THE BROOKINGS INSTITUTION

WEBINAR

THE NEW LANDSCAPE OF ABORTION RIGHTS IN AMERICA

Washington, D.C.

Tuesday, July 12, 2022

PARTICIPANTS:

ELAINE KAMARCK, Moderator
Senior Fellow and Founding Director, Center for Effective Public Management
The Brookings Institution

CAMILLE BUSETTE
Senior Fellow and Director, Race, Prosperity, and Inclusion Initiative
The Brookings Institution

ARIANA B. KELLY (D)
Delegate
Maryland House of Delegates

BERNADETTE MEYLER
Carl and Sheila Spaeth Professor of Law
Professor, by courtesy, English Associate Dean for Research and Intellectual Life
Stanford Law School

* * * * *

P R O C E E D I N G S

MS. KAMARCK: Good morning, everyone, and welcome to this Brookings seminar. My name is Elaine Kamarck and I'm a senior fellow here at the Brookings Institution and the Founding Director of the Center for Effective Public Management. I'll be your moderator today for a very important topic, "The New Landscape of Abortion Rights in America".

Before we get started, let me remind you that if you want to submit a question via email you can do so at Events@Brookings.edu and via Twitter @BrookingsGov #PostRoe.

So, let's begin.

Nearly 3 weeks ago the Supreme Court overturned Roe v. Wade, rescinding the constitutional right to abortion, a protection that had been in place for nearly 50 years. This ruling transfers abortion related decision making and enforcement responsibilities to individual states. Consequently, millions of Americans are left questioning if and to what extent they are still protected under the law, how different states will enact and interpret different laws, and what, if any, action Congress or the Federal Government might be taking to impact abortion in this new era.

Today we're going to explain this altered landscape of abortion rights and the lasting impact this ruling with have on vulnerable populations across the country. To do so we have three experts on the topic. Let me introduce them to you in the order that I will call on them.

Our first guest is professor Bernadette Meyler, the Carl and Sheila Spaeth professor of law at Stanford Law School. She is also a Ph.D. in English literature and her research and teaching bring together the sometimes surprisingly divided fields of legal history, law, literature. She examines the long history of constitutionalism, reaching back into the English common law ancestry of the U.S. Constitution. Her 2019 book, "Theaters of Pardoning", demonstrates that the representation of pardoning tracks changing conceptions of sovereignty. And her current project, common law originalism, shifts to the American context looking at multiple 18th century common law meanings, both Colonial and English, of various constitutional terms and phrases.

Our next speaker will be the Honorable Ariana Kelly, who has represented the 16th District in the Maryland House of Delegates since 2010. Kelly has been an important and effective advocate for the diverse needs of women and her families. Her legislative record is really impressive. It

includes requiring insurance coverage for autism, family and medical leave, expanding access to prenatal and mental health care. In 2018 she passed legislation to require consent education be included in Maryland's sex education curriculum, which has sparked national conversations and led other states pursuing similar legislation.

For our purposes here today, however, I want to note that Delegate Kelly was the driving force behind the landmark Abortion Care Access Act, which has been copied in many other states and which we'll hear about in a moment.

And, finally, last but not least, is our Brookings' own Camille Busette. She's a Senior Fellow in Governance Studies with affiliated appointments in economic studies and the Metropolitan Policy programs. She is also the Director of the Race, Prosperity, and Inclusion Initiative, Brookings' cross program initiative focused on issues of equity, racial justice, and economic mobility. At Brookings her work is focused on systemic racism, the economic advancement of black and Native American boys, the importance of social relationships to economic mobility, and equity in healthcare and in local and state government policy priorities. And it builds on her work for low-income populations at EARN, now SaverLife, and the Center for America Progress.

So, with this great group to begin, let me start with Professor Meyler.

Bernadette, as a constitutional scholar I would like you to place the Dobbs case in the broader historical context. You recently wrote, and I quote, "Going forward, the majority said the Court will instead consider whether the law being challenged is the same as or analogous to historical restrictions." And then later you say without a method for determining the existence of scope of a right outside of a resort to the history books, the Supreme Court's new approach augers an era rife with discrimination and replete with confusion.

And, in addition, I'd like you to comment a subtext here, the probability that one state could enforce its laws in another state. In the Kavanaugh writings on this, he opined that those states could not constitutionally prohibit women from traveling inter-state to obtain an abortion. But as we'll see when Ariana discusses state legislatures, they seem to be passing laws with exactly the opposite intent in mind. And, of course, many in the pro-life movement are now focusing on Federal action.

So, I'd like you start by bringing some clarity to both of these debates.

Bernadette, the floor is yours.

MS. MEYLER: Thank you so much and thanks so much for having me, Elaine. It's a pleasure to be here with this panel.

So, I'll begin with this question of how the Court in Dobbs thinks about the scope, or lack thereof, of a right to abortion in relation to historical statutes. And I think it's not coincidental that the Court issued its decision on the Second Amendment and the Dobbs decision in very close proximity because both of them use very similar methods.

