Nos. 23-235 and 23-236

IN THE

Supreme Court of the United States

FOOD AND DRUG ADMINISTRATION, *et al.*,

Petitioners,

v.

ALLIANCE FOR HIPPOCRATIC MEDICINE, *et al.*,

Respondents.

DANCO LABORATORIES, L.L.C.,

Petitioner,

v.

ALLIANCE FOR HIPPOCRATIC MEDICINE, *et al.*,

Respondents.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR *AMICI CURIAE* DISABILITY RIGHTS EDUCATION & DEFENSE FUND, *ET AL.* IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICI CURIAE*

Amici curiae, listed in the Appendix, are ten organizations, many comprised of people with disabilities, and four individuals that promote the rights of people with disabilities to participate fully and equally in society. *Amici* pursue these goals using various tools, including legal advocacy, training, education, legislation, and public policy development.

Collectively and individually, *Amici* have a strong interest in ensuring that people with disabilities have equitable access to health care, including abortion care, so they can make self-determined decisions about their futures that protect their lives and health. People with disabilities are just as likely to become pregnant as people without disabilities but are at significantly higher risk for severe pregnancy- and birth-related complications, including death. Additionally, people with disabilities experience significant disparities in health care delivery and access. *Amici* are concerned that if affirmed, the Fifth Circuit's suspension of the Food and Drug Administration's (FDA) modifications of its Risk Evaluation and Mitigation Strategies (REMS) in 2016 and 2021—many of which mitigate or alleviate existing barriers to health care—will disproportionately harm people with disabilities.[1]

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1. Pursuant to Rule 37.6, *Amici* affirm that no counsel for any party authored this brief in whole or in part, and no person or entity other than *Amici*, their members, and their counsel has made a monetary contribution to support the brief's preparation or submission.

SUMMARY OF THE ARGUMENT

If the Court allows the Fifth Circuit's ruling to stand, the impact on the disability community will be decidedly negative, pervasive, and disproportionate. As explained in this brief, people with disabilities are at much higher risk of medical complications and death during pregnancy than people without disabilities. They are therefore much more likely to need care, but barriers to medical care, including abortion care, are encountered at every turn and can be insurmountable. Physical barriers, like inaccessible medical facilities and equipment, prevent access to care. Transportation barriers, including inaccessible public transit, prevent access to care. And, for people with disabilities, financial barriers are more likely to be present and prohibitive—preventing access to care—than they are for people without disabilities.

Even when these barriers can be overcome, people with disabilities often face discrimination and sub-standard care when they seek treatment. They are far more likely than those without disabilities to experience medical mistreatment and receive fair or poor-quality medical care from providers. They are also far more likely to experience discrimination by providers, both overtly and implicitly. Flexible treatment options, such as telehealth appointments and allowing advanced practice clinicians, including physician's assistants and nurse practitioners, to be certified prescribers can help people with disabilities avoid these barriers and receive the care they need.

Affirming the Fifth Circuit's decision will roll back the clock on medication abortion access and force patients to

return to an era without flexibility. Allowing for medically and scientifically unnecessary restrictions on medication abortion access will make seeking and receiving care more difficult for everyone in need of access, but this is especially true for people with disabilities in light of the considerable additional burdens they face when accessing care. Put simply, allowing for the imposition of additional restrictions to access mifepristone will disparately cause damage to the health and safety of the disability community. The Court should reverse the Fifth Circuit's decision and prevent that outcome.

ARGUMENT

I. REINSTATING OUTDATED AND MEDICALLY UNNECESSARY RESTRICTIONS ON ACCESS TO MIFEPRISTONE WILL DISPROPORTIONATELY HARM PEOPLE WITH DISABILITIES.

Access to abortion care is extremely important for people with disabilities, who are just as likely to become pregnant as people without disabilities[2] but are at significantly higher risk for severe pregnancy- and birth-related complications. Pregnant people with disabilities have a "significantly higher risk of almost all adverse maternal outcomes," including twice the risk for severe preeclampsia; six times the risk for thromboembolism (blood clots in the lungs or veins of the legs); four times the risk for cardiovascular events (including heart attacks

2. Lisa I. Iezzoni et al., *Prevalence of Current Pregnancy Among U.S. Women with and without Chronic Physical Disabilities*, Med Care at 8 (June 1, 2014) (people with "chronic physical disabilities become pregnant at similar rates" as people without disabilities).

and other disorders of the heart and blood vessels); and nearly three times the risk for infection.[3] Pregnant people with disabilities are eleven times more likely to die during childbirth than people without disabilities.[4] Pregnancy can also exacerbate existing health conditions, such as disabilities that affect heart health.[5] Pregnancy may also require the cessation of medications and treatments necessary to manage disabilities, with adverse repercussions and unnecessary relapses.[6] People with disabilities are thus more likely to experience pregnancy complications and other health consequences, and may be more likely to need access to medication abortion.

These increased medical risks are compounded by the pervasive barriers to equitable healthcare access that people with disabilities experience, discussed below. Studies have shown that people with disabilities

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3. Jessica Gleason et al., *Risk of Adverse Maternal Outcomes in Pregnant Women with Disabilities*, JAMA Network Open at 2, 4–7 (Dec. 15, 2021), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2787181 (people with disabilities are at higher risk for pregnancy and birth-related complications and death).

4. *Id.* at 5–6.

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

6. *See, e.g.*, Kerstin Hellwig et al., *Multiple Sclerosis Disease Activity and Disability Following Discontinuation of Natalizumab for Pregnancy*, Jama Network Open at 1 (Jan. 24, 2022), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2788309.

experience considerably more barriers to accessing reproductive healthcare than people without disabilities.[7] Such barriers include inaccessible healthcare facilities, nonexistent adaptive equipment, inaccessible public and private transportation, logistical barriers such as getting time off work or finding a support person to assist at or provide transportation to an appointment, financial barriers, and provider bias—all of which result in substandard care access for people with disabilities. These disproportionate risks and barriers experienced by people with disabilities make access to abortion care essential to protecting their lives, health, and autonomy.

