



Jaime Miracle, Deputy Director
House Health Committee
Testimony in Opposition to HB 324
October 8, 2025

Chair Schmidt, Vice Chair Deeter, Ranking Member Somani, and members of the House Health Committee, thank you for accepting my testimony in opposition to House Bill 324, a bill to limit access to medications based on junk science. My name is Jaime Miracle, and I am the deputy director for *Abortion Forward*, formerly Pro-Choice Ohio.

In 2023 voters overwhelmingly passed the Ohio Reproductive Freedom Amendment and added Article 1, Section 22 to the Ohio Constitution. This section reads, in part,

“Every individual has the right to make and carry out one’s own reproductive decisions, including but not limited to, contraception; fertility treatment; continuing one’s own pregnancy; miscarriage care; and abortion. The State shall not, directly or indirectly, burden, penalize, prohibit, interfere with, or discriminate against either: an individual’s voluntary exercise of this right or a person or entity that assists an individual exercising this right, unless the State demonstrates that it is using the least restrictive means to advance the individuals health in accordance with widely accepted and evidence-based standards of care.”¹

The most important part of this excerpt for HB 324 is “in accordance with widely accepted and evidence-based standards of care.” HB 324 is in direct conflict with the Ohio Constitution because it seeks to use junk science to override widely accepted, evidence-based standards of care.

By requiring the director of the Ohio Department of Health to use non-standardized, potentially inaccurate information in determining which medications would be restricted if HB 324 passes, the bill falls outside of “widely accepted” data and “evidence-based standards of care.” What happens when the available evidence used to determine the safety of a medication conflicts with other research on the medication safety?

This bill does not allow for the director to use real, peer-reviewed research published in scholarly journals. It limits them to only a handful of data sources, some of which may or may not be able to show the true picture of the medication’s safety. It also always requires the director to use the “greater” number of complications, even when a single report claims to show a higher level of severe adverse effects than decades of previous research. It does not allow for the critical thinking and analysis necessary to scrutinize information and make informed decisions about what drugs should or should not receive higher levels of regulation.

Mifepristone was first approved by the FDA in 2000. Updates to the approval occurred in 2016 and again in 2021, using evidence-based standards of care to increase access to this safe and

¹ <https://codes.ohio.gov/ohio-constitution/section-1.22>

effective medication. The 2021 update removed the in-person dispensing requirement for Mifepristone. Studies have repeatedly shown that the use of telemedicine for medication abortion is safe, increases access to the medication, and reduces barriers faced by individuals in underserved areas, like those living in rural areas who would otherwise have to travel hours to get to the closest physical clinic to access abortion care.

One of these studies published in the journal *Nature Medicine* in 2024 was a multi-state study of the provision of Mifepristone along with misoprostol, one of the available protocols for medication abortion via telemedicine. The study included both real-time videoconferences or other synchronous communication, or asynchronous communication using secure messaging services. This research found a rate of severe adverse event of 0.25%, and only 1.3% of abortions were followed by emergency room visits. They found no evidence of differences in effectiveness or safety between the synchronous and asynchronous models of care.² This complication rate is similar to that found in other research of in-clinic models of care, where studies have found the rate of severe adverse effects of 0.2% to 0.5%.^{3,4,5}

Proponents of this bill have been citing a single, self-published, non-peer reviewed report by an anti-abortion organization, The Ethics and Public Policy Center (EPPC), to claim Mifepristone is more dangerous than has been found by previous research. This report has multiple flaws that make the claimed results suspect at best. I'd like to highlight a few of these deficiencies:

1. The authors have refused to reveal the source of their data, precluding the ability of any other research team to independently analyze or replicate their results. If the team at EPPC stands behind their results, why are they too scared to allow someone to independently verify their results?
2. The report uses data from anyone who has taken Mifepristone, not just individuals using it for medication abortion. By not exclusively using data from abortion, it is impossible to claim that the potential complication was connected to an abortion, miscarriage care, or the use of Mifepristone for the treatment of other conditions such as Cushing's syndrome.
3. Important terms used in the report like, "other abortion-specific complications" and "hemorrhage" are not defined in the report. Without definitions and more information about what was included in those categories, it is impossible to know if the situations were severe in nature or even related to abortion at all.⁶

² Upadhyay, U.D., Koenig, L.R., Meckstroth, K. *et al.* Effectiveness and safety of telehealth medication abortion in the USA. *Nat Med* **30**, 1191–1198 (2024). <https://doi.org/10.1038/s41591-024-02834-w>

³ Raymond, E. G., Shannon, C., Weaver, M. A. & Winikoff, B. First-trimester medical abortion with mifepristone 200 mg and misoprostol: a systematic review. *Contraception* **87**, 26–37 (2013). [https://www.contraceptionjournal.org/article/S0010-7824\(12\)00643-9/fulltext](https://www.contraceptionjournal.org/article/S0010-7824(12)00643-9/fulltext)

⁴ Upadhyay, U. D. *et al.* Incidence of emergency department visits and complications after abortion. *Obstet. Gynecol.* **125**, 175–183 (2015).

https://journals.lww.com/greenjournal/fulltext/2015/01000/incidence_of_emergency_department_visits_and.29.aspx

⁵ Cleland, K., Creinin, M. D., Nucatola, D., Nshom, M. & Trussell, J. Significant adverse events and outcomes after medical abortion. *Obstet. Gynecol.* **121**, 166–171 (2013).

https://journals.lww.com/greenjournal/abstract/2013/01000/significant_adverse_events_and_outcomes_after.25.aspx

⁶ https://www.ansirh.org/sites/default/files/2025-09/Anderson%20and%20Hall%20Review_Final.pdf

Ohioans deserve accurate information about their healthcare, not politically motivated regulations using junk science to limit access to a medication with a proven safety and efficacy record over more than 25 years. Let's call this what it is: a political attack on the will of the people who have so clearly demonstrated that reproductive rights are important to them.

After the *Dobbs* decision overturned *Roe* in 2022, many states enacted laws banning or severely limiting access to abortion. Today, 12 states have banned abortion and another six states severely limit it with six-week bans or similar legislation. But amidst this chaos, it is estimated that one in four abortions in the US are obtained via telemedicine.⁷ Medication abortion access via telemedicine has been a critical piece to ensure people have access to abortion in our post-*Dobbs* world. This, not false flags about concerns for patient safety, is why HB 324 has been introduced – to limit access to a lifeline that many individuals in Ohio and across the country have found, and to deny them have access to the abortion care they need. I urge you to not fall for the lies and to vote no on HB 324.

I welcome any questions you may have for me today.

⁷ <https://societyfp.org/wp-content/uploads/2025/06/WeCount-Report-9-December-2024-data.pdf>