IMPACT REPORT
Anti-Abortion Legislation as a Threat to Direct-to-Patient Telehealth

Why this matters to the telehealth community

In the current legislative sessions, at least six states introduced and advanced bills that establish precedent to restrict telehealth, with the direct-to-patient model as the real target. These bills restrict telehealth prescribing authority, place onerous administrative burdens on providers and healthcare systems, and create medically unnecessary in-person visitation mandates by restricting mail-order medication delivery and adding new drugs to state-controlled substance schedules. While these bills are intended to restrict access to medication abortion, their impact has the potential to restrict access to telehealth services in oncology, psychiatry, cardiology, behavioral health, and other telehealth specialties.

The telehealth community's vision for a future of healthcare is fundamentally one that expands access to a direct-to-patient model. Telehealth **core principles** call for health **policies** that are technology, modality, and site-neutral. This report highlights how current legislative trends counter these principles. These trends fall into three primary categories that could undermine direct-to-patient telehealth as a viable pathway to safe, effective care within the established standard of care.

- **In-Person Mandates:** Iowa SSB 3115, Ohio HB 324, Nebraska LB 512. Statutory language requires a physical examination by the prescribing physician before dispensing or reclassifying pharmaceuticals as controlled substances as a means to trigger in-person prescribing requirements.
- **Controlled Substance Reclassification:** South Carolina HB 4760. Scheduling status triggers existing state-law in-person prescribing requirements for all controlled substances. No new telehealth-specific language is introduced here, but the rescheduling places a de facto ban on direct-to-patient telehealth.
- **Offense for Criminal Distribution:** Mississippi HB 1613, Iowa HF 2155, Arizona HB 2364. Distribution, shipment, or mail delivery constitutes a criminal offense. Telehealth prescribing that results in mail delivery is considered felony distribution.

I. IN-PERSON VISIT MANDATES – TELEHEALTH ELIMINATION BY STATUTE

The most direct threat comes from bills that prohibit telehealth by creating mandatory and medically unnecessary in-person visitation requirements to prescribe medication abortion. The language of these bills may be applied to reach other drugs that legislators choose to target.

Ohio HB 324 Creates a State-Run Drug Blacklist That Eliminates Telehealth Prescribing

Ohio HB 324 (passed the House, Nov. 2025) creates a permanent administrative mechanism via a publicly posted list of drugs that triggers a mandatory in-person visit requirement to be determined at the discretion of the state's Director of Health. Any drug that causes "serious adverse effects" in more than five percent of patients is eligible for the list.

Relevant Bill Language
HB 324 operative framework: *A prescriber must conduct an in-person exam, provide a clear disclosure of risks, and offer follow-up care for all drugs that cause "serious adverse effects" in over five percent of patients. "Serious adverse effect" means any of the following: death; infection requiring hospitalization; hemorrhaging requiring hospitalization; organ failure; or sepsis.*

The Broader Telehealth Threat

- **Expanding state drug regulation sets a precedent with far-reaching consequences.** Once a state health director has an emboldened authority to designate drugs as "telehealth-prohibited," that can be applied to any medication: controlled substances, high-risk cardiac medications, and biologics. This is the template for a parallel FDA, one run by political appointees with no peer-review standard. The bill's sponsor specifically named SSRIs as a potential target, in addition to reproductive healthcare-related drugs, during committee hearings.
- **Dr. Eric Shapiro, in formal opponent testimony, warned:** "What is to stop the director of health from artificially limiting access to [any drug]? The bill's proponents are willing to accept any report that supports their desire to limit access to certain telehealth prescriptions… individuals who wish to limit access to certain telehealth prescriptions will be able to cherry-pick data and avoid peer review and interfere with the practice of medicine."

Iowa SSB 3115 Bans Telehealth Prescribing by Requiring In-Person Dispensing and Adds Civil Liability

Iowa SSB 3115 (passed Senate Judiciary subcommittee, Feb. 2026) requires abortion medications mifepristone and misoprostol to be administered and prescribed in person. The bill prohibits mail or courier delivery of the medications from any provider.

Relevant Bill Language

SSB 3115 on in-person requirement and civil liability: *"[T]he bill would require providers to only dispense abortion drugs mifepristone and misoprostol in person, rather than through telehealth or by mail… The bill would allow providers who break the law to be sued 'for all damages caused by the abortion-inducing drug suffered by' the woman who took the abortion pills, the father of the unborn baby, or the woman's immediate family."*

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- **Civil liability exposure chills all telehealth prescribing.** When a bill creates such an opportunity for third-party lawsuits, every prescriber in the state must factor potential liability into any telehealth prescription. Whether or not this is enforced, it creates confusion and a chilling effect for remote prescribing.