The FDA's actions in 2016 and 2021 to eliminate outdated and medically unnecessary limits on access to mifepristone mitigated the impact of some of the barriers experienced by people with disabilities by allowing them to access the drug in alternative, accessible ways. The FDA's decisions were based on clear evidence that mifepristone is safe and effective without overly burdensome regulation.[8]

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7. *See* M. Antonia Biggs et al., *Access to Reproductive Health Services Among People with Disabilities*, JAMA Network Open at 8 (Nov. 29, 2023), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812360 (reporting that 70% of respondents with disabilities experienced barriers to accessing reproductive health care compared to 43% of respondents without disabilities); Tara Lagu et al., *Access to Subspecialty Care for Patients with Mobility Impairment*, Annals of Internal Med. at 441 (Mar. 19, 2013) (hereinafter "Lagu, *Access to Subspecialty Care*") (finding that only 44% of gynecology practices that were surveyed could accommodate a patient with a mobility disability).

8. *See* FDA Ctr. for Drug Eval. & Research, *Medical Review, Application No. 020687Orig1s020* at 5, 14–17 (Mar. 29, 2016), https://www.accessdata.fda.gov/drugsatfda_docs/

The Fifth Circuit's decision reinstating these restrictions will disproportionately impact people with disabilities by again requiring them to endure and navigate burdens to abortion care that people without disabilities do not face, or risk significant harms, including death.

II. PEOPLE WITH DISABILITIES EXPERIENCE PHYSICAL BARRIERS TO REPRODUCTIVE HEALTHCARE INCLUDING INACCESSIBLE FACILITIES AND NONEXISTENT ADAPTIVE EQUIPMENT THAT CAN RESULT IN TOTAL DENIALS OF CARE.

Physical obstacles are a pervasive barrier to care for many people with disabilities[9] despite medical providers'

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nda/2016/020687Orig1s020MedR.pdf (relying on updated data inclusive of over 80 high-quality studies studying hundreds of thousands of women to determine the safety of the 2016 mifepristone regulation updates); *see also* ANSIRH, *Analysis of Medication Abortion Risk and the FDA Report: "Mifepristone U.S. Post-Marketing Adverse Events Summary through 12/31/2018,"* Univ. of Cal., S.F.: Issue Brief at 1 (Apr. 2019), https://www.ansirh.org/sites/default/files/publications/files/mifepristone_safety_4-23-2019.pdf (reporting that the overall mortality rate associated with medication abortion is only 0.65 deaths per 100,000 medication abortions (24 deaths in 3.7 million medication abortion cases), similar to that reported for abortion overall (0.7 deaths per 100,000 procedures)).

9. *See* Nat'l Council on Disability, The Current State of Health Care for People with Disabilities at 1, 49-51 (2009) (hereinafter "NCD, Current State of Health Care"); *see also* Tara Lagu et al., '*I Am Not the Doctor For You*': *Physicians' Attitudes About Caring For People With Disabilities*, 41 Health Affairs 1387, 1389–1390 (2022) (hereinafter "Lagu, *Not the Doctor for You*"); Nancy R. Mudrick et al., *Physical accessibility*

legal responsibilities to ensure that their practices are accessible. [10] Although there is no comprehensive national data on the issue of medical facility accessibility because of the difficulty of evaluating the many different characteristics of physical sites, smaller studies and anecdotal reports of people with disabilities indicate that facility inaccessibility is a significant barrier to health care for people with mobility disabilities. In a recent study that surveyed physicians regarding their treatment of patients with disabilities, every single respondent stated that their practices featured physical barriers to health care for people with disabilities, such as inaccessible buildings and equipment.[11] One respondent even stated: "I know for a fact our building is not accessible."[12,13] A

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in primary health care settings: Results from California on-site reviews, DISABILITY AND HEALTH J. 159 (2012); Lagu, *Access to Subspeciality Care*, *supra* n.7, at 443.

10. *See* 42 U.S.C. § 12182(a), (b) (nondiscrimination requirements under Title III of the Americans with Disabilities Act (ADA) for private places of public accommodation including offices of health care providers); *see also id.* § 12132 (nondiscrimination requirements under Title II of the ADA for public entities like state funded hospitals); 29 U.S.C. § 794(a) (nondiscrimination requirements for programs receiving federal funds like medical practices that take Medicaid funds); 28 C.F.R. § 39.150(b) (regulations enforcing Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. § 794) and applicable to Title II of the ADA via 42 U.S.C. § 12134 promulgating guidelines for entities with inaccessible facilities).

11. *See* Lagu, *Not the Doctor for You*, *supra* n.9, at 1389.

12. *Id.*

13. An architecturally accessible medical facility includes, among other things: accessible routes from parking or public

California-based study that conducted comprehensive in-person site inspections of 2,389 primary care offices (one of the largest studies of its kind) found that 53% of provider sites met all parking/exterior access criteria, 56% met all building entrance and interior public areas access criteria, and, a mere 34.3% met all interior office and restroom access criteria.[14] The authors of the study noted that architectural accessibility might actually be higher in California than in places in the United States with older cities and a larger number of older buildings.[15]

Inaccessible medical equipment is also a pervasive barrier to health care access for people with disabilities.[16] The lack of accessible equipment contributes to people with disabilities being denied care, deterred from seeking care, or receiving substandard care.[17] Adjustable height exam tables, accessible weight scales, and accessible

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transportation stops into the building; accessible parking; accessible entry doors with the required door handles and clearance width; accessible routes of travel between rooms; clear floor space and maneuvering clearance in each room; and accessible restrooms including grab bars and an appropriate height sink. 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/ (hereinafter "DOJ, *Access to Medical Care*").

