UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF LOUISIANA
LAFAYETTE DIVISION

THE STATE OF LOUISIANA, by and through its Attorney General, LIZ MURRILL, and ROSALIE MARKEZICH,
Plaintiffs

VS.

U.S. FOOD AND DRUG ADMINISTRATION, et al.,
Defendants.

Case No. 6:25-cv-01491-DCJ-DJA

Judge David C. Joseph

Magistrate Judge David J. Ayo

MOTION FOR LEAVE TO FILE AS AMICI CURIAE

The Disability Rights Education and Defense Fund and Others, by and through undersigned counsel, respectfully move for leave of the Court to file the accompanying Amicus Brief in opposition to Plaintiffs State of Louisiana and Rosalie Markezich's Memorandum of Law in Support of Their Motion for Preliminary Relief Under 5 U.S.C. § 705 (ECF No. 20). For the reasons set forth in the accompanying memorandum in Support, the Proposed Amici respectfully request that the Court grant this motion.

s/ Chloé M. Chetta
Chloé M. Chetta, 37070
BARRASSO USDIN KUPPERMAN FREEMAN & SARVER, L.L.C.
909 Poydras Street, Suite 2350
New Orleans, LA 70112
(504) 589-9700
cchetta@barrassousdin.com

Kristen D. Amond, 37011
KRISTEN AMOND LLC
3640 Magazine Street
New Orleans, LA 70115
(504) 556-5523
kristen@amondlaw.com

s/ Maria Michelle Uzeta
Maria Michelle Uzeta, WDLA No. 918851
Admitted *pro hac vice*
Disability Rights Education & Defense Fund
3075 Adeline Street, Suite 210
Berkeley, CA 94703
(510) 644-2555
muzeta@dredf.org

Mallory Tosch Hoggatt, *pro hac vice* pending
Allen Overy Shearman Sterling US LLP
800 Capitol Street, Suite 2200
Houston TX 77002
(713) 354-4900
Mallory.ToschHoggatt@aoshearman.com

Elizabeth June, *pro hac vice* pending
Allen Overy Shearman Sterling US LLP
1101 New York Avenue NW
Washington, DC 20005
(202) 683-3800
Elizabeth.June@aoshearman.com

Counsel for Amici Curiae Disability Rights Education and Defense Fund and Others

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF LOUISIANA
LAFAYETTE DIVISION

THE STATE OF LOUISIANA, by and through its Attorney General, LIZ MURRILL, and ROSALIE MARKEZICH,
Plaintiffs

VS.

U.S. FOOD AND DRUG ADMINISTRATION, et al.,
Defendants.

Case No. 6:25-cv-01491-DCJ-DJA

Judge David C. Joseph

Magistrate Judge David J. Ayo

AMICUS BRIEF OF
DISABILITY RIGHTS EDUCATION AND DEFENSE FUND AND OTHERS

TABLE OF CONTENTS

Page

INTEREST OF AMICI CURIAE 1

SUMMARY OF THE ARGUMENT 1

ARGUMENT 3

I. Reinstating the in-person dispensing requirement would violate federal law by imposing an undue and discriminatory barrier to care. 3

A. Congress prohibited REMS that unduly burden access, especially for patients with functional limitations. 3

B. Federal disability law requires the provision of equal access and reasonable modification. 7

C. An in-person dispensing mandate is an unlawful structural barrier under both frameworks. 11

II. Reinstating the in-person dispensing requirement for mifepristone would exclude people with disabilities from equal access to reproductive health care. 13

A. Telemedicine mitigates pervasive physical barriers to in-person care, including inaccessible facilities and medical equipment. 14

B. Telemedicine alleviates transportation and logistical barriers that exclude disabled people from care. 16

C. Telemedicine reduces financial barriers that prevent people with disabilities from accessing care. 18

D. Telemedicine protects the privacy, safety, and medical independence of people with disabilities by reducing exposure to third-party coercion and abuse. 19

E. Telemedicine Reduces exposure to discrimination and medical mistreatment that deter people with disabilities from seeking care. 19

III. Telemedicine access to mifepristone is essential, life-preserving health care for people with disabilities who face elevated risks of complications, including death. 21

CONCLUSION 23

TABLE OF AUTHORITIES

Page

Cases

Alexander v. Choate, 469 U.S. 287 (1985) 12

Am. Coll. of Obstetricians & Gynecologists v. United States Food & Drug Admin., 472 F. Supp. 3d 183 (D. Md. 2020) 5

Barden v. City of Sacramento, 292 F.3d 1073 (9th Cir. 2002) 10

Block v. Tex. Bd. of Law Exam'rs, 952 F.3d 613 (5th Cir. 2020) 9

Clark v. La., Dep't of Pub. Safety, 63 F.4th 466 8

Delano-Pyle v. Victoria Cnty., Tex., 302 F.3d 567 (5th Cir. 2002) 8

Frame v. City of Arlington, 657 F.3d 215 (5th Cir. 2011) (en banc) 7, 8, 9, 12

Francois v. Our Lady of the Lake Hosp., Inc., 8 F.4th 370 (5th Cir. 2021) 7

Henrietta D. v. Bloomberg, 331 F.3d 261 (2d Cir. 2003) 10

Johnson v. Gambrinus Co./Spoetzl Brewery, 116 F.3d 1052 (5th Cir. 1997) 9

King v. Our Lady of the Lake Hosp., Inc., 455 F. Supp. 3d 249 (M.D. La. 2020) 7

Liese v. Indian River Cnty. Hosp. Dist., 701 F.3d 334 (11th Cir. 2012) 10

Luke v. Texas, 46 F.4th 301 (5th Cir. 2022) 7

Purcell v. Kennedy, 2025 WL 3101785 (D. Haw. Oct. 30, 2025) 5

Rosen v. Montgomery Cnty. Md., 121 F.3d 154 (4th. Cir. 1997) 8

Tennessee v. Lane, 541 U.S. 509 (2004) 9

United States v. Baylor Univ. Med. Ctr., 736 F.2d 1039 (5th Cir. 1984) 7

Statutes

21 U.S.C. § 355-1(f) 4

21 U.S.C. § 355-1(f)(2)(C) 11

21 U.S.C. § 355-1(f)(2)(C)(i)–(ii) 4

21 U.S.C. § 355-1(f)(2)(C)(iii) 4

29 U.S.C. § 794 7

29 U.S.C. § 794(a) 14

42 U.S.C. § 12101(a)(3) 7

42 U.S.C. § 12101(a)(5) 10

42 U.S.C. § 12132 ..... 8, 14

42 U.S.C. §§ 12182(a), 12181(7)(F) 8, 14

42 U.S.C. § 12182(a) 14

42 U.S.C. § 12182(b) 14

42 U.S.C. § 12182(b)(2)(A)(ii) 10

42 U.S.C. §§ 12181(7)(F) 8

Pub. L. No. 115-271, tit. III, § 3032(b) 4

Other Authorities

28 C.F.R. § 35.130(b)(7)(i) 10

28 C.F.R. § 36.302(a) 10

28 C.F.R. § 39.150(b) 14

45 C.F.R. § 84.4(b)(2) 7

153 CONG. REC. S11831 (daily ed. Sep. 20, 2007) 4

89 Fed. Reg. 40066, 40165 (May 9, 2024) (codified at 45 C.F.R. § 84.90 et seq.) 15

Adele C. Viguera et al., *Risk of recurrence in women with bipolar disorder during pregnancy: prospective study of mood stabilizer discontinuation*, AM. J. PSYCHIATRY 1817, 1818–21 (2007) 22

Allison M. Whelan & Michele Goodwin, *Abortion Rights and Disability Equality: A New Constitutional Battleground*, 79 Wash. & Lee L. Rev. 965 (2022) 5

Am. Diabetes Ass'n., *Standards of Care in Diabetes—2023 Abridged for Primary Care Providers*, 41 DIABETES J. 4, 28 (2022) 22

