

IN THE
Supreme Court of the United States

DANCO LABORATORIES, L.L.C.,

Applicant,

v.

THE STATE OF LOUISIANA, *et al.*,

Respondents.

GENBIOPRO, INC.,

Applicant,

v.

THE STATE OF LOUISIANA, *et al.*,

Respondents.

ON EMERGENCY APPLICATIONS TO VACATE OR STAY ORDER OF THE
UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

**BRIEF OF FORMER MILITARY OFFICIALS, FORMER
CIVILIAN NATIONAL SECURITY LEADERS, AND VET
VOICE FOUNDATION AS *AMICI CURIAE* IN SUPPORT OF
APPLICATIONS BY DANCO AND GENBIOPRO TO STAY OR
VACATE THE FIFTH CIRCUIT'S STAY PENDING APPEAL**

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INTEREST AND IDENTITY OF *AMICI*¹

Amici are United States military veterans, former civilian national security leaders, and a non-profit organization that supports the wellbeing of current and former servicemembers. As former senior officials with expertise in military recruitment, readiness, medical care, and personnel matters, they submit this brief to offer a unique perspective on the threat that restricted access to mifepristone poses to military readiness and national security.

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

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

U.S. Army Major General (Ret.) Paul Eaton is the Former Commanding General, Army Infantry Center and School. He gave 33 years of service to the military, including as the Commanding General of the command charged with reestablishing Iraqi Security Forces from 2003 to 2004.

¹ This brief was not authored in whole or part by counsel for a party. No one other than *amici* and their counsel made a monetary contribution to the preparation or submission of the brief.

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

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Operations Iraqi Freedom and Enduring Freedom. She also served in senior logistics leadership roles at U.S. Pacific Command and Air Force Materiel Command. Throughout her career, she held key positions in logistics, engineering, and security, with responsibility for sustainment, readiness, and force protection across global operations.

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

SUMMARY OF ARGUMENT

This case implicates military readiness—the ability of the military to recruit, retain, and sustain a force prepared for immediate deployment. Women are essential to that force. For female servicemembers, access to comprehensive reproductive healthcare, including abortion, is critical to maintaining the readiness upon which the Nation’s security depends.

When access to such care is restricted, servicemembers face delays, extended absences, and structural barriers that directly impair their ability to serve. These individual burdens carry systemic consequences. They undermine recruitment, increase attrition, and disrupt unit cohesion. The unique demands of military service compound these harms. Servicemembers cannot choose their duty locations, must operate within rigid schedules and command structures, and cannot readily arrange leave or transportation to an in-person appointment. Nationwide abortion restrictions, layered atop these structural constraints, significantly limit servicemembers’ ability to obtain timely care and remain available for duty.

These are not speculative concerns. Restricted access has direct, measurable effects on unit readiness, personnel availability, and mission execution. Where permitted, telehealth access to reproductive healthcare mitigates these harms by enabling servicemembers to obtain care efficiently, reducing disruptions to both individual careers and unit operations. Reinstating the in-person dispensing requirement for mifepristone is contrary to the public interest, imposing predictable constraints—travel, delay, absence, attrition—that concretely harm military readiness and, in turn, national security.

ARGUMENT

Military readiness is a paramount national interest. Reinstating the in-person dispensing requirement for mifepristone would limit the ability of servicemembers to access reproductive healthcare efficiently, imposing grave costs on military readiness and, as a result, national security. Telehealth access to mifepristone enables servicemembers stationed in states that permit such care to obtain essential healthcare without extended travel or leave. This preserves military personnel availability, reduces unit disruption, and supports recruitment and retention.

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

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

“Military readiness” is the capacity to “produce, deploy, and sustain military forces that will perform successfully in combat.”² Without sufficient readiness, adversaries may perceive diminished capability, increasing the risk of conflict.³ This readiness is particularly urgent today, given ongoing global conflicts in the Middle

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

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

East. As of April 2026, the U.S. military had more than 50,000 personnel in the region.⁴ The Administration has warned that this is a time of “urgency” and growing threats, and that the military “must be prepared.”⁵

Capable personnel are the foundation of military readiness. They must be physically prepared and able to respond to threats with urgency. A key component of this readiness is the capacity “to rapidly mobilize, deploy, and redeploy” troops.⁶ “Speed matters,” particularly when confronting global challenges in real time.⁷ Barriers to healthcare, including reproductive healthcare, impair this speed by forcing servicemembers to take extended leave or delaying their return to duty.