14. *See* Mudrick, *supra*, n.9, at 163–64.

15. *Id.* at 166.

16. *See* NAT'L COUNCIL ON DISABILITY, ENFORCEABLE ACCESSIBLE MEDICAL EQUIPMENT STANDARDS at 7, 29 (May 20, 2021) (hereinafter "NCD, ACCESSIBLE MEDICAL EQUIPMENT").

17. *Id.* at 29–30.

diagnostic machines like mammography machines and radiologic machines all help to ensure that a person with a disability is receiving safe and equitable care.[18] Although the U.S. Access Board issued Standards for Accessible Medical Diagnostic Equipment in 2017, they have yet to be incorporated into the Code of Federal Regulations.[19] The lack of clear and enforceable regulations governing the accessibility of medical equipment means that medical providers often do not understand their obligations and do not own or use accessible medical equipment.[20,21]

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18. *See* DOJ, *Access to Medical Care*, *supra* n.13, at 15 (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).

19. *See* Architectural and Transportation Barriers Compliance Board, STANDARDS FOR ACCESSIBLE MEDICAL DIAGNOSTIC EQUIPMENT, 82 Fed. Reg. 2810 (Jan. 9, 2017).

20. *See* Lisa Iezzoni et al., *U.S. Physicians' Knowledge About the Americans With Disabilities Act And Accommodation Of Patients With Disability* 41 Health Affairs 96-104 (2022) (reporting that 35.8 percent of the physicians surveyed reported knowing little or nothing about their legal responsibilities under the ADA); *see also* Lagu, *Not the Doctor for You*, *supra* n.9, at 1389 (a physician respondent incorrectly asserts that adjustable height exam tables are "designed to be adjustable for the practitioner, not for the patient's comfort or the patient's ability to get in").

21. It is important to note that the lack of specific regulations does not justify discrimination. *See Robles v. Domino's Pizza, LLC*, 913 F.3d 898, 909 (9th Cir. 2019) ("[T]he lack of specific

The National Council on Disability's (NCD) *Current State of Health Care* report identified that inaccessible medical equipment is a fundamental barrier to health care services for people with mobility disabilities, and the NCD's *Enforceable Accessible Medical Equipment Standards* report reaffirmed and expanded upon this finding.[22] A study that surveyed over 2,000 primary care offices in California found that medical equipment was the most pervasive area of inaccessibility, with only 8.4% of offices having an adjustable height exam table and only 3.6% having an accessible weight scale.[23] A separate study of eight types of subspecialty care practices found that gynecology practices reported the highest rate of inaccessibility at only 44% accessible, primarily because of inaccessible medical equipment.[24] Yet another study found that women with mobility disabilities were about 18% less likely than non-disabled women to access preventative screening services like Papanicolaou tests ("pap smears") (63.3% versus 81.4%) or mammograms (45.3% versus 63.5%), and hypothesized that this difference was due

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regulations cannot eliminate a statutory obligation [not to discriminate]." (internal citations omitted)). The text of the Americans with Disabilities Act and its implementing regulations, and guidance from the Department of Justice all lead to the conclusion that medical providers must ensure that their facilities and services are reasonably accessible to and useable by people with disabilities, irrespective of whether the DOJ has adopted technical specifications for the facilities or services at issue. *See, e.g.*, DOJ, *Access to Medical Care*, *supra* n.13.

22. *See* NCD, Current State of Health Care, *supra*, n.9, at 49–50; *see also* NCD, Accessible Medical Equipment, *supra*, n.16, at 29–32.

23. Mudrick, *supra* n.9, at 163–64.

24. *See* Lagu, *Access to Subspecialty Care*, *supra* n.7, at 444.

to inaccessible medical equipment.[25] In response to non-existent accessible medical equipment, some physicians have reported shocking practices like sending patients who are wheelchair users to a supermarket, grain elevator, zoo, or cattle processing plant in order to record their weight when their practices did not have an accessible weight scale.[26] These types of horrific and discriminatory experiences prevent and deter people with disabilities from accessing health care, including abortion care.

FDA's current REMS for mifepristone give people with disabilities the flexibility to avoid these physical barriers and equipment deficiencies by accessing mifepristone through telehealth appointments and accompanying mail prescription or pick up at their local pharmacy. If this Court affirms the Fifth Circuit's ruling, people with disabilities will be stripped of these alternative, accessible care options. Reinstatement of the in-person dispensing requirement will result in people with disabilities being prevented and deterred from obtaining necessary care. Further, reducing access to mifepristone by reinstating the old REMS will likely result in a higher demand for procedural abortions, which cannot be provided to people with mobility disabilities in absence of accessible medical offices and accessible medical equipment.

These impacts are pervasive, whether a disabled person lives in an area where abortion options are generally available, or not. If a power wheelchair user with partial paralysis becomes pregnant and needs an abortion, their

25. *See* Lisa I. Iezzoni et al., *Mobility Impairments and Use of Screening and Preventive Services*, 90 Am. J. of Pub. Health 955, 957 (June 2000).

26. *See* Lagu, *Not the Doctor for You*, *supra* n.9, at 1389–90.

options for care are more limited than for a non-disabled person. If they live in an urban area where abortion is protected there may be several clinics nearby, but the patient would need to evaluate which clinic—if any—would be accessible to them before their appointment. This could delay scheduling and affect their ability to get a prescription before they reach a gestational age at which they can no longer access medication abortion. If they live in a rural area or a state that restricts access to abortion, their clinic options would be even more limited. If the clinic closest to them has even a single step up to the front entrance, the patient would be physically unable to enter the clinic in their wheelchair, resulting in a total care denial. If the clinic did not have an accessible exam table, the patient would be unable to independently transfer onto the table or could be injured by staff assisting the transfer. Once on the table, the patient could be injured without the correct supports to hold their body in place.