Autistic Self Advocacy Network, *Access*, *Autonomy & Dignity: People with Disabilities and the Right to Parent* (Sept. 2021), https:// nationalpartnership.org/wp-content/uploads/2023/02/repro-disability-parenting.pdf. 20

Center for Disease Control, *Disability Barriers to Inclusion*, https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html (accessed Jan. 12, 2024) 19

Center for Drug Evaluation and Research, Application Numbers: 020687 and 91178 Rationale Review, No. 6:25-CV-01491, ECF No. 1-50. 5

The Disability Network Southwest Michigan, *A Lack of Accessible Public Transportation Creates Isolation* (May 2, 2022), https://www.dnswm.org/a-lack-of-accessible-public-transportation-creates-isolation/ 17

Erica Twardzik et al., *Transit Accessibility Tool (TRACT): Developing a novel scoring system for public transportation system accessibility*, 34 J. TRANSPORT & HEALTH (Jan 2024), https://www.sciencedirect.com/science/article/pii/S2214140523001780 17

Ilhom Akobirshoev et al., *Birth Outcomes Among US Women with Intellectual and Developmental Disabilities* Disability Health J. 406, 408 (2017) 6

Jamie Ducharme, *For People With Disabilities, Losing Abortion Access Can Be a Matter of Life or Death*, TIME (Jan. 25, 2023), https://time.com/6248104/abortion-access-people-with-disabilities/ 22

Jennifer L. Brinkley, *Discrimination and Barriers: Abortion Access for Disabled Individuals After Dobbs*, 77 Okla. L. Rev. 53 (2024) 6

Jessica L. Gleason et al., *Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities* 1 (Dec. 15, 2021) 6, 20, 21, 22

Kavitha Surana, *Afraid to Seek Care Amid Georgia's Abortion Ban, She Stayed at Home and Died*, PROPUBLICA (Sept. 18, 2024), https://www.propublica.org/article/candi-miller-abortion-ban-death-georgia 22

Kerstin Hellwig et al., *Multiple Sclerosis Disease Activity and Disability Following Cessation of Natalizumab for Pregnancy* 11 (Jan. 24, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788309 22

Leah R Koenig, *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, JMIR PUB. HEALTH SURVEILL (July 11, 2023). 17

Lisa I. Iezzoni et al., *Mobility Impairments and Use of Screening and Preventative Services*, 90 AM. J. OF PUB. HEALTH 955, 957 (2000) 15

Lisa I. Iezzoni et al., *Prevalence of Current Pregnancy Among U.S. Women with and without Chronic Physical Disabilities*, MED CARE at 8 (Jun. 1, 2014) 21

M. Antonia Biggs et al., *Access to Reproductive Health Services Among People with Disabilities*, JAMA NETWORK OPEN, Vol. 6, No. 11 (2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812360 ..... 13, 20

Mayo Clinic, *Heart conditions and pregnancy: Know the risks* (Aug. 10, 2023), https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/pregnancy/art-20045977 22

Nancy R. Mudrick et al., *Change is Slow: Acquisition of Disability Accessible Medical Diagnostic Equipment in Primary Care Offices over Time*, HEALTH EQUITY 157, Vol. 8, No. 1 (2024) 14

Nancy R. Mudrick et al., *Physical Accessibility In Primary Health Care Settings: Results from California On-Site Reviews*, DISABILITY AND HEALTH J. 159, Vol. 5, No. 3 (2012), https://dredf.org/wp-content/uploads/2015/02/Mudrick-Breslin-Liang-Yee-DHJO-article-V5-No3-2012.pdf 14, 15

NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 1, 49-50 (2009) 14, 15, 17

NAT'L COUNCIL ON DISABILITY, ENFORCEABLE ACCESSIBLE MEDICAL EQUIPMENT STANDARDS 1, 29-32 (2021). 15

NAT'L COUNCIL ON DISABILITY, TRANSPORTATION UPDATE: WHERE WE'VE GONE AND WHAT WE'VE LEARNED 1 (2015), https://www.ncd.gov/report/transportation-update-where-weve-gone-and-what-weve-learned/; 17

Nayoung Kim et al., *Understanding Telehealth Among U.S. Adults with Disabilities: Utilization Patterns, Associated Factors, and Motivations for Utilization*, AM. J. HEALTH EDU 56, Vol. 57, No. 1 (Sep. 12, 2025). 13

Patricia J. Zettler et al., *Mifepristone, Preemption, and Public Health Federalism* 9 J.L. & Biosciences 1 (2022) 5

Rauf Melekoglu et al., *Successful Obstetric and Anaesthetic Management of a Pregnant Woman With Achondroplasia*, BMJ CASE REP. 1 (Oct. 25, 2017) 22

Rebecca Vallas et al., *Economic Justice is Disability Justice*, THE CENTURY FOUNDATION (April 21, 2022), https://tcf.org/content/report/economic-justice-disability-justice/ 18

Sima I. Patel & Page B. Pennel, *Mgmt. of Epilepsy During Pregnancy: An Update*, 9 THERAPEUTIC ADVANCES IN NEUROLOGICAL DISORDERS 118, 124 (2016) 22

Stephen Brumbaugh, *Travel Patterns of American Adults with Disabilities* 1, U.S. DEP'T OF TRANSP. (Sept. 2018), https://www.bts.gov/sites/bts.dot.gov/files/2022-01/travel-patterns-american-adults-disabilities-updated-01-03-22.pdf 16, 17, 19

SUSAN THAUL, CONG. RSCH. SERV., RL34465, FDA AMENDMENTS ACT OF 2007 1 (2010). 3

Tara Lagu et al., *Access to Subspecialty Care for Patients with Mobility Impairment: A Survey* ANNALS OF INTERNAL MED. 441, Vol. 158, No. 6 (2013), https://pubmed.ncbi.nlm.nih.gov/23552258/. 13, 14, 15

Tara Lagu et al., *'I Am Not the Doctor For You': Physicians' Attitudes About Caring For People With Disabilities*, HEALTH AFFAIRS Vol. 41, No. 10 1387, 1389–1390 (2022), https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00475 .....14, 16, 20

U.S. Dep't of Justice Civil Rights Division, *Access to Medical Care for Individuals with Mobility Disabilities*, ADA.GOV (last updated Jun. 26, 2020, https://www.ada.gov/resources/medical-care-mobility/ 14, 15

U.S. GEN. ACCT OFF., TRANSPORTATION – DISADVANTAGED POPULATIONS: SOME COORDINATION EFFORTS AMONG PROGRAMS PROVIDING TRANSPORTATION SERVICES, BUT OBSTACLES PERSIST 6 (2003), http://tinyurl.com/6zzvbtuh 16

UNH INSTITUTE ON DISABILITY, ANNUAL DISABILITY STATISTICS COMPENDIUM 2025 (2025) https://www.researchondisability.org/sites/default/files/media/2025-03/pdf-online_full-compendium-with-title-acknowledgement-pages.pdf (last visited Feb 4, 2026) 18

Whelan & Goodwin, *Abortion Rights and Disability Equality: A New Constitutional Battleground*, 79 Wash. & Lee L. Rev. 965, 997 .....5, 6

Zachary A. Morris et al., *The Extra Costs Associated with Living with a Disability in the United States*, J. OF DISABILITY POL. STUDIES Vol. 33, 158, 162 (2021), https://journals.sagepub.com/doi/10.1177/10442073211043521 18

INTEREST OF AMICI CURIAE

Amici are eight disability organizations, scholars, and others[1] dedicated to advancing the civil and human rights of people with disabilities and to ensuring their full and equal participation in society. Amici pursue these goals through legal and legislative advocacy, public policy development, education and training, and community engagement. A complete list of the Amici is attached as an appendix to this brief.

Collectively and individually, Amici have a strong interest in ensuring that people with disabilities have equitable access to health care, including care delivered through telemedicine, so that they can make autonomous decisions that protect their health and lives. People with disabilities experience substantial barriers in accessing health care: physical inaccessibility, transportation limitations, financial strain, and entrenched medical bias. This is particularly true in the context of critical reproductive health care. Telemedicine mitigates many of these barriers.