Nebraska LB 512 Mandates Medically Unnecessary In-Person Examination and Follow-Up, Adding Criminalization for Non-Compliance

Relevant Bill Language

- *"Before a physician provides an abortion-inducing drug, the physician shall: (1) Examine the woman in person; (2) Independently verify that the woman is pregnant; (3) Determine whether the woman has an ectopic pregnancy; (4) Document in the medical record the gestational age and location of the pregnancy; (5) Determine the woman's blood type, and if a woman is Rh negative, offer to administer Rh immunoglobin…; and (6) Document in the medical record whether or not the woman received treatment for Rh negativity."* LB 512, Sec. 3 (full pre-prescribing requirements)
- *"A physician who provides an abortion-inducing drug, or the physician's agent, shall schedule a follow-up visit between the physician and the woman… Such follow-up visit shall occur no earlier than the third day and no later than the fourteenth day after the date the abortion-inducing drug was provided."* LB 512, Sec. 4 (mandatory follow-up)
- *"Violation of the Chemical Abortion Safety Protocol Act" constitutes "unprofessional conduct" defined as "any departure from or failure to conform to the standards of acceptable and prevailing practice of medicine and surgery or the ethics of the profession, regardless of whether a person, patient, or entity is injured."* LB 512, Sec. 7 (enforcement — unprofessional conduct):

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- **"Unprofessional conduct" hook** redefines acceptable medical practice for licensing purposes. Any telehealth physician who prescribes drugs that induce an abortion without conducting an in-person examination under this statute has committed "unprofessional conduct," subjecting prescribers to additional oversight by licensing bodies.
- **The follow-up visit mandate mirrors controlled-substance frameworks:** the statutory requirement that patients physically return within 3–14 days post-prescription is medically unnecessary for a medication abortion and is structurally identical to the in-person follow-up requirements for Schedule II/III controlled substances in many states. Mandating medically unnecessary in-person contact for patients for care treatment prohibits telehealth care.

II. CONTROLLED SUBSTANCE RECLASSIFICATION: THE BACKDOOR TELEHEALTH BAN

In most states, Schedule IV status triggers a set of **mandatory in-person prescribing requirements**, heightened documentation obligations, and Prescription Drug Monitoring Program (PDMP) reporting that effectively prohibit telehealth as a viable prescribing pathway. By reclassifying mifepristone and misoprostol (the latter of which is approved for ulcers with no REMS requirements), states are leveraging drug scheduling systems as a political tool to restrict medications instead of centering the patient, healthcare, or relying on scientific evidence.

Ohio HB 324 Creates a Framework for Restricting Any Medication

In addition to the medically unnecessary, mandatory in-person requirement created by this legislation, Ohio HB 324 fails to restrict a named drug. It creates a permanent administrative list of drugs requiring in-person prescribing, maintained by the state health director, triggered by a five percent serious adverse events threshold drawn from insurance data, FDA reports, and patient self-reports.

Relevant Bill Language

(C)(1) *For purposes of this section, the director of health is responsible for determining if a dangerous drug causes one or more severe adverse effects in greater than five per cent of the drug's users. In making such a determination, both of the following apply:*

(a) *The director shall consult with the superintendent of insurance and executive directors of the state board of pharmacy and state medical board.*

(b) *The director shall base the determination on the greater of insurance claims, patient reports of severe adverse effects to health care professionals, and any applicable data available from the United States food and drug administration.*

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- **The bill's co-sponsor intends to extend these restrictions beyond medication abortion and explicitly names SSRIs as a potential future target**. Antidepressants are among the most commonly prescribed medications via telehealth in the country. The expansion of behavioral health via telehealth depends on the remote prescribing authority for this class of drugs.
- **The data standard is politically manipulable.** The bill uses insurance claim data — the same data source used by the Ethics and Public Policy Center (EPPC) in a widely-criticized study claiming 1-in-10 mifepristone users suffer serious adverse events (a claim that combines miscarriage care, Cushing syndrome treatment, and other non-abortion uses of the drug without disaggregation). The same methodology could be applied to any drug with a politically motivated data sponsor.

South Carolina HB 4760 Reclassifies Mifepristone and Misoprostol as Schedule IV, Adding Felony Distribution Penalties

South Carolina HB 4760 (passed the House 76-28, sent to Senate Feb. 5, 2026) simultaneously creates new criminal penalties for providing abortion-inducing drugs and adds mifepristone and misoprostol to Schedule IV of the state Controlled Substances Act.