In general, the Court has looked more broadly historically at defining rights. So, if we were thinking about substantive due process rights, generally there would be a question of whether the right was somehow a fundamental right, that it should be protected by ordered liberty, whereas the Court here is looking very specifically at whether abortion itself was protected historically not only at the time of the founding, but also in the 19th century. And so just as Alito has an elaborate appendix of 19th century state statutes prohibiting abortion, because he says well, the 14th Amendment was ratified in the 19th century so we can look to the 19th century and 19th century prohibitions to decide whether abortion should be protected or not.

Now, there is a very clear problem here, which is that women weren't voting in the 19th century. The 19th Amendment was ratified in the 20th century. Women weren't voting for any of these statutes in the 19th century. And so, if we think about returning to 19th century laws for guidance about which fundamental rights are protected as part of the due process clause of the 14th Amendment, we're going to enshrine a lot of discrimination. Not only were women not voting, we don't see sexual minorities enfranchised in any way. There's not kind of recognition of their rights.

So, there would be a whole kind of swath of issues that would arise if we look at the specific laws pertaining to particular rights from the 19th century, which I think is really a deviation from how the Court has generally thought about rights. And it's similar in the Second Amendment situation where Justice Thomas said well, we're not going to apply what we usually do in terms of levels of scrutiny, rationality review, strict scrutiny, intermediate scrutiny. Instead, we're going to say was there a similar restriction on bearing arms historically. Now, of course, we have an evolution in what arms are available, right. We didn't have nuclear weapons at the time of the founding. There are all sorts of things

that weren't present. And so just looking at the specific text is an extremely narrow way, I think, of understanding the history and will lead to a really cramped vision of how we think about rights in general, whether we're protecting them or not protecting them.

Now, turning to this other question about what happens with states and what happens when, as clearly is occurring already, we have extremely different landscapes with respect to protecting abortion between different states or criminalizing it.

Now, I want to say that there are sort of two different paths that states have been taking in penalizing both women seeking abortions and those who are helping them, whether it's the doctors who are performing the abortions or others who are involved in the process. One route is through civil liability. So, this is related to SB8, which was coming out of Texas. And that route of civil liability basically says that a private person can bring suit against either the person who's obtained an abortion or someone helping them and recover an enormous judgment against them. Now, there are some issues with this if we're thinking about it going inter-state. So, there are two questions that come up. One is whether a state is going to be able to exercise jurisdiction over some of the people who are being subject to suit. So, imagine a doctor in California performs an abortion on someone coming from another state that penalizes abortion, say coming from Texas, and they haven't advertised in Texas, they haven't done anything to kind of reach out into Texas, and then but they're still being sued. I think there's a question of whether or not Texas Courts could exercise jurisdiction over that person.

Now, at a later stage though, there's a question about whether California would have to recognize a judgment. If a Texas Court did issue a judgment against that person, would California have to recognize that judgment under the Full Faith and Credit clause. Now, California has passed a statute saying that it's — under a public policy kind of rational, that it's claiming that it's exempting people from judgments or from the application of judgments elsewhere against them who are performing abortions or who are, you know, involved in helping women obtain abortions. But I think there are going to be legal battles around the extent to which California can claim to exempt itself form Full Faith and Credit under that rationale or not.

Now, there's also — just briefly I'll say that there's also a kind of criminal angle as well, right. So, if states are criminalizing either women seeking abortions out of state or those providing the

abortions, that's going to be another question of whether those criminal laws can apply extra territorially outside of the state. Now, one issue with that, say if they are trying to prosecute a doctor elsewhere, would be that the Sixth Amendment protecting the rights of criminal defendants guarantees a trial in the vicinity of the crime. So, if say someone is performing an abortion in California and that's been criminalized in Texas, there would be serious questions about whether they could be tried in Texas given that the act occurred in California.

So, there are a lot of issues related to that. I'll just raise also that there are other questions about how medication abortions are obtained. The FDA has said that medication can be shipped inter-state for the purpose of procuring an abortion, but then — so it may be that the Federal Government has preempted state regulation on the front, but that's going to be another I think ongoing legal battle.

Thank you so much.

MS. KAMARCK: Wow. This is amazing. There is so much to unpack.

Let me follow up on one thing though for those of us who are not legal scholars.

Is the broad reasoning that you led with, which I know you've written about, where the Court goes to this odd notion that it had to have been something at the time in history. I mean, you know, it strikes me that taking abortion, for instance, you know, for much of human history abortion was a very dangerous thing to do. I mean, you know. And of course, in the last 50 years it's not a very dangerous thing to do. So, you could sort of see where people wanted to prohibit this. It killed women, et cetera.

And so, I'm wondering, where does this come from? Is this brand new on the Court or is the majority new? Did Alito always propose this? I mean how new is this in terms of the thinking of the Court.