Amici are therefore deeply concerned that granting Plaintiffs' request for a preliminary injunction staying or enjoining the effectiveness of the Food and Drug Administration's 2023 Risk Evaluation and Mitigation Strategy ("REMS")—which permits dispensing of mifepristone by mail and at certified pharmacies—would foreseeably harm people with disabilities.

SUMMARY OF THE ARGUMENT

If this Court grants Plaintiffs' request for a preliminary injunction to suspend or withdraw the 2023 REMS for mifepristone and reinstate the in-person dispensing requirement, the

[1] Disability Rights Education and Defense Fund; Autistic Self Advocacy Network; Autistic Women and Nonbinary Network; New Disabled South; Women Enabled International; Robyn Powell, PhD, JD, Assistant Professor, Stetson University College of Law (in an individual capacity and not representative of the institution); Ruth Colker, Distinguished University Professor and Heck Faust Memorial Chair in Constitutional Law at Moritz College of Law, Ohio State University (in an individual capacity and not representative of the institution); Tony Coelho, former U.S. Congressman, Founder of The Coelho Center for Disability Law, Policy, and Innovation.

consequences for the disability community will be devastating. Reinstating the in-person requirement would strip people with disabilities of accessible options for obtaining essential medication, conflicting directly with federal laws that require equal access and reasonable modifications and prohibit discrimination on the basis of disability. An in-person requirement would impose undue burdens on disabled people in violation of 21 U.S.C. § 355-1(f) and would also violate Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 by erecting unnecessary barriers to care that exclude people with disabilities.

Granting Plaintiffs' requested relief would deepen the already substantial barriers disabled people face in accessing health care: physical inaccessibility, transportation limitations, financial strain, and entrenched medical bias. For many disabled people, telemedicine access to mifepristone is not mere convenience but a critical safeguard. Disabled people experience heightened rates of reproductive coercion and intimate partner violence, in part because reliance on others for daily assistance can compromise privacy and autonomy. Eliminating remote access would strip away a vital layer of safety and control.

The stakes are grave. Disabled people face elevated risks of severe pregnancy-related complications, deterioration of existing health conditions, and death during pregnancy and childbirth. For some, being forced to continue a pregnancy is life-threatening. Telemedicine acess to mifepristone is essential to safeguarding the health of disabled pregnant people. Depriving them of that access would endanger their lives, and subject some to preventable death.

Granting Plaintiffs' request would roll back years of progress and force patients into a demonstrably inaccessible system of care. Imposing a medically unnecessary in-person dispensing requirement for mifepristone would render care more difficult—or altogether impossible—for people who already face systemic barriers to accessing critical medical care. In short, even a

temporary reinstatement of the in-person dispensing requirement would cause profound and irreparable harm to pregnant people with disabilities. For these reasons, the Court should deny Plaintiffs' request for a preliminary injunction.

ARGUMENT

I. Reinstating the in-person dispensing requirement would violate federal law by imposing an undue and discriminatory barrier to care.

A. Congress prohibited REMS that unduly burden access, especially for patients with functional limitations.

Reinstating the in-person requirement in the 2023 REMS would contradict congressional intent. By removing the in-person requirement in the 2023 REMS, the Food and Drug Administration ("FDA") eliminated a barrier to reproductive care that perpetuated access inequities and harmed the disabled population. The current 2023 REMS reflects the Agency's mandate under the Food and Drug Administration Amendments Act of 2007 ("FDAAA") to strike the appropriate balance between patient safety and access to care. Reinstating such a barrier would unduly burden access to medical care for people with disabilities.

Congress enacted the FDAAA to strengthen and expand the FDA's authority over prescription drug, vaccine, and medical device regulations to ensure their safety and effectiveness.[2] From the outset, however, Congress recognized that expanded regulatory authority carried the risk of restricting patient access to necessary medications. A central concern in the enactment of the FDAAA was therefore how to balance legitimate safety objectives against the equally vital need to ensure that patients can actually obtain medically appropriate care.[3]

---

[2] SUSAN THAUL, CONG. RSCH. SERV., RL34465, FDA AMENDMENTS ACT OF 2007 1 (2010).

[3] *Id.* at 2. ("For those products requiring premarket approval, a central issue for Congress is how best to balance the need for the Agency to help speed the products it regulates to market if they are safe and effective, and correct them, or keep them from entering or staying on the market, if they are not.")

The REMS framework was Congress's solution to this problem for drugs associated with serious safety risks. The statute permits the FDA to impose additional conditions on the prescribing or dispensing of certain medications, but only to the extent necessary to ensure safe use and subject to certain other statutory constraints. Critically, Congress made clear that REMS must not function as barriers to care. Before the Senate voted to pass the FDAAA, then-Senator Tom Coburn emphasized the importance of ensuring that REMS requirements do not unnecessarily impede patient access:

> This legislation is a very delicate balancing act . . . Another new authority granted to the FDA in a REMS is possible restrictions on distribution and use. If used, this restriction has the potential to impede patient access to important therapies and therefore should not be imposed where less burdensome approaches are available. This concept of a "less burdensome approach" is an important one and it is essential that product manufacturers have the opportunity to present alternative proposals to the Agency that would accomplish the goal of safety without imposing unduly restrictive actions to products and ultimately to patients.[4]

Consistent with these concerns, Congress directed that REMS strike the appropriate balance: allowing the FDA to impose additional safety measures where necessary, while ensuring that patients retain access to medications that can be used safely.[5] To that end, the statute expressly prohibits REMS requirements that are "unduly burdensome on patient access to the drug," requiring the FDA to "consider[] in particular the impact on: (i) patients with serious or life-threatening diseases or conditions; and (ii) patients who have difficulty accessing health care (such as those patients in rural or medically underserved areas."[6]

---

4 153 CONG. REC. S11831, S11839-40 (daily ed. Sep. 20, 2007) (statement of Sen. Coburn).

5 *See* 21 U.S.C. § 355-1(f).

6 21 U.S.C. § 355-1(f)(2)(C)(i)–(ii).

In 2018, Congress further strengthened these protections by amending the FDAAA to require explicit consideration of the burdens REMS impose on "patients with functional limitations."[7] This amendment reflects Congress's recognition that people with disabilities face distinct and often compounding barriers to accessing health care, and that regulatory requirements can create significant obstacles for disabled patients.

In lifting the in-person dispensing requirement for mifepristone in 2023, the FDA considered the burdens this restriction imposed on patients and the health care system in alignment with congressional intent.[8] This update came in part as a response to the considerable actions of health care providers and non-profit organizations who emphasized the burdensome nature of the in-person dispensing requirement in letters to the FDA and litigation against the Agency.[9]

Although these regulatory changes were not made exclusively with disabled patients in mind, the removal of structural barriers to reproductive care has nonetheless broadened access for this population.[10] These changes align with the academic literature in which scholars stress the barriers that in-person requirements create for disabled patients.[11] For example, physical and

---

7 21 U.S.C. § 355-1(f)(2)(C)(iii), as amended by Pub. L. No. 115-271, tit. III, § 3032(b).

8 Center for Drug Evaluation and Research, Application Numbers: 020687 and 91178 Rationale Review, No. 6:25-CV-01491, ECF No. 1-50, at 18–19.

9 *See Purcell v. Kennedy*, 2025 WL 3101785 at *4 (D. Haw. Oct. 30, 2025) (quoting letter to FDA from physician and two nonprofit organizations stating that in-person requirement negatively impacts public health and access to care); *Am. Coll. of Obstetricians & Gynecologists v. United States Food & Drug Admin.*, 472 F. Supp. 3d 183 (D. Md. 2020) (plaintiffs argue that maintaining the in-person requirement amidst the Covid-19 pandemic incurs needless and burdensome risk for patients).