Under the current REMS, this patient could avoid substantially all these barriers and risks by attending a telehealth appointment and receiving their prescription through the mail or picking it up at their local pharmacy.

Affirming the Fifth Circuit's decision to reinstate antiquated restrictions on access to mifepristone—despite overwhelming evidence supporting the safety and efficacy of provision of care without these restrictions—will impose further barriers to reproductive health care services for people with disabilities. Prior to the Fifth Circuit's decision reinstating the in-person dispensing requirement, the FDA's 2021 REMS update allowed pharmacies to become certified to dispense mifepristone to patients through a combination of telehealth appointments and mailed prescriptions. Reinstating the in-person dispensing

requirement, and removing the ability of patients to obtain mifepristone from their local pharmacy or through the mail, will unnecessarily force people with disabilities to encounter the physical barriers associated with in-person doctor's office visits. As such, an affirmation of the Fifth Circuit's decision reinstating the old REMS will strip people with disabilities and providers of accessible options for accessing and prescribing mifepristone.

III. PEOPLE WITH DISABILITIES EXPERIENCE TRANSPORTATION AND LOGISTICAL BARRIERS TO REPRODUCTIVE HEALTH CARE THAT RAISE PRIVACY, ABUSE, AND COERCION CONCERNS.

A. People with disabilities regularly face inaccessible forms of transportation that create barriers to accessing abortion care.

People with disabilities seek abortion care at nearly the same rates as people without disabilities but face logistical barriers to receiving reproductive health care that can be insurmountable.[27] Logistical issues like arranging transportation are the most common barriers that people with disabilities face when trying to access reproductive health care, with one study finding that 50.7% of people with disabilities experienced logistical barriers to care compared to 29.7% of those without disabilities.[28]

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27. *See generally* Biggs, *supra* n.7, at 6.

28. *Id*. at 6–7, 10 (reporting that 50.7% of respondents with disabilities experienced logistical barriers to accessing reproductive health care like arranging transportation, getting time off work or school, or finding childcare compared to 29.7% of respondents without disabilities).

According to the United States Census Bureau, approximately 41.1 million Americans have one or more disabilities.[29] Of these 41.1 million, an estimated 25.5 million have disabilities that make traveling outside the home difficult and 3.6 million do not leave their homes at all.[30] Further research indicates 30% of individuals with disabilities in the United States have difficulty accessing transportation.[31] Insufficient levels of service and inaccessible routes are two of the primary transportation barriers experienced.[32] Even before the disruptions caused by the Covid-19 pandemic and changes to abortion laws, 5.8 million people in the United States delayed medical care because they lacked access to transportation, and this pattern has stayed consistent.[33] According to a 2022 study, people with disabilities were significantly more likely than non-disabled people to arrive late to appointments, miss

29. U.S. Census Bureau, *Anniversary of Americans With Disabilities Act: July 26, 2021* (May 26, 2021), https://www.census.gov/newsroom/facts-for-features/2021/disabilities-act.html.

30. Stephen Brumbaugh, *Travel Patterns of American Adults with Disabilities*, US Dep't of Transportation, 1 (Sept. 2018), https://www.bts.gov/sites/bts.dot.gov/files/2022-01/travel-patterns-american-adults-disabilities-updated-01-03-22.pdf.

31. U.S. General Accounting Office, Transportation-Disadvantaged Populations: Some Coordination Efforts Among Programs Providing Transportation Services, but Obstacles Persist at 6 (June 2003), https://www.gao.gov/assets/gao-03-697.pdf.

32. Jill L. Bezyak et al., *Public Transportation: An Investigation of Barriers for People with Disabilities*, 28(1) J. Disability Pol'y Studies at 52–53 (2017).

33. Abigail L. Cochran et al., *Transportation barriers to care among frequent health care users during the COVID pandemic*, BMC Pub. Health at 2 (2022).

appointments, or delay their care due to transportation barriers.[34] These transportation barriers critically impact the ability of people with disabilities to access timely reproductive care, including abortion care.

More than a third of U.S. women of reproductive age lived over an hour from an active abortion facility in the second half of 2022.[35] This reality is especially troublesome for people with disabilities who face pervasive transportation barriers, even within their city of residence, including "lack of public transportation in suburban and rural areas, difficulty scheduling rides, and difficulty relying on paratransit to get to appointments on time" that affect their ability to access medical care generally.[36] Direct-to-patient telehealth abortion options are an important way of addressing these barriers.[37] For example, one study found that telehealth abortion appointments saved patients a median of 10 miles and 25 minutes of round-trip driving, and 1 hour 25 minutes of round-trip public transit time.[38] When patients in the study were asked what would have happened had they not obtained the telehealth abortion, nearly half stated that

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34. Cochran, *supra* n.33, at 7.

35. Benjamin Rader et al., *Estimated Travel Time and Spatial Access to Abortion Facilities in the US Before and After the Dobbs v. Jackson Women's Health Decision*, JAMA Network Open at 2046, https://jamanetwork.com/journals/jama/fullarticle/2798215.

36. NCD, Current State of Health Care, *supra* n.9, at 77.

37. Leah R Koenig, *The Role of Telehealth in Promoting Equitable Abortion Access in the United States: Spatial Analysis*, JMIR Pub. Health Surveillance (July 11, 2023).

38. *Id.*

telehealth made it possible to obtain timely abortion care, even in states that protect abortion access.[39] Therefore, the removal of an in-person dispensing requirement for mifepristone and availability of direct-to-patient telehealth options are especially important to ensure that people with disabilities can overcome transportation barriers and have meaningful access to abortion care.