While the U.S. military remains among the most powerful in the world, its readiness cannot be assumed. A March 2026 Heritage Foundation study concluded that the U.S. military “is burdened by readiness levels that are more problematic than they should be” and “is at significant risk of not being able to defend America’s vital national interests with assurance.”⁸

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

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

⁶ Herrera, *supra* note 2, at 7.

⁷ Eric Edelman et al., Nat’l Def. Strategy Comm’n, *Providing for the Common Defense: The Assessment and Recommendations of the National Defense Strategy Commission* 33, 66 (2018), <https://www.usip.org/sites/default/files/2018-11/providing-for-the-common-defense.pdf>.

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

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

Given these challenges, the military benefits from recruiting and retaining women. Department of Defense leaders have long recruited female servicemembers to “maintain and improve mission readiness.”¹³ As a result of these efforts, as of 2024, women comprised around 18 percent of the active-duty force.¹⁴ Indeed, women represent a highly recruitable population with strong potential for advancement.¹⁵

Since the enactment of the Women’s Armed Services Integration Act of 1948, women have increasingly filled essential roles across the military.¹⁶ Women have long

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

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

¹¹ See *id.*

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

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

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

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

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

been on the front lines, in combatant vessels, aircraft, and other combat roles.¹⁷ In 2013, the federal government rescinded a ground combat exclusion rule, allowing women to serve in direct ground combat roles to help “remov[e] as many barriers as possible to joining, advancing, and succeeding in the U.S. Armed Forces.”¹⁸ Ensuring women’s continued participation is critical to sustaining military readiness.

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

Restrictions on abortion directly impair military readiness. When servicemembers cannot access reproductive healthcare efficiently, they face extended absences, delayed treatment, and forced choices between their health and their careers—each of which undermines deployability, recruitment, and retention. Telehealth access to mifepristone mitigates these harms by enabling servicemembers stationed in states that permit such care to obtain abortion without the disruptions that degrade unit effectiveness. The Fifth Circuit’s stay threatens this access and thereby inflicts concrete harm on military readiness.

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

Access to abortion affects physical preparedness. When abortion is not readily accessible, servicemembers may be required to take extended leave and travel long distances—barriers that telehealth access to mifepristone can mitigate in those states

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

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

that permit it. *See infra* Section II.C. That disruption hinders a servicemember’s ability to serve and has ripple effects on unit operations. Military units that are not fully staffed cannot respond quickly, and units with fill-in soldiers are less effective.¹⁹ And delayed care can result in serious health consequences requiring additional leave or separation from the military, further eroding unit readiness.²⁰

Government officials have recognized that barriers to reproductive healthcare weaken readiness by diminishing recruitment and retention efforts. Following *Dobbs*, then-Pentagon Under Secretary of Defense for Personnel and Readiness Gilbert R. Cisneros, Jr. warned that barriers to abortion could drive attrition, noting that “some service members may choose to leave the military altogether” due to difficulty in obtaining care.²¹ And during a Congressional hearing on servicemembers’ reproductive health and readiness, Representative Jackie Speier similarly cautioned that restrictions on abortion “creat[e] a real incentive for women not to serve.”²²

Servicemembers themselves report the same impact. In 2023, active-duty servicemembers confirmed that barriers to reproductive access “are impacting their willingness to continue to serve in the military,” creating a “retention and morale

¹⁹ Kesling, *supra* note 10.

²⁰ See Daniel Grossman et al., *Care Post-Roe: Documenting Cases of Poor-Quality Care Since the Dobbs Decision*, Advancing New Standards in Reproductive Health 11-14, 19 (2024), https://www.ansirh.org/sites/default/files/2024-09/ANSIRH%20Care%20PostRoe%20Report%209.04_24_FINAL%20EMBARGOED_0.pdf.

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

²² *Service Members’ Reproductive Health and Readiness: Hearing Before the Subcomm. on Mil. Pers. of the H. Comm. on Armed Servs.*, 117th Cong. 17 (2022) (“Hearing”), <https://www.congress.gov/117/chr/CHRG-117hhr/51197/CHRG-117hhr/51197.pdf>.

issue.”²³ Active-duty members testified before Congress that restricted access “degrades morale,” “affects retention,” and could discourage new recruits from joining the military altogether.²⁴

Accessible reproductive healthcare directly supports retention. Women are more likely than men to leave military service, and the ability to control decisions about whether and when to have children contributes to women’s disproportionate departures.²⁵ Indeed, reproductive healthcare access affects the retention of all servicemembers, including men.²⁶ When a servicemember’s spouse or dependent cannot access care, the servicemember may need to take extended leave, or leave the military altogether.²⁷ The effects of lack of access to reproductive healthcare extend beyond individual servicemembers to their families, and, in turn, to the military as a whole.

