026), https://www.warren.senate.gov/wp-content/uploads/media/doc/_senate_defund_report.pdf.

[37] *See generally* Br. for Pet. at *7–8, *Struck v. Sec'y of Def.*, 409 U.S. 1071 (1972) (No. 72-178), 1972 WL 135840.

[38] *See* Hugh McClean, *The Military's Abortion Crisis in the Aftermath of* Dobbs v. Jackson Women's Health Organization, 16 U.C. Irvine L. Rev. 1, 8–11 (2026); *see also* Steve Walsh, *Faced With Obstacles to Abortion, Military Women Have Built Their Own Support System*, NPR (Oct.

hurdles are unique to servicemembers; telehealth access to mifepristone by mail, in states where such care is permitted, eliminates them entirely.

Even in states where abortion is available, servicemembers encounter long drives, scheduling hurdles, and fear of professional consequences. One active-duty servicemember testified before Congress that to obtain an abortion, she drove 3.5 hours from the base where she was stationed, only to discover she was subject to a three-day mandatory delay period.[39] Given her training schedule, she was forced to delay her care, eventually obtaining it in another state.[40] Another active-duty servicemember testified that the idea of disclosing her pregnancy to male-dominated leadership made her feel "devastated, lost, and alone."[41] She feared her military career would "fall[] apart" if she had to discuss her pregnancy with leadership.[42] She was ultimately able to book a Saturday appointment at an abortion clinic to avoid the "critical hurdle" of requesting time off.[43] For servicemembers who do request

30, 2024, at 05:00 ET), https://www.npr.org/2024/10/29/nx-s1-5162443/women-in-the-military-abortion-roe-v-wade.

[39] Hearing, *supra* note 22, at 5 (testimony of Sharon Arana).

[40] *Id*. at 5–6.

[41] *Id*. at 7 (testimony of Theresa Mozzillo).

[42] *Id*.

[43] *Id*.

time off to obtain an abortion, there is no guarantee that their supervisor will grant the request.[44]

A 2025 study confirmed these experiences across a broader population. Among 178 servicemembers who obtained an abortion while on active duty, more than half took personal leave to access care, almost half traveled more than one hour, and almost a third experienced adverse professional consequences.[45]

Requiring servicemembers and veterans to obtain in-person care from unfamiliar civilian providers also imposes unique psychological burdens—particularly for those with service-related trauma—that telehealth can mitigate. Andrea Goldstein, a lieutenant commander in the U.S. Navy Reserve with over 16 years of service, described the unique barriers servicemembers face when forced to seek in-person care from unfamiliar civilian providers:

> I far prefer to get my medical care through the VA because the providers there are trauma- and service-informed. They understand and are specifically trained with cultural competency regarding my experience. Being forced to go to a private clinic for something as personal as reproductive healthcare, to sit in an unfamiliar waiting room and put myself in the hands of a provider who may not be equipped to treat someone with military trauma is daunting. Telemedicine removes those barriers. It lets you access care from the privacy of your own home, on

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[44] *See* Shoshanna Ehrlich, *Three Women Veterans on the Devastating Reality of the VA Abortion Ban*, Ms. Mag. (Mar. 16, 2026, at 07:54 PT), https://msmagazine.com/2026/03/15/women-veterans-abortion-health-pregnanc-emergency-rape-incest-total-ban-trump/.

[45] Caitlin Russell et al., *Policy Knowledge and Abortion Access for US Active-Duty Servicewomen: A Mixed-Methods Study*, 71 J. Midwifery & Women's Health 46, 48–51 (2025), https://pmc.ncbi.nlm.nih.gov/articles/PMC12914618/.

> your own terms, without that uncomfortable and potentially unsafe in-person experience.[46]

Servicemembers and veterans may also face protestors or harassment at non-military facilities that provide abortion.[47] These burdens—unfamiliar providers, lack of trauma-informed care, and exposure to harassment—are not just personal inconveniences: they deter servicemembers from seeking care, delay treatment, and reduce personnel available for duty. By contrast, telehealth access to mifepristone allows servicemembers to obtain care in the comfort and privacy of their own homes.