People with disabilities are more likely to use public transportation than people without disabilities, and inaccessible public transit can result in an inability to access care for people with disabilities.[40] The Americans with Disabilities Act (ADA), enacted over three decades ago, was meant to ensure accessible transportation for people with disabilities, but unfortunately inaccessible public transportation continues to be an issue.[41] Ridership by people with disabilities on fixed-route bus and rail systems in the United States has grown far faster than ridership on ADA paratransit.[42] However, these

39. Koenig, *supra* n.37

40. Brumbaugh, *supra* n.30, at 6.

41. *See generally* Nat'l Council on Disability, Transportation Update: Where We've Gone and What We've Learned (May 4, 2015); *see also* Erica Twardzik et al., *Transit Acessibility Tool (TRACT): Developing a novel scoring system for public transportation system accessibility*, 34 J. Transport & Health 101742 (Jan. 2024).

42. Complementary paratransit services function as a "safety net" for people with disabilities who are demonstrably unable to make use of mainstream transit systems. 49 C.F.R. § 37.123(e). They are not intended to be a comprehensive system of transportation that meets all of the travel needs of persons with disabilities. *See* Federal Transit Administration, *Premium Charges for Paratransit Services* (Feb. 27, 2020), https://www.

systems are often inaccessible to people with disabilities, failing to accommodate wheelchairs and mobility aids, discriminating against service animals, and lacking communication access.[43] As of 2019, 20% of all public transit stops in the United States failed to meet accessibility criteria, illustrating this point.[44] In New York City, as a specific example, only 28% of the City's 472 subway stations were accessible for people with disabilities in 2019, which is among the lowest percentages of any major transit system in the world.[45] This demonstrated that even in states like New York that are protective of abortion

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transit.dot.gov/regulations-and-guidance/civil-rights-ada/premium-charges-paratransit-services.

43. NCD, Transportation Update, *supra* n.41, at 22, 175, 196, 201–02. Paratransit presents its own host of problems for disabled travelers, including capacity constraints, untimely services, long telephone holds, and even ride denials. *Id.* at 73. Additionally, by law, transit agencies can charge twice as much for paratransit as for fixed-route service. 49 C.F.R. § 37.131(c). This presents problems for people with disabilities, who disproportionally live in poverty. *See* Emily A. Shrider and John Creamer, *Poverty in the United States: 2022*, U.S. Census Bureau (September 2023) https://www.census.gov/content/dam/Census/library/publications/2023/demo/p60-280.pdf (showing that 24% of people with disabilities live below poverty levels).

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

45. Jugal K. Patel, *Where the Subway Limits New Yorkers With Disabilities*, New York Times (Feb. 11, 2019, https://www.nytimes.com/interactive/2019/02/11/nyregion/nyc-subway-access.html.

rights,[46] transportation barriers to accessing care can cause major hurdles for people with disabilities. Direct-to-patient telehealth options without in-person dispensing requirements must be protected to ensure that disabled pregnant people can access medication abortion without having to navigate inaccessible public transportation.

If telehealth options for access to medication abortion are removed and advanced practice providers are no longer able to become certified prescribers of mifepristone, long wait times for overwhelmed clinics may force people to rely on air travel to access abortions, even in states that protect abortion rights. The proportion of patients traveling to other states to obtain abortion care has doubled in recent years, reaching nearly one in five abortion seekers in the first half of 2023, compared with one in ten in 2020.[47] However, inaccessible air travel is a common problem for people with disabilities and can push abortion access out of reach.[48]

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46. *See* N.Y. Pub. Health Law §§ 2599-aa to bb (enacted in recognition that "comprehensive reproductive health care is a fundamental component of every individual's health, privacy and equality").

47. Kimya Forouzan et al. *The High Toll of US Abortion Bans: Nearly One in Five Patients Now Traveling Out of State for Abortion Care*, Guttmacher Institute (Dec. 7, 2023), https://www.guttmacher.org/2023/12/high-toll-us-abortion-bans-nearly-one-five-patients-now-traveling-out-state-abortion-care?utm_source=substack&utm_medium=email.

48. Amanda Morris, *Embarrassing, Uncomfortable and Risky: What Flying is Like for Passengers Who Use Wheelchairs*, New York Times (Aug. 8, 2022), https://www.nytimes.com/2022/08/08/travel/air-travel-wheelchair.html#:~:text=For%20passengers%20who%20use%20wheelchairs%2C%20air%20

While non-disabled pregnant people may be able to travel on short notice to receive needed abortion care, these barriers to transportation for pregnant people with disabilities create a clear need for medication abortion options that include direct-to-patient telehealth appointments, no in-person dispensing requirements, and certified advanced practice provider prescribers.

B. Logistical barriers like transportation reliance on third parties place people with disabilities at risk for reproductive coercion and compromise their medical privacy.

Telehealth options and pharmacy access to mifepristone also protect the health care privacy and reproductive autonomy of pregnant people with disabilities. People with disabilities are likely to utilize transportation assistance such as personal care attendants or informal caregivers, which can create health care privacy concerns when trying to arrange transportation to in-person abortion appointments.[49] There are approximately 53 million caregivers providing

travel%20in%20the%20United,and%20of%20federally%20mandated%20services (reporting the experience, as a person with a disability and wheelchair user, of being physically dropped by airline employees assisting him in transferring to his seat, being unable to use airplane restrooms, receiving no help with his checked luggage, and having to wait extended periods of time for assistance getting on and off the plane); *see also* Ned S. Levi, *Airlines damage passenger wheelchairs–more than 200 a week,* Travelers United (Aug. 7, 2023), https://www.travelersunited.org/the-time-is-now-for-the-airlines-to-stop-damaging-so-many-passenger-wheelchairs/ (noting that in 2022, U.S. airlines reported 11,389 mishandled wheelchairs and scooters).