10 Allison M. Whelan & Michele Goodwin, *Abortion Rights and Disability Equality: A New Constitutional Battleground*, 79 Wash. & Lee L. Rev. 965 (2022).

11 *See, e.g.,* Patricia J. Zettler et al., *Mifepristone, Preemption, and Public Health Federalism*, 9 J.L. & Biosciences 1 (2022); Whelan & Goodwin, *Abortion Rights and Disability Equality: A New Constitutional Battleground*, 79 Wash. & Lee L. Rev. 965, 997.

logistical obstacles to finding accessible clinics and arranging transportation pose particular dangers in this context due to the unique time sensitivity of reproductive care.[12]

These mobility and transportation barriers—along with other obstacles imposed by an in-person requirement—compound the challenges already facing disabled patients, who encounter significant barriers in accessing effective medical care and historically have worse health outcomes than patients without disabilities. Disabled women experience substantially higher rates of complications during pregnancy, and women with intellectual and developmental disabilities face a significantly increased likelihood of preterm deliveries, low birth weight infants, and stillbirths.[13] Moreover, disabled individuals are more than twice as likely to skip medical appointments or delay healthcare due to their unique financial constraints.[14] These constraints include that households with caregivers for disabled persons who cannot work require 28% greater income to maintain the same standard of living as households without a disabled member, and that the poverty rate among disabled individuals between the ages of eighteen and sixty-four is 25%.[15] Patient access was a central concern for Congress in enacting the REMS program and the FDA honored that priority in lifting the in-person dispensation requirement. Reinstating in-person requirements would contravene both congressional and agency intent by exacerbating existing barriers and actively

---

12 Whelan & Goodwin, *Abortion Rights and Disability Equality: A New Constitutional Battleground*, 79 Wash. & Lee L. Rev. 965, 997.

13 Jessica L. Gleason et. al., *Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities* 1 (Dec. 15, 2021), [hereinafter Gleason, *Risk of Adverse Maternal Outcomes*], (finding that women with disabilities had a higher risk of gestational diabetes, placenta previa, premature rupture of membranes, preterm premature rupture of membranes, and postpartum fever as well as maternal death); Jennifer L. Brinkley, *Discrimination and Barriers: Abortion Access for Disabled Individuals After Dobbs*, 77 Okla. L. Rev. 53 (2024) (citing Ilhom Akobirshoev et al., *Birth Outcomes Among US Women with Intellectual and Developmental Disabilities*, 10 Disability Health J. 406, 408 (2017)).

14 Brinkley, *Discrimination and Barriers*, 77 Okla. L. Rev. 53, 76 (2024).

15 *Id.*

imposing additional barriers to patient access, effectively undermining the Agency's mandate to measure both patient safety and access to care.

B. Federal disability law requires the provision of equal access and reasonable modification.

Reinstating, even briefly, an in-person requirement would run afoul of the precedent of the Fifth Circuit and its sister circuits, which have consistently interpreted Section 504 of the Rehabilitation Act ("Section 504") and the Americans with Disabilities Act ("ADA") to require meaningful, practical access to programs and services like health care—meaning that health care providers must provide disabled individuals equal access and "*equal opportunity* to obtain the same result [or] to gain the same benefit" as nondisabled individuals[16]

Congress enacted Section 504 of the Rehabilitation Act of 1973 to prohibit discrimination on the basis of disability in programs or activities receiving federal financial assistance, including virtually all public and private health care systems.[17] Building on Section 504's foundational protections, Congress then enacted the ADA in 1990, expressly recognizing that "discrimination against individuals with disabilities persists in such critical areas as . . . health services."[18] While

---

16 *See, e.g.*, *United States v. Baylor Univ. Med. Ctr.*, 736 F.2d 1039, 1049 (5th Cir. 1984) (holding that Medicare and Medicaid payments subject a hospital to the coverage of Section 504 of the Rehabilitation Act); *Frame v. City of Arlington*, 657 F.3d 215, 225 (5th Cir. 2011) (en banc) (reinforcing that the Fifth Circuit "interpret[s] Title II and the Rehabilitation Act *in pari materia*"); *Francois v. Our Lady of the Lake Hosp., Inc.*, 8 F.4th 370, 377 (5th Cir. 2021) (quoting 45 C.F.R. § 84.4(b)(2)) (reaffirming that health care providers receiving federal funds must provide disabled individuals "*equal opportunity* to obtain the same result, to gain the same benefit, or to reach the same level of achievement"); *King v. Our Lady of the Lake Hosp., Inc.*, 455 F. Supp. 3d 249, 255 (M.D. La. 2020) (noting that "the ADA and the RA both focus on the equal opportunity to participate in, or benefit from, the defendant's [health care] goods and services"); *Luke v. Texas*, 46 F.4th 301, 306 (5th Cir. 2022) (finding that failure to provide a deaf inmate an interpreter for court proceedings constituted a "lack of meaningful access to . . . public services" in violation of Title II).

17 29 U.S.C. § 794.

18 42 U.S.C. § 12101(a)(3).

the ADA applies more broadly to health care providers and pharmacies charged with dispensing mifepristone, the FDA itself is subject only to Section 504 as a federal agency.

Congress enacted the ADA to ensure that people with disabilities can access and use health care services on equal terms, and it imposed affirmative obligations on public and private actors to prevent exclusion, denial of benefits, or discrimination in health care. Title II of the ADA prohibits disability discrimination by public entities, regardless of whether those entities receive federal funding.[19] Title III prohibits discrimination by places of public accommodation, including the "professional office of a health care provider, hospital, or other service establishment."[20]

The Fifth Circuit and its district courts have recognized that federal disability laws prohibit policies and practices that operate to deny equal opportunity or equal access to people with disabilities, and require reasonable accommodations to mitigate barriers caused by such policies and practices.[21] In *Frame v. City of Arlington*, the en banc Fifth Circuit Court confirmed that Title II prohibits a city from deciding to build or alter a sidewalk in a manner inaccessible to individuals with disabilities, and found this prohibition congruent with the obligation to provide reasonable accommodation.[22] In doing so, the Fifth Circuit reviewed Congress's findings and purposes, and

---

19 42 U.S.C. § 12132.

20 42 U.S.C. §§ 12182(a), 12181(7)(F).

21 *See Delano-Pyle v. Victoria Cnty., Tex.*, 302 F.3d 567, 575 (5th Cir. 2002) (quoting *Rosen v. Montgomery Cnty. Md.*, 121 F.3d 154 (4th. Cir. 1997)) (agreeing with "our sister circuit [the Fourth Circuit that] . . . [t]he ADA expressly provides that a disabled person is discriminated against when an entity fails to '*take such steps as may be necessary* to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently than other individuals because of the absence of auxiliary aids and services'"); *see also Frame*, 657 F.3d at 236 ("[W]hen a city decides to build or alter a sidewalk and makes that sidewalk inaccessible to individuals with disabilities without adequate justification, the city discriminates in violation of Title II.").

22 657 F.3d at 231–33; *see also Clark v. La., Dep't of Pub. Safety*, 63 F.4th 466, 470 (clarifying that "Section 504 of the Rehabilitation Act prohibits disability discrimination by recipients of federal funding").

concluded that "[c]ontinuing to build inaccessible sidewalks without adequate justification would unnecessarily entrench the types of discrimination Title II was designed to prohibit."[23]

The Fifth Circuit has endorsed and enforced the ADA's reasonable-modification mandate and its commitment to removing barriers in the delivery of services, which is central to ensuring equal access to health care.[24] To satisfy this requirement under Fifth Circuit precedent, covered entities must modify policies, practices, or procedures when necessary to avoid discrimination, unless the entity can demonstrate that the modification would fundamentally alter the nature of the service.[25] Simply put, the Fifth Circuit has held that where an entity could easily eliminate obvious barriers to access, it must do so to fulfill the statutory reasonable-modification mandate.[26] The Fifth Circuit's rigorous application of the reasonable-modification and effective-communication requirements ensures that people with disabilities in the states over which the Fifth Circuit presides enjoy the full measure of protection that Congress intended.