MS. MEYLER: Yes. So, there is a strand of cases that provided a precedent here. They were really the ones that were driven by Former Chief Justice William Rehnquist. And he had articulated a test that was much more based in this very specific history. And it was most famously used by Justice Scalia in a case that involved saying that a non-marital father had no rights as a parent. And what Scalia did was he said well, there are no protections in the historical statues for specifically non marital fathers. There might be protections for fathers, but there's all of this stuff criminalizing adultery and extra marital

relations, et cetera. And so, we can't imagine that a non-marital father has the same rights as another father. So, he insisted on sort of very specifically understanding the rights as only the right of a non-marital father rather than a right of a father per se and then saying oh, we don't see in history that protection for a non-marital father.

So, if you go down that route though — I think it's generally been acknowledged even since that case — if you go down that route, then you're going to really have extremely limited rights. Many of the rights that we currently have, rights to contraception, rights to same sex marriage, aren't going to be protected.

MS. KAMARCK: Woo. And, you know, you just think about, how that was most of human history was also pre-DNA testing. So, we never really did know who fathers were and now we absolutely know who fathers are. That whole way of thinking about it is sort of fascinating and frankly a little disturbing.

Okay. Let's turn to Ariana.

Ariana, for this immediate future at least, and maybe for many years to come, all the action on this topic is going to be at the state level. And I think you need to go all the way back to the era of segregation or even slavery itself to find a time when the rights of a large number of people differed so dramatically from state to state. While a lot of attention has been paid to the laws, many of which seem distinctly dystopian, that have been passed in right to life states, states like Maryland, California, Oregon, and Connecticut have been working to counteract these movements.

The State of Maryland, and you in particular, have been a leader in these laws. Please take a few minutes to tell us about the legislation you passed, what brought you to do it, what it does, and the affect it's having on similar legislation in other states.

MS. KELLY: Thank you so much. And thank you for having me. This is a wonderful discussion of an unfortunate — I wish we were not having this discussion, but I'm glad that this forum exists to have it.

I'm coming to you from Ireland, so I apologize if my WiFi isn't great. But I just wanted to note that Ireland, an overwhelmingly Catholic country, in 2018 had a national referendum to legalize abortion, supported by almost 70 percent of the population. They think here in the U.S. we have lost our

marbles.

I represent Montgomery County, which is a suburb just outside of Washington, D.C., home to the three of the six Supreme Court Justices who got us to where we are now. So, you're welcome. What I see that we're really looking at as state legislators right now is figuring out how to address sort of three different buckets of challenges. The first is what the bill that I passed this year really addressed, which is access — access to care. So, states that support abortion rights need to figure out how to address a huge increase in need to provide care for folks from both in their state and outside of the state.

And then addressing sort of a second bucket of issues, which is stigma, right. There's this movement — now that the Roe decision has been overturned there's an increased pressure to stigmatize abortion care, right. The states that are banning abortion are not having no impact on our national culture. And this is something we've been dealing with for decades. That's sort of the second piece that Maryland's Abortion Care Access Act tried to address, both increasing access to care and reducing stigma around abortion care and providing abortion care. The anti-choice or pro forced birth movement really has worked just to stigmatize abortion care and also those people who provide abortion care, those clinicians. I like to call them healthcare heroes, but they might call them abortionists, as we saw in the opinion.

And then the third bucket of challenges that we have to face are what Bernadette sort of was just beginning to talk about, is this sort of — I like to think of it as legislative terrorism coming from other states. The goal isn't necessarily to be able to prosecute people in other states, right. The goal is to raise those questions. There are questions about whether they can do this, and just raising that question, it's a terrorist act. It creates fear among patients who might to travel and among clinicians who might be working in a safe state but be terribly afraid that a civil or a criminal judgment is going to come after them. And creating that fear is very similar to the active violent terrorism we saw in the '80s and '90s where this same movement murdered 11 clinicians and clinic volunteers, right. It's just a different form of terrorism that creates fear around accessing abortion care.

So that's sort of the legislative landscape that legislators like me in pro-choice states are working in.

Since we're talking about reproductive healthcare and women's rights, I just want to acknowledge that in the U.S. right now it seems as though we're sort of playing the tape backwards, right. We're here today in 2022, we've moved back to maybe 1973 and there is some potential again, as Bernadette mentioned, to move back before 1965 in Griswold v. Connecticut. Like we are going back in time. And we do that, it's really important as a legislator to think about sort of the things that have happened and have not happened since the 1970s, and particularly in the movement to advance the rights of women.

So, we had some great successes, like Title IX and the right to credit and changes in divorce law and jury service and things like that. But if you really look at what those second wave feminists were looking for, I think we got maybe one of the big four things that they wanted to secure women's rights, right. We got Roe v. Wade, the right to abortion. Gone now, but we got it. But the ERA failed, right. It fell to states short of ratification. That's important because women are not in the U.S. Constitution, right. In 1971 Pat Buchanan convinced Richard Nixon to veto the bipartisan Universal Childcare Bill. Again, most other countries have this, but here in the U.S. we don't. We also have no paid Federal maternity leave, right. Most other mothers and parents across the world have this. In the U.S. here we don't. It's really important, because as we're looking at abortion laws, there's zero overlap between those states with paid family leave, paid maternity leave laws, and the states that are banning abortion, right. States like mine in Maryland, we just passed paid family and medical year the same year that we passed the Abortion Care Access Act, because we're demonstrating a commitment to supporting families who choose to have children.