49. *See* Brumbaugh, *supra* n.30, at 9.

care to adults with a disability or illness, and 80% of these caretakers assist with transportation, the highest of any task. [50] People with disabilities are less likely to own or have access to a personal vehicle; additionally, they are less likely to drive even if they own a vehicle.[51] The most common method to address transportation limitations for people with disabilities is to ask others for rides.[52] This makes pregnant people with disabilities seeking abortion care particularly reliant on others for access to in-person abortion care which can compromise their privacy, their ability to access care at all, and even their safety.

Because of transportation barriers for people with disabilities, there can often be a greater interdependence between people with disabilities and others for transportation and support with accessing reproductive health care. People with disabilities also report difficulty going to reproductive health clinics "because their partner or family member did not want them to go," and when combined with an increased likelihood of people with disabilities to experience intimate partner violence, reproductive coercion, and abuse, as discussed further below, this greater interdependence may expose a pregnant person with disabilities to unwanted pressure or violence by their caregiver or loved one.[53] These refusals for assistance to accessing reproductive health care by providers, family, or partners can result in

50. AARP Family Caregiving & National Alliance for Caregiving, *Caregiving in the United States* at 4, 33 (May 2020) https://www.aarp.org/content/dam/aarp/ppi/2020/05/full-report-caregiving-in-the-united-states.doi.10.26419-2Fppi.00103.001.pdf.

51. Brumbaugh, *supra* n.30, at 3–4.

52. *Id.* at 9.

53. Biggs, *supra* n.7, at 10.

informal deprivations of medical decision-making power, even if a disabled person is not under guardianship or a supported decision-making agreement.

Telehealth options for abortion care and the ability to receive mifepristone by mail may alleviate some of these logistical and privacy concerns by increasing access to care without having to depend on transportation from others for in-person appointments and dispensing of medication. If a disabled person is required to make a medically unnecessary, in-person visit to a clinic under the outdated mifepristone REMS, the logistical barriers for arranging transportation can make abortion access nearly impossible. Having the option to access abortion care from the privacy and security of their own space is critical to protect the reproductive autonomy of people with disabilities. It reduces the chance that access to abortion can be impacted by the motives or beliefs of a third party who has no cognizable role or right in the making of this reproductive choice. Pregnant people with disabilities are entitled to medical privacy and telehealth options for medication abortion can address these logistical barriers for many.

If the Fifth Circuit's decision to reinstate outdated restrictions on mifepristone stands, transportation and logistical barriers to reproductive health care for people with disabilities will become even more burdensome. Restrictions including the in-person dispensing requirement, eliminating pharmacy certifications that allow people to access mifepristone through telehealth appointments and mailed prescriptions, and restricting advanced care practitioner certifications for prescribing, will unnecessarily require people with disabilities to navigate extensive transportation and privacy barriers.

IV. REQUIRING MIFEPRISTONE TO BE DISPENSED IN PERSON WOULD EXACERBATE ALREADY DISPROPORTIONATE FINANCIAL BARRIERS FACED BY INDIVIDUALS WITH DISABILITIES.

Individuals with disabilities face severe financial barriers accessing medical care. Reversion to outdated and medically unnecessary limitations to mifepristone access would likely lead to an increase in the significant financial barriers people with disabilities face when accessing care. People with disabilities disproportionally live in poverty, experience higher rates of unemployment, and rely on Medicaid for their insurance. These costs compound on each other and further restrictions to medication abortion access will likely result in prohibitive financial barriers to accessing abortion care for people with disabilities.

Individuals with disabilities are twice as likely to be poor and unemployed as people without disabilities.[54] The median adjusted income for this population is $39,297, compared to $46,318 for non-disabled individuals.[55] This disparity in median adjusted incomes is further intensified

54. Pam Fessler, *Why Disability and Poverty Still Go Hand in Hand 25 Years After Landmark Law*, NPR (July 23, 2015), https://www.npr.org/sections/health-shots/2015/07/23/424990474/why-disability-and-poverty-still-go-hand-in-hand-25-years-after-landmark-law.

55. Disability Compendium, *2020 Annual Disability Statistics Compendium*, https://disabilitycompendium.org/compendium/2020-annual-disability-statistics-compendium?page=10 (last visited Jan. 1, 2024).

as households with a disabled adult need on average 28% more income to cover costs associated with disability, which amounts to an extra $17,690 per year.[56] Research further suggests that existing poverty measurements significantly underestimate the level of poverty faced by those with disabilities.[57]

Fewer than one in five individuals with disabilities are employed and those who are employed are more likely to have lower average wages than those without disabilities.[58] The high level of unemployment people with disabilities face means they are much less likely to have private insurance from employers and more likely to rely on Medicaid for their insurance coverage.[59,60,61] Under

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56. Rebecca Vallas et al., *Economic Justice is Disability Justice*, The Century Foundation (Apr. 21, 2022), https://tcf.org/content/report/economic-justice-disability-justice/.

57. *Id.*

58. Fessler, *supra* n.54; Nanette Goodman et al., *The Extra Cost of Living with a Disability in the U.S. – Resetting the Policy Table* at 2 (2020), https://www.nationaldisabilityinstitute.org/wp-content/uploads/2020/10/extra-costs-living-with-disability-brief.pdf.

59. Jae Kennedy et al., *Disparities in Insurance Coverage, Health Services Use, and Access Following Implementation of the Affordable Care Act: A Comparison of Disabled and Nondisabled Working-Age Adults*, 54 INQUIRY: J. of Health Care, Organization, Provision, and Financing at 4 (2017).

60. *Id.* at 4.