The Supreme Court has confirmed that the ADA imposes affirmative obligations on covered entities to ensure equal access and reasonable modifications,[27] and sister circuits have uniformly held that the reasonable-modification requirement and its narrow defenses apply with

---

23 *Id*. at 230.

24 *See Frame*, 657 F.3d at 231–33; *see also Block v. Tex. Bd. of Law Exam'rs*, 952 F.3d 613, 618 (5th Cir. 2020) (affirming that Title II requires reasonable modifications for access to public programs).

25 *See, e.g., Johnson v. Gambrinus Co./Spoetzl Brewery*, 116 F.3d 1052, 1058 (5th Cir. 1997) (quoting Title III for the premise that failure to make "reasonable modifications" to policies is discrimination unless such modifications "would fundamentally alter the nature of such goods, services, facilities, privileges, advantages, or accommodations").

26 *See id.*

27 *See Tennessee v. Lane*, 541 U.S. 509, 533 (2004) (holding that "Title II's affirmative obligation to accommodate persons with disabilities . . . [is] a reasonable prophylactic measure, reasonably targeted to a legitimate end.").

full force in health care settings.[28] Taken together, this body of law establishes that, within this circuit and beyond, disabled individuals possess robust legal protections ensuring equitable access to health care, and that this circuit will ultimately hold covered entities accountable for failures to provide reasonable accommodations absent a showing of undue burden or fundamental alteration.

In enacting the ADA, Congress expressly identified specific barriers that impede access to health care for people with disabilities and directed covered entities to address such barriers. These barriers include architectural, transportation, and communication obstacles, rigid or overprotective rules and policies, and the failure to modify existing facilities and practices to accommodate disability-related needs.[29] To carry out this intent, the ADA requires covered entities to make reasonable modifications to policies, practices, and procedures, and to remove or mitigate such barriers when necessary to ensure access to health care, unless doing so would fundamentally alter the nature of the service or impose an undue burden.[30]

The legal framework established by Congress in Section 504 and the ADA, as interpreted by the Supreme Court and uniformly applied by the Fifth Circuit and its sister circuits, compels only one conclusion: Reinstating an in-person requirement, even temporarily, would contravene federal disability law. Such a mandate would erect precisely the type of rigid, exclusionary barrier that Congress sought to eliminate and that courts have consistently held unlawful. Where, as here, reasonable modifications exist that would preserve meaningful access to health care for individuals

---

28 *See, e.g., Henrietta D. v. Bloomberg*, 331 F.3d 261, 273–76 (2d Cir. 2003) (applying meaningful-access standard to public health benefits); *Barden v. City of Sacramento*, 292 F.3d 1073, 1076 (9th Cir. 2002) (emphasizing program-level accessibility); *Liese v. Indian River Cnty. Hosp. Dist.*, 701 F.3d 334, 342–45 (11th Cir. 2012) (addressing effective-communication obligations in hospitals).

29 42 U.S.C. § 12101(a)(5).

30 *See* 42 U.S.C. § 12182(b)(2)(A)(ii); 28 C.F.R. § 35.130(b)(7)(i); 28 C.F.R. § 36.302(a).

with disabilities without fundamentally altering the nature of the services provided, the law demands accommodation rather than exclusion.

C. An in-person dispensing mandate is an unlawful structural barrier under both frameworks.

Reinstating an in-person dispensing requirement for mifepristone would operate as a structural barrier to care that violates both the FDAAA's prohibition on unduly burdensome REMS and federal disability nondiscrimination law. Although framed as a neutral condition on access to a medication, an in-person mandate would predictably exclude people with disabilities from obtaining care. Both statutory frameworks prohibit precisely this type of barrier.

Under the FDAAA, the FDA may impose elements to assure safe use only to the extent necessary to mitigate identified safety risks, and it must ensure that such elements are not "unduly burdensome on patient access to the drug."[31] Congress specifically directed the Agency to consider the impact of REMS on patients with serious or life-threatening conditions, patients in medically underserved areas, and—following the 2018 amendment—patients with functional limitations. An in-person dispensing requirement that forecloses access to mifepristone by mail and at pharmacies, despite substantial evidence that the medication can be used safely without such a restriction, would impose exactly the kind of unnecessary access barrier Congress sought to prevent. Where a less burdensome alternative exists that achieves the Agency's safety objectives—as telemedicine does here—reinstating an in-person mandate contravenes the statute's express command.

Federal disability law prohibits unnecessary barriers that deny people with disabilities equal access to health care. Congress recognized this denial often results from indifference to

[31] 21 U.S.C. § 355-1(f)(2)(C).

predictable burdens,[32] and that architectural, transportation, communication, and policy-based barriers function as mechanisms of discrimination.

An in-person dispensing mandate imposed without medical necessity would re-entrench those very barriers by conditioning access to essential medication on physical presence in clinical settings that many disabled people cannot safely, affordably, or privately navigate. When a regulation foreseeably deprives people with disabilities of timely access to medically necessary care—despite the availability of a safe and less burdensome alternative—it violates this statutory balance that Congress struck.

Disability discrimination frequently operates when covered entities fail to provide accommodations that meet the realities of disabled people's lives. A blanket in-person requirement, regardless of disability status, transportation access, caregiving needs, financial constraints, or medical risk, disregards the duty to ensure equal access and provide reasonable modifications. Telemedicine is precisely the type of effective modification that mitigates structural barriers and enables equal participation in health care. Eliminating that pathway without a safety-based justification would turn a neutral policy into a mechanism of exclusion.

Reinstating the in-person dispensing requirement would therefore not merely alter the method by which mifepristone is obtained. It would reimpose a structural barrier that Congress has expressly instructed federal agencies and regulated entities to avoid: a medically unnecessary condition that impedes access for patients with functional limitations and denies disabled people

[32] *See, e.g., Alexander v. Choate*, 469 U.S. 287, 295 (1985) (recognizing that, in passing Section 504, "[d]iscrimination against the handicapped was perceived by Congress to be most often the product, not of invidious animus, but rather of thoughtlessness and indifference—of benign neglect"); *Frame v. City of Arlington*, 657 F.3d 215, 230–31 (5th Cir. 2011).

equal access to care. Under both the FDAAA and federal disability nondiscrimination law, such a barrier is unlawful.

II. Reinstating the in-person dispensing requirement for mifepristone would exclude people with disabilities from equal access to reproductive health care.

Telemedicine has fundamentally expanded access to health care for people with disabilities, who face significant barriers to reproductive health care.[33] A 2025 study found that 44.5% of people with disabilities used telemedicine in the prior year, most often for accessibility.[34] That reliance reflects necessity, not preference: Disabled people routinely confront inaccessible health care facilities and equipment, inaccessible transportation, logistical hurdles such as arranging personal assistance, financial constraints, and persistent provider bias. These barriers collectively result in delayed, foregone, or wholly denied care.

Against this backdrop, telemedicine is not just a nice alternative; it is a critical means of ensuring timely, accessible, and medically necessary services for people with disabilities.[35] By reducing or eliminating barriers that routinely prevent disabled people from accessing in-person care, telemedicine directly advances equal access to health care. Reinstating an in-person dispensing requirement would undo these gains, allowing entrenched access barriers to persist and excluding many disabled people from care.

---

[33] *See* M. Antonia Biggs et al., *Access to Reproductive Health Services Among People with Disabilities*, JAMA NETWORK OPEN, Vol. 6, No. 11 (2023) (reporting that 69% of respondents with disabilities experienced barriers to accessing reproductive health care) [hereinafter Biggs, *Access to Reproductive Health*], https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812360; *see also* Tara Lagu et al., *Access to Subspecialty Care for Patients with Mobility Impairment: A Survey*, ANNALS OF INTERNAL MED. 441, Vol. 158, No. 6 (2013) (finding that 44% of gynecology practices that were surveyed could not accommodate a patient with a mobility disability) [hereinafter Lagu, *Access to Subspecialty Care*], https://pubmed.ncbi.nlm.nih.gov/23552258/.