When I asked the Maryland right to life representative about their position on that bill when they were coming to oppose the Abortion Access bill, they said that they preferred a free market approach to maternity leave. These issues are not disconnected. And I think we'll talk probably more about that a little bit later too. But there's a huge economic impact.

And I think it's also important to note that we're talking about sort of what to do if you experience an unintended pregnancy. And this has a major impact on that. But we are also talking about the ability to safely bring a child into this world. The side of abortion care that we don't talk about as much is those folks who have planned wanted pregnancies, and something goes wrong. And this decision is

going to have a devastating impact on people's ability to choose to have a child safely. It's really, really disturbing. And that's one of the things we wanted to make sure in Maryland we were protecting.

So, I just also want to note that no matter what you hear from folks in states that are banning abortion, you know, this is not about children. I think it's about controlling women, especially poor women and women of color. It's about keeping women in their place and keeping communities of color disproportionately poor. That's what we're going to see happening and it's devastating. And at least in Maryland, and I know many of our similarly minded states, we're going to be working against that to the best of our ability.

But ultimately, these forces that were able to do those things in the '70s, to hold back that second wave women's rights movements from any of the major accomplishments they were looking for and have successfully overturned, Roe, right, they've always had a disproportionate amount of power in our society and we're seeing that now. They were not used to losing, they were really ticked off about Roe. It was their one major loss for the last 50 years and they finally rolled it back and they are now emboldened, right. They've won in the red states and they are absolutely targeting the blue states right now. They believe that emergency contraception and IUDs and some forms of other birth control pills are abortion, the oppose certain fertility treatments, the oppose gender affirming care, the disagree on the basic definition of ectopic pregnancy and what might be a threat to a pregnant person's health. Like they disagree on the science. They oppose abortion because of fetal anomaly under almost every circumstance. We've already talked, I'm sure, about rape and incest exceptions. You know, this is a really radical portion of U.S society that has now hijacked the Court with this opinion. And their interested in stigmatizing and shaming abortion and terrorizing abortion providers in blue states.

So, Maryland is a pro-choice state, as I mentioned before, and the Abortion Care Access Act, which went into effect on July 1, is a bill that I sponsored, and our legislature overrode the Republican governor's veto to make sure this act went into effect. The history of abortion law in Maryland is really interesting. We had a statewide referendum to codify the protections of Roe v. Wade 30 years ago. It was extremely contentious, there was an eight-day Senate filibuster, people lost their legislative seats. It was — you know, it scarred people in Maryland politics. But 65 percent of voters approved of the referendum and since the we have not passed a single pro-choice bill in the 30 years. That being

said, we have also not passed any anti-choice or pro forced birth bills, right. Maryland was the Switzerland of abortion under Roe v. Wade. And, in fact, you saw a lot of folks say abortion is settled law in Maryland. The issue is taken off the table as a political issue, which ended up really benefitting anti-choice elected officials.

But the problem is that over the last 30 years, since we codified Roe v. Wade, how healthcare is delivered had completely changed. Advanced practice clinicians are now providing lots of our primary care and reproductive healthcare. That's not doctors, that's nurse midwifes, nurse practitioners, physician assistants. They do a lot of this care. But there was a law on the books in Maryland that said you had to be a doctor to provide an abortion. As a result of that, two out of three Maryland counties had no abortion providers. Since 30 years ago, medication abortion came on the market. It's now more than half of abortion care. All these other providers I was talking about have prescriptive authority. It made no sense for us to have a law on the books saying you had to be a doctor to provide abortion care.

The Affordable Care Act obviously revolutionized how we cover preventative services, particularly with no cost sharing, no copay, no deductible, but abortion wasn't part of that, right. The Affordable Care Act also expanded Medicaid, which means a lot more people had access to health coverage through our Medicaid program, which had some discrimination and some stigma around abortion care embedded in it. We needed to update that, right.

Over the last 30 years we've really changed how we look at health disparities, racial disparities. And when we look at things with a health equity lens, it's clear, you know, there are huge disparities in infant and maternal mortality. The importance of culturally competent care and culturally congruent care from trusted local providers, you know, can't be overstated. And so, we wanted to make sure that abortion access had that health equity lens applied to it when we passed our law.

So, what we ended up doing was passing a bill that modernized the law, removed financial and logistical barriers to care, and really revolutionized abortion care in Maryland simply by deciding to treat it like healthcare. We knew that Roe was going to be overturned and we wanted to make sure that we were a state that was prepared for an increase in patient load, that we had an adequate number of providers, that those providers were diverse and geographically located across the

state, and we wanted to remove any stigma from our existing abortion care law. So, we removed that physician only restriction that I talked about. We had the strong support of our obstetricians and gynecologists in Maryland. They're the doctors. Doctors never say sure, let other clinicians do that. Never. But in this circumstance, they did. They knew that these providers were already doing miscarriage management, they were already doing labor and delivery, contraceptive services. There was no medical reason for these providers not to be providing abortion care. It was purely political. So, we got rid of that in our law and a lot of other states have been following that. I think Delaware just did it. I think 15 states now allow advanced practice clinicians. I hope every state that allows abortion looks at this as something that makes a lot of sense. And the OB/GYNs support.