61. Medicaid and CHIP Payment and Access Commission, *People with disabilities*, MacPac.gov (2017), https://www.macpac.gov/subtopic/people-with-disabilities/ (reporting that "[o]ver

the Hyde Amendment, federal funds may not be used to provide abortion care except in cases of rape, incest, severe and long-lasting physical health damages, or life endangerment of the pregnant person and most states do not supplement their Medicaid programs to allow for abortion coverage.[62] As such, people with disabilities, who are likely to be covered by Medicaid, often lack insurance coverage for their abortion and must find ways to pay out of pocket for their health care.

People with disabilities also bear higher and more frequent health care costs. Individuals with disabilities often face higher out-of-pocket health care expenses and this can result in an increase of 65% in expenditures when compared to individuals without disabilities.[63] Certain expenses, such as adaptive accessibility equipment, personal attendant care, direct service providers, home modifications, assistive technology, food for medically directed diets, and special clothing, are frequent and

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10 million people qualify for Medicaid based on a disability… Medicaid beneficiaries enrolled through disability pathways include those with physical conditions (such as quadriplegia, traumatic brain injuries); intellectual or developmental disabilities (for example, cerebral palsy, autism, Down syndrome); and serious behavioral disorders or mental illness (such as schizophrenia or bipolar disorder)").

62. Congressional Research Service, *The Hyde Amendment: An Overview* at 1 (July 2022), https://crsreports.congress.gov/product/pdf/IF/IF12167.

63. Sophie Mitra et al., *Extra costs of living with a disability: A review and agenda for research*, 10 Disability & Health J. 475, 479 (2017).

common out-of-pocket expenses.[64] These out-of-pocket expenses, coupled with the fact that abortion care is usually not covered by Medicaid programs, demonstrate that people with disabilities face higher than average costs in accessing much needed health care.[65]

Medication abortion is less expensive than procedural abortions and telehealth access to medication abortion lowers associated logistical costs for accessing care. In 2021, the median out-of-pocket cost for abortion services was "$568 for medication abortion, $625 for first-trimester procedural abortion, and $775 for second-trimester abortion services."[66] Increased regulation of abortion provision, often without clear evidence that such regulation improves patient care, may also be associated with increased cost for patients.[67] Delayed access to abortion increases the cost, availability of care, and risk of health complications. [68,69] Direct-to-patient telehealth

64. Vallas, *supra* n.56, at 12.

65. *Id.*

66. Rosalyn Schroeder et al., *Trends in Abortion Care in the United States, 2017–2021*, Advancing New Standards in Reproductive Health (ANSIRH), University of California, San Francisco, at 14 (2022).

67. *Id.*

68. Jenna Jerman & Rachel K. Jones, *Secondary Measures of Access to Abortion Services in the United States, 2011 and 2012: Gestational Age Limits, Cost, and Harassment*, 24-4 Women's Health Issues e419, e421-24 (2014), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4946165/.

69. Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125(1) Obstet Gynecol 175 (Jan. 2015).

abortion care can reduce the health care costs, improve wait times for appointments, as well as reduce associated travel costs to accessing care.[70] Therefore it is critical to reinstate the 2016 and 2021 FDA changes to mifepristone that allow for direct-to-patient telehealth options, certified pharmacy dispensing of prescriptions through the mail, and expand eligible certified prescribers to include advance practice providers.

All of these financial barriers interact with one another. The high level of unemployment in the disabled community contributes to the higher levels of poverty and reliance on Medicaid, which does not provide insurance coverage for abortion care in most states. The lack of accessible transportation, as discussed previously, increases the associated travel costs to abortion care, especially if patients need to make multiple, medically unnecessary trips to a clinic to receive care as the Fifth Circuit would require. Without timely access to medication abortion through telehealth appointments, mailed prescription options, and prescriptions by advance practice providers, pregnant people with disabilities may be forced to travel further distances for appointments or seek a procedural abortion later in their pregnancy at significantly higher cost. Allowing the Fifth Circuit's decision to stand will result in even more obstacles to medication abortion access for people with disabilities who disproportionately face financial barriers to abortion care.

70. Koenig, *supra* n.37.

V. REQUIRING MIFEPRISTONE TO BE DISPENSED IN-PERSON EXACERBATES DISCRIMINATION, ABUSE, AND MEDICAL RISK FOR PEOPLE WITH DISABILITIES.

People with disabilities face discrimination in reproductive health care, higher rates of sexual abuse, and greater risk to health and life from pregnancy. In combination, such realities "can make it extremely difficult or even impossible for people with disabilities to function," much less seek and receive necessary medical care while in crisis.[71] The Fifth Circuit's restrictions on access to mifepristone will only exacerbate these problems.

First, stripping people with disabilities of accessible options for accessing mifepristone will likely increase their exposure to negative health care experiences that can be avoided under the FDA's current REMs. People with disabilities are more likely than people without disabilities to experience medical mistreatment and receive fair- or poor-quality medical care from their regular physicians.[72,73]

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71. CDC, *Common Barriers to Participation Experienced by People with Disabilities* (Sept. 16, 2020), https://www.cdc.gov/ncbddd/disabilityandhealth/disability-barriers.html.

72. Biggs, *supra* n.7, at 6.

73. The inadequacy of health care for patients with disabilities disparately impacts BIPOC (Black, Indigenous, People of Color) and LGBTQ people with disabilities, who face additional barriers in accessing health care stemming from "a history and current practice of abuse, systemic racism, and bias in health care that also undermines trust in providers." ASAN, *Access, Autonomy, and Dignity: Abortion Care for People with Disabilities* at 12 (Sept. 2021), https://nationalpartnership.