[34] Nayoung Kim et al., *Understanding Telehealth Among U.S. Adults with Disabilities: Utilization Patterns, Associated Factors, and Motivations for Utilization*, AM. J. HEALTH EDU 56, Vol. 57, No. 1 (Sep. 12, 2025).

[35] *See* Biggs, *Access to Reproductive Health*, *supra* note 32, at 10.

A. Telemedicine mitigates pervasive physical barriers to in-person care, including inaccessible facilities and medical equipment.

Physical barriers remain a central obstacle to health care access for people with disabilities,[36] despite long-standing legal obligations[37] requiring providers to ensure accessibility.[38] Inaccessible medical buildings, exam rooms, and equipment often result in outright denials of care.

Empirical evidence confirms the pervasiveness of these barriers. In one recent study surveying physicians about their treatment of patients with disabilities, every respondent acknowledged that their practice contained physical barriers to care, including inaccessible facilities or equipment.[39] One study inspecting 2,389 primary care offices found that only 53% met all exterior access criteria, 56% met entrance and interior public-area criteria, and just 34.3% met interior office and restroom accessibility standards.[40]

Inaccessible medical equipment is an equally significant barrier, particularly for people

---

36 *See* NAT'L COUNCIL ON DISABILITY, THE CURRENT STATE OF HEALTH CARE FOR PEOPLE WITH DISABILITIES 1, 49–50 (2009) [hereinafter NCD, CURRENT STATE OF HEALTH CARE]; Tara Lagu et al., *'I Am Not the Doctor For You': Physicians' Attitudes About Caring For People With Disabilities*, HEALTH AFFAIRS Vol. 41, No. 10 1387, 1389–1390 (2022) [hereinafter Lagu, *Not the Doctor for You*], https://www.healthaffairs.org/doi/10.1377/hlthaff.2022.00475; Nancy R. Mudrick et al., *Physical Accessibility In Primary Health Care Settings: Results from California On-Site Reviews*, DISABILITY AND HEALTH J. 159, Vol. 5, No. 3 (2012) [hereinafter Mudrick, *Physical Accessibility in Primary Settings*], https://dredf.org/wp-content/uploads/2015/02/Mudrick-Breslin-Liang-Yee-DHJO-article-V5-No3-2012.pdf; Nancy R. Mudrick et al., *Change is Slow: Acquisition of Disability Accessible Medical Diagnostic Equipment in Primary Care Offices over Time*, HEALTH EQUITY 157, Vol. 8, No. 1 (2024); Lagu, *Access to Subspecialty Care supra* note 32, at 443.

37 42 U.S.C. § 12182(a), (b); 42 U.S.C. § 12132; 29 U.S.C. § 794(a); 28 C.F.R. §39.150(b).

38 *See* U.S. Dep't of Justice Civil Rights Division, *Access to Medical Care for Individuals with Mobility Disabilities*, ADA.GOV (last updated Jun. 26, 2020) [hereinafter DOJ, *Access to Medical Care*], https://www.ada.gov/resources/medical-care-mobility/ (summarizing U.S. DEP'T OF JUST., ADA STANDARDS FOR ACCESSIBLE DESIGN, (Sept. 15, 2010)).

39 *See* Lagu, *Not the Doctor for You*, *supra* note 35, at 1389.

40 *See* Mudrick, *Physical Accessibility in Primary Settings supra* note 35, at 163–64.

with mobility disabilities.[41] Adjustable-height exam tables, accessible weight scales, and accessible diagnostic equipment are essential to providing safe and equitable care.[42] Yet access to such equipment remains rare. One study specifically found that only 8.4% of primary care offices had an adjustable-height exam table and only 3.6% had an accessible weight scale.[43] A separate study of subspecialty practices found that gynecology offices reported the highest rates of inaccessibility—44%—primarily due to inaccessible equipment.[44] Unsurprisingly, women with mobility disabilities are significantly less likely than nondisabled women to receive preventive services such as Pap smears or mammograms, a disparity that researchers attribute to equipment inaccessibility.[45]

Although the U.S. Access Board issued Standards for Accessible Medical Diagnostic Equipment in 2017, the Department of Health and Human Services ("HHS") did not codify those standards until 2024, and providers are not required to have even a single accessible exam table until July 2026.[46] The historical lack of enforceable regulations governing the accessibility of medical equipment means that medical providers are uninformed of their legal obligations and do not own or know how to use accessible medical equipment. This prolonged regulatory gap has left

---

41 *See* NCD, CURRENT STATE OF HEALTH CARE, *supra* note 35, at 49–50; *see also* NAT'L COUNCIL ON DISABILITY, ENFORCEABLE ACCESSIBLE MEDICAL EQUIPMENT STANDARDS 1, 29–32 (2021).

42 *See* DOJ, *Access to Medical Care*, *supra* note 37 (adjustable height exam tables allow wheelchair users to independently transfer onto an exam table without the risk of injury posed by assisted transfer and include features that support the person once on the table; accessible weight scales allow a wheelchair user to wheel their chair onto the scale and be weighed in their chair; and accessible diagnostic machines are designed to accommodate different types of body positions or allow a wheelchair user to utilize the machine while in their chair).

43 Mudrick, *Physical Accessibility in Primary Settings*, *supra* note 35, at 164.

44 *See* Lagu, *Access to Subspecialty Care*, *supra* note 32, at 444.

45 *See* Lisa I. Iezzoni et al., *Mobility Impairments and Use of Screening and Preventative Services*, 90 AM. J. OF PUB. HEALTH 955, 957 (2000), https://ajph.aphapublications.org/doi/pdf/10.2105/AJPH.90.6.955.

46 89 Fed. Reg. 40066, 40165 (May 9, 2024) (codified at 45 C.F.R. § 84.90 et seq.).

many providers unprepared and unequipped to serve disabled patients. Some physicians have reported sending wheelchair users to grocery stores, zoos, or industrial facilities to obtain a weight measurement[47]—experiences that are not only degrading but powerfully deterrent. These realities cause disabled people to delay or avoid health care altogether.

The 2023 REMS for mifepristone allows disabled patients to avoid these pervasive physical and equipment-related barriers by accessing certain reproductive care through telemedicine and then filling their prescription by mail or at a local pharmacy. Reinstating the in-person dispensing requirement would eliminate this accessible alternative, forcing disabled people back into an environment where barriers predictably prevent or deter care.

B. Telemedicine alleviates transportation and logistical barriers that exclude disabled people from care.

Transportation barriers alone prevent millions of disabled people from accessing health care. In the United States, approximately 25.5 million people have disabilities that make travel difficult, and 3.6 million people do not leave their homes at all.[48] Nearly 30% report difficulty accessing transportation.[49] Disabled people between the ages of eighteen and sixty-four are less likely to own or drive a vehicle[50] and more likely to rely on public transit or paratransit systems that are unreliable, inaccessible, or unavailable.[51] These transportation barriers critically impact

---

47 *See* Lagu, *Not the Doctor for You*, *supra* note 35, at 1389.

48 Stephen Brumbaugh, *Travel Patterns of American Adults with Disabilities* 1, U.S. DEP'T OF TRANSP. (Sept. 2018), https://www.bts.gov/sites/bts.dot.gov/files/2022-01/travel-patterns-american-adults-disabilities-updated-01-03-22.pdf [hereinafter Brumbaugh, *Travel Patterns*].

49 U.S. GEN. ACCT OFF., TRANSPORTATION – DISADVANTAGED POPULATIONS: SOME COORDINATION EFFORTS AMONG PROGRAMS PROVIDING TRANSPORTATION SERVICES, BUT OBSTACLES PERSIST 6 (2003), http://tinyurl.com/6zzvbtuh.