Relevant Bill Language

HB 4760, Title of Act: *"TO AMEND THE SOUTH CAROLINA CODE OF LAWS BY ADDING ARTICLE 8 TO CHAPTER 41, TITLE 44 SO AS TO CREATE CRIMES AND ASSOCIATED PENALTIES REGARDING THE USE OF ABORTION-INDUCING DRUGS, WITH EXCEPTIONS; BY AMENDING SECTION 44-53-250, RELATING TO SCHEDULE IV CONTROLLED SUBSTANCES, SO AS TO ADD MIFEPRISTONE AND MISOPROSTOL..."*

- HB 4760, Sec. 44-41-820(B), criminal penalties: *"Any person who knowingly performs an abortion by means of an abortion-inducing drug in violation of this section is guilty of a felony and, upon conviction, must be imprisoned for not more than five years, or fined not more than fifty thousand dollars, or both." [Escalating to 10 years, 50 years if the pregnant woman suffers serious injury or is under 18.]*
- HB 4760, Sec. 44-41-820(C)(5), the narrow in-person carve-out: *"[T]he act of administering an abortion-inducing drug when the drug is administered by a physician licensed by the South Carolina Board of Medical Examiners who administers the abortion-inducing drug in person to the pregnant woman when such administration is otherwise lawful..."*

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- **The only legal safe harbor requires in-person administration.** The bill's sole affirmative defense against felony prosecution is that the drug was dispensed in person by a licensed SC physician. There is no telehealth exception. There is no mail-order exception. The Schedule IV classification, combined with felony penalties, creates absolute criminal liability for any telehealth prescribing of these drugs.
- **Schedule IV status is the infrastructure threat**. Once mifepristone and misoprostol are Schedule IV in South Carolina, every prescribing restriction that applies to benzodiazepines, sleep aids, and other Schedule IV drugs applies to them. If a legislator subsequently wants to apply those same restrictions to any other medication, the Schedule IV pathway is the proven playbook.
- **The pharmacist carve-out reveals the targeting.** HB 4760 Section 44-41-820(C)(6) exempts pharmacists filling prescriptions for "a bona fide medical reason" — but only if a diagnosis code indicating non-abortion use is written on the prescription. This creates a surveillance mechanism: every prescription for mifepristone or misoprostol must carry a certified statement of intended non-abortion use. Telehealth prescribers cannot practically comply with this requirement without an in-person examination.

Mississippi HB 1613: Uses Overbroad Language to Criminalize a Person for Having FDA-Approved Medication in Their Possession

Mississippi HB 1613 began as a non-substantive fix to the state's aggravated drug trafficking law. An amendment on the House floor (passed 77-39, Feb. 11, 2026) added "abortion-inducing drugs" to the list of traffickable controlled substances, without specifically naming the pharmaceuticals included in that category.

Relevant Bill Language

- *"AN ACT TO AMEND SECTION 41-29-139, MISSISSIPPI CODE OF 1972, TO REVISE THE ELEMENTS FOR THE CRIME OF AGGRAVATED DRUG TRAFFICKING TO INCLUDE 200 OR MORE DOSAGE UNITS; TO RESTRICT THE SALE OF ABORTION-INDUCING DRUGS; AND FOR RELATED PURPOSES."* HB 1613, Act Title (as amended):
- The amendment would prohibit the *"creating, distributing, dispensing, prescribing, or possessing with intent"* of abortion-inducing drugs without an in-person physical examination. HB 1613 amendment, prohibitions.

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- **Undefined term is the danger** — the bill's sponsor, Rep. Celeste Hurst, has been unable or unwilling to name the exact drugs covered by the amendment stating: "There are a couple of drugs that were specifically created for other purposes." A drug trafficking statute that covers an undefined category of "abortion-inducing drugs" creates open-ended criminal exposure for pharmacists, telehealth prescribers, and mail-order dispensaries that ship to Mississippi patients.
- **Trafficking charges create a federal nexus** — once distribution of a drug is classified as drug trafficking under state law, interstate shipment raises potential federal trafficking exposure. This mechanism could convert a telehealth prescribing violation into a federal felony that would be applicable to any out-of-state provider using the mail or a carrier to deliver medication to a Mississippi patient.
- **The amendment was added to a pre-existing non-substantive or "technical" bill** — this is not an oversight. Using an existing criminal infrastructure bill as a vehicle to restrict telehealth abortion care removes public scrutiny that a standalone bill would have.

Iowa HF 2155 Creates a Felony for Manufacturing or Distributing Abortion-Inducing Drugs

Iowa HF 2155 (introduced in the 2026 session) makes the manufacture or distribution of abortion-inducing drugs a Class C felony, which in Iowa carries a maximum 10-year prison sentence.