Physicians are often "ill equipped to offer high-quality, culturally responsive care" for people with disabilities and do not "dedicate the resources necessary to understand disability-specific concerns related to pregnancy and childbirth."[74] Women with disabilities also report "negative reactions toward their pregnancy" by their health care provider.[75] Indeed, "[a]dults with disabilities are nearly twice as likely as people without disabilities to report unmet health needs because of barriers to care."[76] This aligns with similar reports from the physicians themselves "describing lack of education at every level of training to support pregnant women with disabilities."[77] Some physicians "expressed explicit bias toward people with disabilities and described strategies for discharging them from their practices," based on concerns about "providing physical and communication accommodations, including

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org/wp-content/uploads/2023/02/repro-disability-abortion.pdf (hereinafter "ASAN, *Abortion Care*"). For instance, BIPOC people with disabilities endure "lack of language access, [] not having their symptoms taken seriously, [ ] having their expressed health goals ignored," and much more. *Id*. at 10; *see also* Autistic Self Advocacy Network, *Access, Autonomy & Dignity: People with Disabilities and the Right to Parent* at 9 (Sept. 2021), https://nationalpartnership.org/wp-content/uploads/2023/02/repro-disability-parenting.pdf (hereinafter "ASAN, *Right to Parent*") (noting the lack of access to high-quality, culturally responsive prenatal health care is "further exacerbated by the structural racism driving the crisis in maternal health outcomes in the United States and the disproportionate harm to BIPOC birthing people").

74. ASAN, *Right to Parent, supra* n.73, at 9.

75. Gleason, *supra* note 3, at 8; *see also* ASAN, *Right to Parent*, *supra*, n.73, at 8.

76. ASAN, *Abortion Care*, *supra*, n.73, at 6.

77. *Id.*

insufficient reimbursement for physicians' efforts and competing demands for staff time and other practice resources."[78] These discriminatory attitudes often bleed into physicians' treatment of disabled patients.[79] Allowing pregnant people with disabilities to access abortion through telehealth appointments and prescription by mail can provide a more comfortable and private environment to access care for those with histories of negative experiences with the medical system. Allowing people with disabilities to obtain medication abortion care from an advanced practice provider instead of only physicians may also relieve some of this tension.

Second, restricting access to mifepristone may enable and compound ongoing abuse. Women with disabilities experience higher rates of intimate partner violence, reproductive coercion, unintended pregnancy, and poor birth outcomes than non-disabled women.[80] Studies have established that people with disabilities endure rape and sexual assault at a rate at least 3.5 times that of those without disabilities.[81] For women with intellectual disabilities, the rate of rape and sexual assault is about seven times that of those without disabilities.[82] Access

78. Lagu, *Not the Doctor for You, supra* n.9, at 1392–93.

79. Gleason, *supra* n.3, at 9.

80. Biggs, *supra* n.7, at 2.

81. BJS, *Crime Against Persons with Disabilities, 2009-2015 - Statistical Tables* at 3 (July 2017), https://bjs.ojp.gov/library/publications/crime-against-persons-disabilities-2009-2015-statistical-tables.

82. *See* NPR, *The Sexual Assault Epidemic No One Talks About* (Jan. 8, 2018), https://www.npr.org/2018/01/08/570224090/the-sexual-assault-epidemic-no-one-talks-about.

to abortion care in light of these realities is an essential tool in preserving the bodily autonomy of people with disabilities.[83] Upholding the Fifth Circuit's decision that limits access to timely medication abortion care may force people with disabilities to carry unwanted pregnancies resulting from violent crime, exposing them to compound trauma.[84]

Last, restricting access to mifepristone further endangers the health of an already high-risk population. As discussed above, pregnant people with disabilities have a significantly higher risk of almost all adverse maternal outcomes.[85]

Confronted with these barriers and risks, people with disabilities are more likely than people without disabilities to consider and rely upon telehealth models to provide prompt and accessible, medically-necessary care.[86] Indeed, reinstating medically unnecessary limitations on medication abortion access will make seeking and receiving care especially difficult for people living in health care deserts, especially people with disabilities

83. Erika Harrell, *Crime Against Persons With Disabilities,2009-2019 Statistical Tables*, U.S. DEP'T OF JUST. 1,4 (2021) https://bjs.ojp.gov/content/pub/pdf/capd0919st.pdf (women with disabilities are greater than three times more likely to be sexually assaulted or raped than non-disabled women).

84. ASAN, *Abortion Care*, *supra* n.73, at 14 ("[T]he risk of sexual abuse and assault invokes bodily autonomy concerns for people with disabilities in multiple ways, and exposes them to compounded trauma.").

85. *See supra* Section I.

86. Biggs, *supra* n.7, at 10.

who often lack access to accessible transportation options. The imposition of outdated restrictions on mifepristone access does not protect the health or safety of people with disabilities—instead, it disproportionately robs them of accessible health care options that preserve their bodily autonomy and privacy and may even put their health and lives at risk. Therein lies the harm likely to occur if the Fifth Circuit's decision is affirmed.

CONCLUSION

In light of these considerations, *Amici* respectfully urge this Court to reverse the judgment of the court of appeals.

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January 30, 2024

APPENDIX

TABLE OF APPENDICES

APPENDIX — *AMICI CURIAE*

Disability Rights Education & Defense Fund

Women Enabled International

American Association of People with Disabilities

Autistic Women & Nonbinary Network

Autistic Self Advocacy Network

The Judge David L. Bazelon Center for Mental Health Law

Civil Rights Education and Enforcement Center

Disability Rights Advocates

Disability Rights New York

National Council on Independent Living

Katherine Pérez, Director of the Coelho Center for Disability Law, Policy, and Innovation, and Visiting Professor of Law at Loyola Law School*

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* Participating in their individual capacity, not as representatives of their institutions. Institutions are listed for affiliation purposes only.

Appendix

Ruth Colker, Distinguished University Professor and the Heck Faust Memorial Chair in Constitutional Law at the Moritz College of Law, Ohio State University*

Tony Coelho, former U.S. Congressman