50 Brumbaugh, *Travel Patterns*, *supra* note 47, at 3.

51 NCD, CURRENT STATE OF HEALTH CARE, *supra* note 35, at 56, 77 (common transportation barriers for disabled people include "lack of public transportation in suburban and rural areas, difficulty scheduling rides, and difficulty relying on paratransit to get to appointments on time").

disabled people's ability to access timely reproductive health care, including the prescription of mifepristone.[52]

Despite decades of ADA requirements, public transportation remains widely inaccessible. Many systems still fail to accommodate wheelchairs and other mobility aids, impose barriers on riders with service animals, and lack effective communication access.[53] As recently as 2019, 20% of U.S. public transit stops did not meet accessibility standards.[54]

These transportation and logistical burdens are not incidental—they are often determinative. Telemedicine is a critical tool for overcoming these barriers and ensuring equal access to reproductive care.[55]

Reinstating the in-person dispensing requirement would reintroduce transportation and logistical barriers that federal disability law forbids and that the 2023 REMS effectively mitigates. Preserving access to mifepristone by mail is therefore essential to preventing disability-based exclusion and ensuring equal access to care.

---

52 *Id. See also* Brumbaugh, *Travel Patterns*, *supra* note 47, at 6.

53 *See* NAT'L COUNCIL ON DISABILITY, TRANSPORTATION UPDATE: WHERE WE'VE GONE AND WHAT WE'VE LEARNED 1, 122, 175, 196, and 201–02 (2015), https://www.ncd.gov/report/transportation-update-where-weve-gone-and-what-weve-learned/; *see also*, Erica Twardzik et al., *Transit Accessibility Tool (TRACT): Developing a novel scoring system for public transportation system accessibility*, 34 J. TRANSPORT & HEALTH (Jan 2024), https://www.sciencedirect.com/science/article/pii/S2214140523001780. Paratransit presents its own host of problems for disabled travelers, including capacity constraints, untimely services, long telephone holds, and even ride denials. NCD, TRANSPORTATION UPDATE at 73.

54 The Disability Network Southwest Michigan, *A Lack of Accessible Public Transportation Creates Isolation* (May 2, 2022), https://www.dnswm.org/a-lack-of-accessible-public-transportation-creates-isolation/.

55 *See* Leah R Koenig, *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, JMIR PUB. HEALTH SURVEILL (July 11, 2023).

C. Telemedicine reduces financial barriers that prevent people with disabilities from accessing care.

People with disabilities experience profound and compounding financial barriers to accessing health care. They are more than twice as likely to live in poverty, significantly more likely to be unemployed, and face substantially higher costs of living due to disability-related expenses. Working-age adults with disabilities have a median adjusted income nearly $10,000 lower than nondisabled adults, [56] while households with a disabled adult incur an average of $18,322 per year in additional disability-related costs.[57] Single adults with disabilities require approximately 37% more income than nondisabled peers to meet basic living expenses, and disability is associated with a 65% increase in out-of-pocket health care spending.[58]

Telemedicine and access to mifepristone by mail mitigates these financial burdens by reducing travel costs, time off work, child and attendant care expenses, and the likelihood of needing more expensive procedural care due to delays. Reinstating the in-person dispensing requirement would revive these barriers—resulting not in theoretical inconvenience, but in the practical impossibility of disabled people obtaining equal access to a critical medication.

---

56 UNH INSTITUTE ON DISABILITY, ANNUAL DISABILITY STATISTICS COMPENDIUM 2025, at 1 (2025) https://www.researchondisability.org/sites/default/files/media/2025-03/pdf-online_full-compendium-with-title-acknowledgement-pages.pdf (last visited Feb 4, 2026).

57 Zachary A. Morris et al., *The Extra Costs Associated with Living with a Disability in the United States*, J. OF DISABILITY POL. STUDIES Vol. 33, 158, 162 (2021), https://journals.sagepub.com/doi/10.1177/10442073211043521.

58 *Id. See also* Rebecca Vallas et al., *Economic Justice is Disability Justice*, THE CENTURY FOUNDATION (April 21, 2022) (identifying durable medical equipment, personal attendant care, direct service providers, home modifications, assistive technology, food for medically directed diets, and special clothing, as frequent and common out-of-pocket expenses), https://tcf.org/content/report/economic-justice-disability-justice/.

D. Telemedicine protects the privacy, safety, and medical independence of people with disabilities by reducing exposure to third-party coercion and abuse.

Telemedicine access to mifepristone safeguards the health care privacy and reproductive autonomy of pregnant people with disabilities. Because many disabled people face significant transportation and logistical barriers, they often must rely on others to attend in-person medical appointments.[59] In the context of reproductive care, this reliance can force disclosure of deeply private medical decisions and expose disabled people to interference, pressure, or retaliation—turning in-person requirements from logistical hurdles into threats to autonomy.[60]

Telemedicine and mail dispensing mitigate these harms by allowing disabled people to obtain care privately, without having to disclose to and rely on third parties and risk coercion. Reinstating the in-person dispensing requirement would strip away this critical protection.

E. Telemedicine reduces exposure to discrimination and medical mistreatment that deter people with disabilities from seeking care.

People with disabilities face widespread discrimination and mistreatment in reproductive health care settings, as well as heightened medical risk during pregnancy. These realities—combined with structural access barriers—can make it extraordinarily difficult for disabled people to seek and receive necessary care.[61] Reinstating an in-person dispensing requirement would exacerbate these harms by forcing disabled people into medical environments where discrimination and mistreatment remain pervasive.

It is disturbingly common for people with disabilities to report receiving fair or poor-quality care from their regular physicians and to experience medical mistreatment when seeking

---

59 *See* Brumbaugh, *Travel Patterns*, *supra* note 47, at 9.

60 *Id*.

61 CDC, *Disability Barriers to Inclusion*, https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html (accessed Jan. 12, 2024).

reproductive health services.[62] Physicians are often ill-equipped to provide disability-competent reproductive care and fail to dedicate the resources necessary to understand disability-related pregnancy risks.[63] Nearly half of disabled people report mistreatment in reproductive health care settings, including ridicule or humiliation by providers, dismissal of symptoms, or minimization of health concerns.[64] Consistent with these experiences, disabled adults are almost twice as likely to report unmet health care needs due to barriers to accessing care,[65] and women with disabilities frequently report negative or dismissive reactions from health care providers in response to their pregnancies.[66]

Physicians themselves acknowledge these deficiencies. Studies document a lack of education at all levels of medical training regarding pregnancy and disability, as well as explicit bias against disabled patients.[67] Some providers report attempting to discharge disabled patients from their practices due to concerns about accommodating disabilities, insufficient reimbursement, or staff time constraints.[68] These attitudes directly affect clinical decision-making and patient treatment, resulting in delayed care, substandard care, or outright denial of services.[69]

---

62 Biggs, *Access to Reproductive Health*, *supra* note 32, at 6.

63 Autistic Self Advocacy Network, *Access, Autonomy & Dignity: People with Disabilities and the Right to Parent* at 9 (Sept. 2021), [hereinafter ASAN, *Right to Parent*], https://nationalpartnership.org/wp-content/uploads/2023/02/repro-disability-parenting.pdf.

64 Biggs, *Access to Reproductive Health*, *supra* note 32, at 6 (36.5% reported medical mistreatment generally; 19.4% reported being ridiculed or humiliated; and 32.6% reported being made to feel like their symptoms were not real or important).

65 ASAN, *Right to Parent*, *supra* note 62.

66 Gleason, *Risk of Adverse Maternal Outcomes*, *supra* note 12, at 8; *see also* ASAN, *Right to Parent*, *supra* note 62, at 8.

67 Gleason, *Risk of Adverse Maternal Outcomes*, *supra* note 12, at 8.

68 Lagu, *Not the Doctor for You, supra* note 35, at 1392–93.

69 *See, e.g.,* Gleason, *Risk of Adverse Maternal Outcomes*, *supra* note 12, at 9.