We required insurance coverage for abortion because it's just like any other preventative service, right. We should have insurance coverage for this, and it should be with no cost sharing. Because if you have a high deductible, maybe a $500 or $1,000 deductible, that can really delay your care. It increases wait time, it increases stress, and of course it adds to stigma, right. Why would this care be different from contraceptive services, which in Maryland already are with no copay, no deductibles, right. So, we did that. And then when we did that we said, you know what, we're not going to treat people who are low-income and participate in the Medicaid program for insurance any differently than we will treat private pay people, right. This is a health equity issue. So, we're going to make sure that Maryland Medicaid permanently funds access to abortion care with no cost sharing and with no budget debate annually because these participants in Medicaid, they don't have fewer human rights or less dignity than anyone else, right. And they shouldn't need a justification, they shouldn't need to say, oh, it was because of sexual assault, here's a police report attached, or something like that.

MS. KAMARCK: Right.

MS. KELLY: We modernized Medicaid and then we established the first in the nation clinical training program. It gave $3.5 million annually to train doctors and advanced practice clinicians in providing abortion care. This is really important. A University of California study found that 44 percent of residency slots are actually in states that will ban or restrict abortion. So that means that our healthcare clinicians are being trained in states where they cannot get access to abortion training. So, states like Maryland are going to need to close that gap. And so, we invested in that, and other states are following

suit.

I've probably talked endlessly, but I will just add on a couple of things about what needs to happen yet — next. And Bernadette touched on some of this. So, Maryland is one of the states that will be adding reproductive liberty to our state constitution. We passed this out of the House already, we will be passing it out of the Senate this year, and it will go to a statewide referendum. A number of other states are already doing that — Vermont, California, and New York. I think Illinois is working on it. We are looking at laws to protect patients and providers from that out of state terrorism I was talking about. You know, we really have concerned clinicians who want to make sure that we will protect them from this type of attack and we're doing everything we can working with our attorney general to figure out what gaps need to be closed in Maryland law. And I know a lot of red states are doing the same thing. We're also looking at those inter-state licensure compacts, because they're medical licensure issues that are at play. And, of course, data privacy is a huge issue, whether you're talking about cell phone records, electronic health records, insurance records, health information exchanges. There's a lot of work that we need to be doing and we're doing it currently in Maryland and many of our friendly states.

MS. KAMARCK: Perfect. Okay. Lots packed in there.

I want to get to — by the way, as you were talking all I could think of is I think there's just probably thousands, if not hundreds of thousands of people who are mostly men who are learning what an ectopic pregnancy is for the first time ever. I know everyone on this panel is a mother and so we're well aware of just how dangerous that is. But there's a whole world we're having to educate right now.

Camille, you know, it doesn't take a Ph.D. to know that the Dobbs decision is going to affect poor women and women of color more than others. But you and your colleagues here at Brookings have written recently that this decision is bigger than that. And let me quote from one of your very good recent papers. "This decision will not only restrict access to reproductive healthcare, but will also fuel a public health syndemic, characterized by disease clusters that are shaped by social, economic, and political determinants that lead to health inequalities and injustices."

And for those in our audience who may not be familiar with the term "syndemic" means, and its link to the Dobbs decision, I hope that you will expand on that, explain that to us.

And then, as a political scientist, I want you to comment on your insights into the Dobbs

decision as it regards the dispersion of talent in the coming decades.

And so, Camille, the floor is yours.

MS. BUSETTE: Sure. Thank you, Elaine. And it is such a pleasure to be here with such expert co-panelists, Bernadette and Ariana, and of course you, Elaine. And I just want to welcome our guests who are online for joining us. Thank you so much. I'm looking forward to a very lively Q&A.

So, I want to start by saying that, you know, the Dobbs decision is going to have generational impact, not only on women, but on families, on whole communities, and on the way in which states and businesses conduct economic development and conduct strategic decisions about what they're going to invest in. So, it's pretty far reaching.

You know, I will start by talking about the syndemic, but I do want to talk about sort of the larger picture. I think we all know certainly now a couple of years into Covid that communities of color and low-income communities are some of the ones that were most affected by the pre-existing nature of disparities in the health landscape. So currently what we see — and this is outside of Dobbs — is that people of color and low-income people are likely to dies from treatable conditions, they are more likely to die during or after pregnancy, and to suffer serious pregnancy related complications, they're more likely to lose children in infancy. And people of color in particular also are at higher risk for many chronic health conditions, from diabetes to hypertension. So, we already saw that folks who are low-income and communities of color are already living in a world of a health disparities.

So, what does Dobbs do, what does Dobbs add to that, and what do we mean by "syndemic"? So, Dobbs adds to this a decrease in the availability of reproductive healthcare. So, in a world where you already have inequality, you are introducing less access to healthcare, which means of course then we're going to have even more inequality. And some of the rates, particularly around maternal mortality and some of the other kinds of conditions that surround really poor health are actually going to be elevated in these communities.