Veterans face particular challenges. After serving their country, many confront chronic health conditions from military service that complicate reproductive healthcare decisions.[48] They also tend to become pregnant at older ages, which raises the risk of pregnancy complications.[49] Recent Department of Veterans Affairs policy changes make these barriers worse. Without telehealth access to mifepristone,

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[46] Email Exchange with Ms. Goldstein (May 4, 2026).

[47] *See Three Years Post-Dobbs, Abortion Providers Experience High Levels of Violence & Disruption*, Nat'l Abortion Fed. (Apr. 23, 2025), https://nationalabortionfederation.org/three-years-post-dobbs-abortion-providers-experience-high-levels-of-violence-disruption/; *see also* Carrie N. Baker, '*Barrage of Harassment, Intimidation and Violent Attacks' on Abortion Clinics, Says National Abortion Federation*, Ms. Mag. (Apr. 25, 2025), https://msmagazine.com/2025/04/25/harassment-intimidation-violence-abortion-clinics-doctors-providers-national-federation/.

[48] *See, e.g.*, Lisa S. Callegari & Sonya Borrero, *Abortion Care for Veterans—A Historic Step Forward*, 3 JAMA Health F. 1 (2022), https://jamanetwork.com/journals/jama-health-forum/fullarticle/2798138.

[49] *Id.*

servicemembers and veterans in states that permit such care would lose a critical remaining pathway to timely reproductive healthcare.

D. Telehealth abortion mitigates access barriers and strengthens military readiness.

Telehealth access to mifepristone directly mitigates the readiness harms described above. For servicemembers stationed where they can access reproductive healthcare remotely, telehealth keeps personnel available, reduces the need for command-level involvement, lessens unit disruption, and allows servicemembers to keep doing their jobs.

Under current rules, where state law permits, patients can have a telehealth evaluation and receive mifepristone by mail—no travel, leave protocols, or command approval required. For servicemembers (especially those stationed at remote installations), telehealth is not merely convenient; it is often the only realistic way to receive timely care. Servicemembers who cannot access mifepristone through telehealth face far more dangerous alternatives, such as delayed care, travel under hazardous conditions, or no care at all—each carrying significantly higher medical risks.

Reinstating the in-person dispensing requirement for mifepristone would impose substantial burdens at every level. At the individual level, servicemembers would face medical, reputational, and professional consequences. At the unit level, absences would reduce operational effectiveness. At the system level, the military

would face harms to preparedness, recruitment, and retention. Together, these burdens would degrade overall military readiness.

Louisiana argues that reinstating the in-person dispensing requirement for mifepristone will not cause the intervenor-manufacturers any cognizable irreparable harm and that the equities therefore favor Louisiana. *See* Br. Pls.-Appellants, Dkt. 147, at 63-69. That fails to consider the impact on military readiness, and the harms described above, which fall on servicemembers, their units, and the Nation's defense operations.

A stay of the 2023 REMS and imposing an in-person dispensing requirement for mifepristone would reintroduce barriers to care that will harm military readiness and, in turn, national security. The Nation's security depends on the military's ability to deploy troops effectively during active conflict. Harms to military readiness tip the balance decisively against Louisiana's requested relief.

CONCLUSION

For these reasons, the Court should affirm the district court and deny Appellants' request to stay the 2023 REMS and to reimpose the in-person dispensing requirement for mifepristone.

Dated: July 22, 2026

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CERTIFICATE OF SERVICE

I hereby certify that a copy of the foregoing document was filed electronically with the Court's CM/ECF system on July 22, 2026. Service will be effectuated by the Court's electronic notification system upon all parties and counsel of record.

Dated: July 22, 2026
Washington, D.C.

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 32(a) of the Federal Rules of Appellate Procedure, Katherine Epstein, hereby certifies that according to the word count feature of the word processing program used to prepare this brief, the brief contains 4,085 words excluding the parts of the brief exempted by Fed. R. App. P. 32(f), and complies with the typeface requirements and length limits of Rules 27, 29, and 32(a)(5)-(7) and the corresponding local rules.

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