Telemedicine and dispensing by mail can reduce exposure to these discriminatory dynamics by allowing patients to access care in a setting that is more private, controlled, and—critically—less likely to subject them to bias based on visible disability. In many telemedicine encounters, a patient's disability may not be apparent or relevant to the provision of care. Reinstating the in-person dispensing requirement would needlessly re-expose disabled people to discriminatory medical environments, compounding their risk of harm and deterring them from seeking care altogether.

III. Telemedicine access to mifepristone is essential, life-preserving health care for people with disabilities who face elevated risks of complications, including death.

Mifepristone can be essential—and in many cases life-saving—health care for people with disabilities. Disabled people are just as likely as nondisabled people to become pregnant, yet they face dramatically higher risks of severe pregnancy-related complications and mortality.[70] Pregnant people with physical, intellectual, and sensory disabilities experience significantly higher rates of nearly all adverse maternal outcomes and are approximately eleven times more likely to die during childbirth than nondisabled people.[71]

Pregnant people with disabilities are also far more likely to experience life-threatening complications, including sepsis, thromboembolism, severe cardiovascular events, infection, and hemorrhage—one of the leading causes of maternal mortality.[72] Certain disabilities, including

---

70 Lisa I. Iezzoni et al., *Prevalence of Current Pregnancy Among U.S. Women with and without Chronic Physical Disabilities*, MED CARE at 8 (Jun. 1, 2014) (People with disabilities become pregnant at similar rates as people without disabilities); Gleason, *Risk of Adverse Maternal Outcomes*, *supra* note 12, at 2, 4–7 (People with disabilities are at higher risk for pregnancy/birth complications and death).

71 Gleason, *Risk of Adverse Maternal Outcomes*, *supra* note 12, at 2, 4–7.

72 *Id*.

epilepsy, diabetes, and achondroplasia, are associated with particularly elevated pregnancy risks.[73] Pregnancy may also exacerbate existing disabilities or require discontinuation of medications essential to managing conditions such as multiple sclerosis or bipolar disorder, leading to serious and avoidable health consequences.[74]

These medical risks do not exist in isolation. They are compounded by the systemic barriers to health care access that disabled people routinely face. Delays in care caused by transportation barriers, inaccessible facilities, financial constraints, or provider bias can turn manageable medical conditions into life-threatening emergencies. For some disabled people, timely access to abortion is the only way to prevent catastrophic harm or death.[75]

---

[73] *See* Sima I. Patel & Page B. Pennel, *Mgmt. of Epilepsy During Pregnancy: An Update*, 9 THERAPEUTIC ADVANCES IN NEUROLOGICAL DISORDERS 118, 124 (2016) (showing people with epilepsy may be at higher risk of death, preeclampsia, premature rupture of membranes (PPROM), and chorioamnionitis (an infection of the placenta and the amniotic fluid) during pregnancy); Am. Diabetes Ass'n., *Standards of Care in Diabetes—2023 Abridged for Primary Care Providers*, 41 DIABETES J. 4, 28 (2022) (people with diabetes may be more likely to face complications including preeclampsia and miscarriage); Rauf Melekoglu et al., *Successful Obstetric and Anaesthetic Management of a Pregnant Woman With Achondroplasia*, BMJ CASE REP. 1 (Oct. 25, 2017) (People with achondroplasia, the most common type of dwarfism, may face a higher risk of cardiac abnormalities, recurrent respiratory infections, complications involving anesthetics, increased caesarean delivery rates, and preterm birth).

[74] *See, e.g.*, Kerstin Hellwig et al., *Multiple Sclerosis Disease Activity and Disability Following Cessation of Natalizumab for Pregnancy* 11 (Jan. 24, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788309 (finding that ceasing treatment of Natalizumab (a highly effective and frequently prescribed treatment for multiple sclerosis) directly before or during pregnancy resulted in MS relapses during pregnancy or postpartum which were potentially life-threatening in one percent of the pregnancies); Adele C. Viguera et al., *Risk of recurrence in women with bipolar disorder during pregnancy: prospective study of mood stabilizer discontinuation*, AM. J. PSYCHIATRY 1817, 1818–21 (2007) (finding that pregnant women with bipolar disorder were significantly more likely to experience at least one mood episode when they had discontinued treatment with mood stabilizers (85.5%) than those who maintained treatment (37.0%)); *see also* Mayo Clinic, *Heart conditions and pregnancy: Know the risks*, (Aug. 10, 2023), https://www.mayoclinic.org/healthy-lifestyle/pregnancy-week-by-week/in-depth/pregnancy/art-20045977.

[75] Kavitha Surana, *Afraid to Seek Care Amid Georgia's Abortion Ban, She Stayed at Home and Died*, PROPUBLICA (Sept. 18, 2024) (woman with lupus and diabetes died because she was forced to order abortion pills online after Georgia abortion ban prevented her from getting legitimate prescription), https://www.propublica.org/article/candi-miller-abortion-ban-death-georgia; Jamie Ducharme, *For People With Disabilities, Losing Abortion Access Can Be a Matter of Life or Death*, TIME (Jan. 25,

Access to mifepristone is therefore not optional or ancillary—it is essential to preserving the health and lives of people with disabilities. Reinstating the in-person dispensing requirement would predictably prevent or delay care for those most at risk, with irreversible consequences. Protecting meaningful access to mifepristone in this context is necessary to prevent irreparable harm and uphold the rights and lives of disabled people. For these reasons, the Court should deny Plaintiffs' request for a stay or preliminary injunction of the 2023 REMS.

CONCLUSION

The 2023 REMS appropriately eliminated an outdated and medically unnecessary in-person dispensing requirement, mitigating longstanding barriers to care faced by people with disabilities by allowing access to mifepristone through safe, effective, and accessible alternatives. The FDA's decision rested on substantial evidence demonstrating that mifepristone can be used safely without imposing regulations that unduly burden patient access. Reinstating the in-person dispensing requirement—even temporarily—would harm people with disabilities by forcing them to again navigate barriers to care that nondisabled patients do not face, increasing the risk of delay, denial of care, and resulting health complications, including potential death.

Reinstatement of the in-person dispensing requirement would not advance patient health or safety. Instead, it would strip disabled people of accessible health care options that protect their autonomy, privacy, and bodily integrity, while exposing them to heightened medical risk. These harms are concrete, foreseeable, and irreparable. For these reasons, Amici respectfully urge this Court to deny Plaintiffs' request for relief.

2023) (woman with connective-tissue disorder in Oklahoma forced to stockpile "morning-after pills" because pregnancy could cause her organ rupture and Oklahoma abortion ban prevents her from obtaining other means of abortion), https://time.com/6248104/abortion-access-people-with-disabilities/.

s/ Chloé M. Chetta
Chloé M. Chetta, 37070
BARRASSO USDIN KUPPERMAN
FREEMAN & SARVER, L.L.C.
909 Poydras Street, Suite 2350
New Orleans, LA 70112
(504) 589-9700
cchetta@barrassousdin.com

Kristen D. Amond, 37011
KRISTEN AMOND LLC
3640 Magazine Street
New Orleans, LA 70115
(504) 556-5523
kristen@amondlaw.com

s/ Maria Michelle Uzeta
Maria Michelle Uzeta, WDLA No. 918851
Admitted *pro hac vice*
Disability Rights Education & Defense Fund
3075 Adeline Street, Suite 210
Berkeley, CA 94703
(510) 644-2555
muzeta@dredf.org

Mallory Tosch Hoggatt, *pro hac vice* pending
Allen Overy Shearman Sterling US LLP
800 Capitol Street, Suite 2200
Houston TX 77002
(713) 354-4900
Mallory.ToschHoggatt@aoshearman.com

Elizabeth June, *pro hac vice* pending
Allen Overy Shearman Sterling US LLP
1101 New York Avenue NW
Washington, DC 20005
(202) 683-3800
Elizabeth.June@aoshearman.com

Counsel for Amici Curiae Disability Rights Education and Defense Fund and Others