So, a syndemic is when you get clusters of diseases, meaning whole communities, whole populations are suffering from similar kinds of ailments. And that combination usually leads to very, very poor life outcomes, very poor well-being outcomes, very poor outcomes in general for children who live in those communities. To just give you some kind of a context, the U.S. currently, of the developing

countries in the world, has one of the lowest economic mobility rates. And that economic mobility, those economic mobility rates are particularly low if you are already low-income and in a community of color.

So, what we're going to do now with Dobbs is we're just going to add to that. So, this basically has the effect of increasing health disparities despite all the work that's been done during Covid, unearthing those and trying to address them, because we simply will not have access to reproductive healthcare. And in addition to that, what it does is it puts children who are the products of births that could not be terminated for one reason or another, puts them at risk of having very poor life outcomes. In most of the states that are considering trigger laws, or have already adopted trigger laws, those states tend to have some of the lowest child health outcomes and well-being outcomes in the country. So that kind of coincides and we're just going to see that accelerate.

So, what does that mean for us as a nation? We're going to have a permanent subclass, which is going to be populated by low-income — and this includes low-income white people, right — low-income people and communities of color who are going to be not only lacking access to reproductive healthcare, but they're also going to be lacking access, as they currently do, to all kinds of other healthcare. So, you have that. Then you're going to have children who grow up in these communities that have low access to all sorts of opportunities, in addition to healthcare. And what you're going to do is you're going to simply for generations just repeat this cycle of generational poverty, low mobility, and everything else that comes with that. So that's just going to be our kind of context for at least one generation. So, I think that's kind of where we stand.

With respect to the sort of larger implications this has for our economy they way states and companies think about their various choices, let me just say that in the wake of Dobbs, which I think it was very, very interesting that a number of companies came forward to say that they would actually subsidize reproductive healthcare for their employees who happened to live in states where reproductive healthcare is now going to be limited. Over time what's going to happen in these companies is they're going to say, okay, if we have to make a decision to expand to a different location, what are we going to do. They're not going to choose the states where there are a lot of barriers to reproductive healthcare. They're going to choose to put themselves in states where there is access to that kind of healthcare. So, what that's going to do is it's also going to attract other kinds of companies who have similar concerns.

So over time, states that have really had started to restrict access to abortions are going to find themselves less attractive economically, at least from private company perspective. Then women who are in the workforce are not going to think, oh, my — you know, I really want to live in a place that doesn't give me access to reproductive healthcare. They're going to want to locate in the same states where there's access to good jobs and access to reproductive healthcare. So, what you're going to see is a kind of talent dispersion and a dispersion in economic investment, particularly private economic investment, that is not going to favor the states that have restrictive abortion laws.

So over time those states are going to have — the states that have restrictions on abortion are going to be less attractive economically, they're not going to draw talent, and they're also going to have a permanent underclass. That is where we're going to end up.

So, I think this going to be a very interesting landscape from an economic and economic mobility — economic development and economic mobility perspective, but it is definitely a landscape where the kinds of health inequities we see now are going to get worse.

MS. KAMARCK: Great. Thank you, Camille.

There is so much to talk about here, so let me do this. There were a couple of really good questions that came in ahead of time and I'm going to read you all of the question and then each of you can pick out — don't think you have to answer every single one, but you might want to pick out something that you have a particular insight into.

Robert Hall wrote in, how is Medicaid going to be impacted by this ruling? And as we know, Medicaid already funds an awful — not quite a majority, but many, many births in the United States. So, there's a question about Medicaid.

From Jane Zahoric (phonetic) — and this is something Bernadette might want to answer — how effective have lawsuits been in actually blocking these decisions? And can we continue to file litigation to postpone state abortion bans indefinitely? Sort of what's the legal road ahead?

From Sariah Wintersmirth (phonetic) — and I love this one — does the ruling enable any new definitions for when child support can begin? And I particularly like this one because in this entire discussion, who's been missing? Fathers. They have something to do with pregnancy and they have been completely missing in this. And these days one can determine fatherhood quite accurately, unlike –

– so it's not prone to mischief. So maybe, Ariana, you might want to tackle that one and tell us what you're thinking in Maryland.

And then, finally, do you think the Courts will uphold FDA preemption of state bans on abortion medications? Because I think that that's maybe the first step. Camille, you may want to take this, or Bernadette. That's kind of the first step of the Federal Government in this thing and obviously as we move forward people are going to try to get the Federal Government in this debate one way or the other. So, it may move out of the state realm at some point. But this is one interesting nose under the — camel's nose under the tent so to speak.

So, I'll just run in the order that we asked and feel free to touch on any of these. We've got about 15 minutes, but I also want to pull out one or two more question from the audience.

So, Bernadette, the floor is yours.

MS. MEYLER: Thanks so much. And there's also so much I'd love to respond to in Camille and Ariana's comments as well.