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

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

²⁵ See GAO Report, *supra* note 13, at 2, 29; see also Douglas Lindsay, *The Military Is Growing Again but Capacity, Not Recruiting, Is the Real Test*, Military.com (Jan. 27, 2026, at 03:00 ET), <https://www.military.com/feature/2026/01/26/military-growing-again-capacity-not-recruiting-real-test.html> (citing stable family support as a consideration for retention across the military).

²⁶ See Lindsay, *supra* note 25.

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

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

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

Federal law prevents the Department of Defense from using funds to provide abortions, “except where the life of the mother would be endangered if the fetus were carried to term or in a case in which the pregnancy is the result of . . . rape or incest.”²⁸ Unless those exceptions apply, “[n]o medical treatment facility or other facility of the Department of Defense may be used to” provide an abortion.²⁹ In practice, servicemembers seeking non-covered abortions must pay out-of-pocket and travel to non-military providers. These restrictions already place a significant burden on servicemembers. Telemedicine access to abortion where it is permitted alleviates these financial and logistical impositions by reducing the costs associated with travel to an in-person clinic.

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

²⁸ 10 U.S.C. § 1093(a).

²⁹ *Id.* § 1093(b).

³⁰ Exec. Order No. 14182, Enforcing the Hyde Amendment, 90 Fed. Reg. 8751, 8751 (Jan. 24, 2025).

³¹ *Id.*

Following the Executive Order, federal agencies issued two significant policy changes affecting servicemembers and veterans. First, in early 2025, the Department of Defense rescinded regulations that authorized transportation allowances for servicemembers to travel for reproductive healthcare.³² For the reasons explained in Section II.C., limiting or impeding such travel places an extraordinary burden on female servicemembers. Second, in December 2025, the Department of Veterans Affairs ceased providing any abortions to veterans and their dependents, including in cases of serious health risks, rape, or incest.³³

Federal law and policy already significantly burden access to abortion for servicemembers, veterans, and their families. Additional restrictions on mifepristone would compound these barriers.

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

Beyond federal restrictions, servicemembers and veterans face significant obstacles to accessing reproductive healthcare at the state level.

Since *Dobbs*, abortion access has been severely curtailed in many states. As of this writing, 25 states place significant restrictions on abortion.³⁴ These restrictions have compounding effects not just for women in those states, but also for women

³² Memorandum from Sarah W. Moore, Deputy Director, Def. Travel Mgmt. Off., Dep't of Def. to Military Advisory Panel (Jan. 29, 2025), https://www.af.mil/Portals/1/documents/2025SAF/Remove_Travel_for_Non-Covered_Reproductive_Health_Care_Services.pdf.

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

³⁴ See *Interactive Map: US Abortion Policies and Access After Roe*, Guttmacher Inst. (last visited May 6, 2026), <https://states.guttmacher.org/policies/>.

nationwide seeking reproductive healthcare. Clinics in states where abortion remains accessible are overwhelmed with patients, including those traveling from out of state.³⁵ Clinic closures have further reduced provider availability,³⁶ meaning that even servicemembers stationed in states where abortion is permitted may have to travel far or face delays to obtain in-person care.

These nationwide access challenges compound the unique burdens military service imposes.³⁷ Servicemembers needing in-person abortion care must often report their pregnancy up the chain of command, obtain commander approval to travel, and navigate unpredictable deployments to locations not of their choosing.³⁸ These procedural and logistical requirements impose substantial burdens civilian patients do not face—burdens that can be avoided entirely with telehealth access to abortion.

Even in states where abortion is available, servicemembers encounter long drives, scheduling hurdles, and fear of professional consequences. One active-duty servicemember testified before Congress that to obtain an abortion, she drove 3.5 hours from the base where she was stationed, only to discover she was subject to a three-day mandatory delay period.³⁹ Given her training schedule, she was forced to

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

³⁶ See Sen. Elizabeth Warren et al., *The “Defund” Disaster: How the Republican Attack on Planned Parenthood Is Hurting Patients and Raising Americans’ Health Care Costs* 1 (2026), https://www.warren.senate.gov/imo/media/doc/_senate_defund_report.pdf.