Relevant Bill Language

- *HF 2155: The bill makes manufacturing or distributing abortion-inducing drugs a Class C felony — the same felony classification used for drug related felonies in Iowa. Distribution by any means, including telehealth prescription and mail delivery, falls within the statute's scope.*

The Broader Telehealth Threat

- Felony classification converts telehealth prescribers into drug distributors. Under HF 2155, an Iowa-licensed physician who prescribes mifepristone via telehealth and causes it to be mailed to a patient is a "distributor" of a Class C drug, which is a felony. An out-of-state telehealth provider who mails mifepristone to an Iowa patient faces potential extradition exposure. This criminal law mirrors South Carolina's civil law mechanism.
- This legislation directly attacks two core telehealth policy priorities, 1) the right of providers to prescribe controlled substances via telemedicine regardless of patient location, and 2) the removal of barriers to interstate telehealth access. By classifying telehealth prescription-plus-delivery as felony drug distribution, HF 2155 doesn't just restrict a single drug; it redefines the legal identity of the telehealth prescriber. A physician who consults remotely and causes medication to be mailed is no longer a "prescriber" under this statute; they are a "distributor" of a controlled substance, subject to criminal prosecution and potential extradition.
    - The ATA's Interstate Barriers Principles (Oct. 2025) explicitly warn that overly restrictive state requirements can "unintentionally impede access to timely care". HF 2155 does so deliberately, using the criminal law apparatus to make the consult → prescribe → deliver model legally untenable in Iowa for any physician, in-state or out.

III. MAIL AND DIRECT-TO-PATIENT DELIVERY PROHIBITIONS

Even where in-person mandates and criminal reclassification have not yet passed, a third category of legislation directly targets the direct-to-patient pharmaceutical delivery infrastructure.

Arizona HB 2364 Criminalizes Selling, Shipping, Delivering, and Receiving Abortion Medication by Mail

Arizona HB 2364 (advancing Feb. 2026, despite a Feb. 6 court ruling striking down Arizona's existing telehealth abortion ban) attempts to criminalize the entire mail-delivery supply chain for medication abortion, which includes a manufacturer, shipper, prescriber, and patient.

Relevant Bill Language

HB 2364 (per AZCIR review, Feb. 2026): The bill attempts to criminalize "selling, shipping, delivering and receiving abortion medication by mail." The bill's sponsor stated the measure was intended to enforce existing law, which has already been struck down by courts as unconstitutional under Arizona's Proposition 139.

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- **The supply chain prohibition is a direct-to-patient threat.** “Selling, shipping, delivering, and receiving" is overbroad and captures every participant in the medication delivery process of “abortion medication” (without naming these medications), including the manufacturer, the specialty pharmacy, the common carrier, the licensed provider, and even the patient. A statute structured this way does not merely restrict abortion access — it criminalizes the direct-to-patient pharmaceutical model itself for any drug placed on the prohibited list.
- **Legislative persistence after court rulings signals intent.** HB 2364 was advanced two weeks after a Maricopa County Superior Court judge permanently struck down Arizona's existing telehealth abortion ban as unconstitutional.

RECOMMENDED RESPONSES

- **Oppose mandatory in-person requirements:** telehealth advocates should explicitly identify that these bills attack telehealth infrastructure, not merely abortion access. The framing "this is an abortion bill" allows legislators to dismiss telehealth concerns as collateral. The framing "this creates a state drug blacklist that eliminates telehealth prescribing" puts the structural threat on the table.

- **Invoke modality-neutrality as a bright-line principle:** the policy principle that health policy must be technology, modality, and site-neutral is undermined by every in-person mandate, mail prohibition, and delivery criminalization in these bills. When telehealth advocates can clearly name this principle and how it is violated pro-telehealth legislators will need to reconcile this inconsistency.

- **Oppose administrative drug blacklist mechanisms categorically:** Ohio HB 324's state health director list is the most dangerous structural innovation amongst these bills. Telehealth coalitions should oppose the creation of state-administered in-person prescribing lists, regardless of which drugs appear on the initial list.

- **Track bills related to engaging with state medical and pharmacy boards on the controlled substance scheduling angle directly:** South Carolina HB 4760's Schedule IV additions put that priority directly at issue. Telehealth advocates in affected states should engage state pharmacy boards and medical licensing boards now. At RHITES, we are closely monitoring any legislation that names itself as relating to drug trafficking or controlled substances, as we understand these bills are often used as vehicles that restrict both telehealth and reproductive healthcare access.