I actually just want to say one thing about one issue that both of them raised, which is sort of how this is connected to all sorts of other issues regarding pregnancy and childcare. And even in the opinion itself, I think you see this inter-connection, because one of the very bad decisions that Alito relies on as a precedent for saying well this has nothing to do with women's equality is this case from the 1970s also that said that pregnancy discrimination is not discrimination on the basis of gender. So that is a kind of precedent for a lot of these efforts to sort of say well pregnancy isn't a women's issue, we don't have to be concerned, we're not going to be talking about pregnancy discrimination as something that is constitutionally impermissible.

So, I think all of these things are bound up together and I really appreciated the way that Ariana framed it in terms of thinking about all of the package of things that the women's movement was trying to accomplish, and Roe as one of those parts of those packages.

So, in terms of the ongoing lawsuits and the efficacy of lawsuits, I mean I think that some of — it's been a mixed bag. Some of them have been effective so far, but I don't think we can rely on that indefinitely, that we're going to see — I think that's not going to be an indefinite solution. Thinking more broadly about the legal road ahead, I think President Biden's Executive Order last week was interesting.

It was fairly limited, but he did direct the Department of Health and Human Services to kind of come up with a more comprehensive report within a month that would outline some further steps forward. And in his speech about the Executive Order, he mentioned that he his having the Department of Justice kind of look into what kinds of legal options are available for the Federal Government in terms of protecting women's access in particular to abortions in cases of emergency. And I think that's one of the things that the President has been pushing, that this is part of requisite healthcare if you have an ectopic pregnancy or some other high risk — something that's going to cause harm to the mother that often states say well, maybe there's an exception for the mother's life being at risk, but then the point at which that's determined to be the case is so late that the person might wind up dying anyway.

So, I think that that's — those are some of the steps that are happening kind of on the Federal level. And then I do think this question about the FDA and provision of abortion by medication through mail is going to be very salient. And I haven't seen really any lawsuits being filed by states yet, but there is an ongoing case in Mississippi that actually had preceded this where there is a question about the extent to which some state roles are preempted by the FDA. And I think that we'll also see that kind of intersect with the efforts of the Supreme Court to cut back on the administrative state because the question of whether or not the FDA guidance is fully authorized by the governing statute or not and various other questions about how far the agency can go in interpreting that statute will be an issue as well as the issue of preemption.

MS. KAMARCK: That's really interesting. Thank you. And we'll watch — do you know offhand the name of that Mississippi case?

MS. MEYLER: Not immediately.

MS. KAMARCK: That's all right. I know, I don't want to put you on the spot, but I'll go look it up because I think that's a very interesting next one to put our eyes on.

Ariana?

MS. KELLY: So out of all of those questions I sort of decided I want to tell a story.

So, before I was in elected office, I was a journalist. I worked for PBS. One of the — actually the exact last story I did was going down to Mississippi to report from the last abortion clinic, The Pink House, in Mississippi. When I reported that story, and this was 18 years ago, I interviewed the lead

protester outside the clinic, who was a doctor who had provided abortion care and then switched sides and decided she was completely opposed to abortion care. When I interviewed her, off camera, not on camera, she told me a really interesting story. I said how can you do this. You had experienced being an ER doc pre-Roe in the Chicago emergency rooms, you saw people dying from illegal abortion care and now you're wanting to make it illegal again. How do you justify that. And she said it would be fine, that their side would — 18 years ago — she said our side will win. We will get the moral victory that we're looking for to make sure that people understand that abortion is murder and patients will still have access because medication abortion is now coming on the market. And so, people will through illegal channels have access to a much safer form of illegal abortion. And that was basically her idea of the movement's plan for getting both, right. For getting the moral victory of making sure the naughty, naughty whores knew that they were bad, while at the same time not seeing women dying.

And that has stayed with me because I think that that is really the future that we're looking at, right. I think that she won, and she got what she wanted. So, whether it's through the FDA, currently, whether we're mailing from in the states or whether it's coming through the mail internationally, which we states have no control over, or it's a black market or through Canada, the way people get their cheap Viagra, many people will have access to early abortion through medication that way.

It does not solve the problem for the folks who don't have the knowledge or the capacity to get that safe medication and it doesn't solve the problem for folks who need abortion care later in pregnancy for a myriad of reasons. So —

MS. KAMARCK: Great.

MS. KELLY: — that is I think just really important to keep in mind.

MS. KAMARCK: Good story.

MS. KELLY: Yeah.

MS. KAMARCK: And you're right, Ariana, it brings it all together.

In the meantime, Bernadette has found the case. Thank you. It's called Genbiopro v. Dobbs. And it's a Mississippi case, right, Bernadette? Okay.

Camille?

MS. BUSETTE: Yeah, sure. I want to kind of talk a little bit about the politics of

restricting abortion medication.

So, where I think this is really quite interesting, having the FDA kind of be thrust in the mix. And today, or late yesterday, Secretary Becerra also said that HHS is now — the position of HHS is that all hospitals must perform abortions where the health of the — or life of the mother is at risk, right. So, what they're now doing is saying there is an overarching sort of Federal jurisdiction and authority in certain kinds of cases. And I think that that's actually interesting and it's obviously going to work its way through the Courts and probably back up to the Supreme Court in about 20 years.