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

³⁸ See Hugh McClean, *The Military’s Abortion Crisis in the Aftermath of Dobbs v. Jackson Women’s Health Organization*, 16 U.C. Irvine L. Rev. 1, 8-11 (2026); see also Steve Walsh, *Faced With Obstacles to Abortion, Military Women Have Built Their Own Support System*, NPR (Oct. 30, 2024, at 05:00 ET), <https://www.npr.org/2024/10/29/nx-s1-5162443/women-in-the-military-abortion-roe-v-wade>.

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

delay her care, eventually obtaining it in another state.⁴⁰ Another active-duty servicemember testified that the idea of disclosing her pregnancy to male-dominated leadership made her feel “devastated, lost, and alone.”⁴¹ She feared her military career would “fall[] apart” if she had to discuss her pregnancy with leadership.⁴² She was ultimately able to book a Saturday appointment at an abortion clinic to avoid the “critical hurdle” of requesting time off.⁴³ For servicemembers who do request time off to obtain an abortion, there is no guarantee that their supervisor will grant the request.⁴⁴

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

Requiring servicemembers and veterans to obtain care from unfamiliar civilian providers also imposes unique psychological burdens—particularly for those with service-related trauma—that telemedicine can alleviate or mitigate. Andrea Goldstein, a lieutenant commander in the U.S. Navy Reserve with over 16 years of

⁴⁰ *Id.* at 5–6.

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

⁴² *Id.*

⁴³ *Id.*

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

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

service, described the unique barriers servicemembers face when forced to seek care from unfamiliar civilian providers:

I far prefer to get my medical care through the VA because the providers there are trauma- and service-informed. They understand and are specifically trained with cultural competency regarding my experience. Being forced to go to a private clinic for something as personal as reproductive healthcare, to sit in an unfamiliar waiting room and put myself in the hands of a provider who may not be equipped to treat someone with military trauma is daunting. Telemedicine removes those barriers. It lets you access care from the privacy of your own home, on your own terms, without that uncomfortable and potentially unsafe in-person experience.⁴⁶

Servicemembers and veterans may also face protestors or harassment at non-military facilities that provide abortion.⁴⁷ These burdens—unfamiliar providers, lack of trauma-informed care, and exposure to harassment—are not merely personal inconveniences. They deter servicemembers from seeking care, delay treatment, and reduce personnel available for duty.

Veterans face particular challenges. After serving their country, many confront chronic health conditions stemming from military service that complicate reproductive healthcare decisions.⁴⁸ They also tend to experience pregnancy at older ages, elevating the risk of pregnancy complications.⁴⁹ Recent Department of Veterans

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

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

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

⁴⁹ *Id.*

Affairs policy changes exacerbate these barriers, but telehealth access to mifepristone alleviates many of them.

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

Telehealth access to mifepristone directly mitigates the readiness harms described above. For servicemembers stationed where it is permitted to obtain such care remotely, telehealth preserves personnel availability, reduces the need for command-level intervention, lessens unit disruption, and allows servicemembers to continue fulfilling their duties.

Under the current regulatory framework, where state law permits, patients can undergo a telehealth evaluation and receive mifepristone by mail without travel, leave protocols, or command approval processes. For servicemembers, this means obtaining essential care without the time and resources that in-person visits demand.

Servicemembers who cannot access mifepristone through telehealth face far more dangerous alternatives, such as delayed care, travel under hazardous conditions, or lack of care altogether—each carrying significantly higher medical risks. For servicemembers stationed at remote installations, telehealth is not merely convenient; it is often the only feasible pathway to timely care.

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

preparedness, recruitment, and retention. Together, these burdens degrade overall military readiness.

A stay of the 2023 REMS reintroduces barriers to care that will immediately and concretely harm military readiness, imposing irreversible national security costs. The Nation's security depends on the military's ability to effectively deploy its troops during a period of active conflict. Harms to military readiness tip the balance decisively in favor of staying or vacating the Fifth Circuit's order.

CONCLUSION

For the foregoing reasons, the Court should grant the applications to stay or vacate the Fifth Circuit's stay of the 2023 REMS.

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