But so, what I do think is interesting about restricting access to abortion medications is now we're talking about restricting access to contraception of different types, right. So, this is contraception sort of after the fact. And so, it's a very slippery slope between that — you know, abortion medication and contraception.

So, when you're thinking about the politics, I think it's pretty clear that the pro-life has a lot of women involved and — but I think moving into restricting contraception is not going to have a similar constellation of political forces. I think this now becomes a little bit more dangerous for particularly Republicans because now you have to contend with sort of your like average voter and your average voter probably sees contraceptive care as part of the kind of normal landscape. And this probably will be very, very difficult I think to work around politically.

So, I think that kind of restriction I think it just a different kettle of — it's just a different political argument, it will have a different political coalition, and I think it's much more dangerous for Republicans than restricting abortion access to operations.

MS. KAMARCK: You know, what your comments remind of, Camille, is that a lot of people said when this decision came down that the Republican Party is now like the dog that caught the bus. You know, like okay. I mean it — and it — one way I can see this developing is that there is one horror story after another. Women dying because of medical need for abortion. Just a lot of really kind of handmaid's tale type things going on, which I suspect will cause a backlash. I mean I just don't see American women in the 21st century standing for this. I can't imagine this, but then again, I had trouble imagining that Roe would be reversed in the first place.

So anyway, we have just a couple of minutes, so very, very briefly, if we could go around

and say — and let me ask you this, what is the next most important thing to look at as we enter this post-Roe world? Is it a case, is it a tendency for certain types of laws in states? What would you say is the — in the near-term, what is the next shoe to drop, so to speak?

And I'll start with Camille and go backwards.

Camille?

MS. BUSETTE: Well, I'm not going to talk about the near-term. Near-term I think is just riddled with cases. But I would say in the medium-term, we're talking about very, very serious state and Federal legislative activity. I think that's going to be the locus of contestation.

MS. KAMARCK: Ariana?

MS. KELLY: I would just bring us back to the question that was raised about the role of men in this conversation. I think it's really important. You know, one fact I have is that men whose partners are involved in an abortion are four times as likely to graduate from college, right. The impact of the child support obligation on men who would not otherwise be paying child support can be devastating for men who are trying to climb out of poverty. I mean this is really huge for men as well and unfortunately, to bring us back to my remarks at the top, women don't have political power in this country, so we need men not just as our allies but to get that this is going to profoundly impact their ability to run a successful business in this country, to be part of the economy, and to have the family they choose to have.

MS. KAMARCK: That's good, which argues for perhaps an earlier parental responsibility in the law than we currently have. And I bet you you're going to be on it, Ariana.

Bernadette?

MS. MEYLER: Yeah, so I mean I think I agree with everyone that there will be a lot of litigation going forward.

In my view, the best way to frame some of the sort of legislation going forward and the movements in favor of protecting abortion is through thinking more comprehensively about reproductive justice. And I think that what everyone else on the panel has been upset about the ways in which a lot of aspects of reproductive justice has been neglected over time, this is an opportunity to put them all back together and say look, this is a comprehensive issue that we need to reduce mortality and child birth here,

we need to have better outcomes for children in America, and we need a whole set of strategies to do that. And that this is all part of a kind of feminist as well as — you know, we need male allies project for reproductive justice.

MS. KAMARCK: Well, listen, with that we don't have too much time for anything else.

I want to thank Camille and Ariana and Bernadette for so much of what they're doing. Bernadette, I think your writings are spectacular. Same to you, Camille, as coming from the scholarly point of view. And, Ariana, you're just a powerhouse in this field and you can see that what's happening in Maryland and what you're pushing in the House of Delegates is having a profound impact on states across the United States. And we have before us in the post-Roe world a very interesting situation, a nation divided, which I don't think we've seen in many, many, many years, but a nation that is deeply divided into two camps. And we I think have right here some of the best experts to guide us through this difficult period coming.

So, again, thank you very much. Thank you to the audience, that you provided some terrific questions. I'm sure we have some of you in attendance because the January 6 hearing was moved to this afternoon and so we weren't in competition. So, again, thank you for your attention to the Brookings webinars, thank you for your attention to this issue.

And, with that, goodbye to everybody.

* * * * *

CERTIFICATE OF NOTARY PUBLIC

I, Carleton J. Anderson, III do hereby certify that the forgoing electronic file when originally transmitted was reduced to text at my direction; that said transcript is a true record of the proceedings therein referenced; that I am neither counsel for, related to, nor employed by any of the parties to the action in which these proceedings were taken; and, furthermore, that I am neither a relative or employee of any attorney or counsel employed by the parties hereto, nor financially or otherwise interested in the outcome of this action.

Carleton J. Anderson, III

(Signature and Seal on File)

Notary Public in and for the Commonwealth of Virginia

Commission No. 351998

Expires: November 30, 2024