Assumptions for IP 1 – Proposed Financial Impact Statement
Department of Administrative Services, Chief Financial Office
Updated as of July 27, 2018

1. Estimated Reduction in Expenditures

Program	Estimated Number of Abortions	12 Month Expenditure Estimate
Oregon Health Plan (OHP)	4,100	$2,300,000
Reproductive Health Equity Act (RHEA)	900	$507,000
Public Employee's Benefit Board (PEBB)	20	$29,000
Oregon Educators Benefit Board (OEBB)	50	$76,000
Total	**5,070**	**$2,912,000**

Assumptions:

a) Of the agencies surveyed (Oregon Health Authority, Department of Corrections, Oregon Youth Authority, and Department of Consumer and Business Services), only the Oregon Health Authority reported having programs that currently support the cost of elective abortions.

b) OHP estimates - based on approximate average of most recent two full fiscal years of experience

c) RHEA estimates – based on current projected number of abortions and expenditures for calendar year 2018 and anticipated increase in utilization once program is fully implemented

d) PEBB/OEBB estimates – based on average of most recent three full plan years

e) Data behind projections provided by Oregon Health Authority

2. Estimated Increase in Expenditures

Services	Additional Caseload from Increased Births	Avg. Cost per Case	Total 1-year cost
OHP delivery / 1-year health care	1,250	$16,800	$21,000,000
WIC – local programs	1,625	$183	$297,375
WIC – food costs	1,625	$413	$671,125
WIC – eWic costs	1,000	$0.9325	$933
WIC – nutrition education materials	1,625	$10	$16,250
WIC – breast pumps / support	812	$300	$243,600
Total Additional Costs			**$22,229,283**

Subtotal WIC: $1,229,283

Assumptions:

a. Based on a study by the Guttmacher Institute, when states restrict the use of funding to support the costs of elective abortions for Medicaid-eligible populations, an estimated **25 percent** of women who would have terminated an unwanted pregnancy take their pregnancy to term. The Guttmacher Institute's estimate is based on an analysis of 38 other studies conducted in the United States. Of these 38 studies, five used detailed data from individual states and compared the ratio of abortions to births before and after Medicaid restrictions took effect. These studies show the following estimated percentage increases in births from Medicaid-eligible women who would have otherwise terminated their pregnancies had Medicaid funds not been restricted for abortion services:

North Carolina	Texas	Ohio	Illinois	Georgia
37%	35%	18-23%	24%	18-23%

b. The proposed financial estimate applies the 25 percent assumption to the approximate 5,000 estimated number of elective abortions supported by OHP and RHEA, both of which provide services to women who meet the income-eligibility requirements of Medicaid. This results in an estimated **increase of 1,250 women** who would carry their pregnancies to term. These additional births are expected to have a direct expenditure impact on: 1) OHP and the Citizen Alien Waived Emergent Medical (CAWEM) program because both the mother and child are already known to meet the eligibility requirements for these services;

and 2) the Women, Infants, and Children (WIC) program given the strong correlation between Medicaid and WIC regarding the participation of pregnant/nursing mothers.

- OHP and CAWEM costs ($21 million): The additional 1,250 births are estimated to result in additional annual costs in terms of the cost of delivery and one year of infant health care.

- WIC costs ($1.2 million): All pregnant, postpartum, and breastfeeding women who meet the income eligibility requirement for Medicaid automatically meet the income eligibility requirement for WIC food and nutrition services. Eligibility is further based on the health or nutrition risks of their children. Based on current program participation rates, of the assumed 1,250 additional births supported by OHP, 65 percent, or approximately 812, would be eligible for WIC services. As both the mother and infant are eligible for WIC services, this results in a total WIC caseload increase of 1,625.

c. Other programs serving low-income populations are assumed to have an indeterminate cost impact based on different income eligibility requirements and lack of data to correlate the OHP population impacted by IP 1 to these programs. Based on discussions with the Department of Human Services, the following programs were reviewed:

   - Temporary Assistance for Needy Families (TANF): the TANF cash assistance program has an income eligibility threshold of 35 percent of the federal poverty level (compared to 138 percent for OHP); whereas essentially all TANF participants are eligible for OHP, it is difficult to assume with confidence the number of new OHP participants with low enough income to meet TANF eligibility.

   - Supplemental Nutrition Assistance Program (SNAP): individuals who meet the income eligibility for OHP would also meet the income eligibility for SNAP. Monthly SNAP payment levels are based on family size *and* family income. Without knowing the family size corresponding to the estimated additional 1,250 births and these families' income levels, it is unknown to what extent SNAP expenditures would be impacted.

   - Employment Related Day Care (ERDC) subsidies: the ERDC program currently has a waiting list. Any potential increase in caseload, which would be difficult to estimate, would add to the already unmet program demand.

   - Child Welfare: this program's caseload is predicated on child harm or neglect; without knowing the family situation related to the estimated additional 1,250 births, any impact on the Child Welfare caseload is unknown.

   - Intellectual and Development Disabilities (IDD): this program provides a range of support and services to children and adults with a severe mental and/or physical

impairment. It is unknown how many of the additional estimated 1,250 births might be eligible for IDD services.

d. Average cost per case based on data provided by the Oregon Health Authority.

e. Any potential cost increase for PEBB and OEBB is considered indeterminate for several reasons: 1) it is unknown how many women might carry their pregnancies to term without PEBB/OEBB coverage for abortion services; 2) any increase in births in these populations is unlikely to have a direct impact on other publically funding programs; 3) given the small number of abortions currently supported by PEBB/OEBB relative to the entire covered population, any additional births would likely have a minimal impact on overall average premium rates; and 4) the impact on expenditures for any additional births covered by PEBB/OEBB would depend on movement between plan tiers, which is unknown.

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3. Estimated Revenue Impact

Revenue Source	Estimated Impact
State Revenue	$0
Federal Revenue – OHP	$13,299,300
Federal Revenue – WIC	$1,229,283

Total federal revenue: $14,528,583

Assumptions:

a. State revenue: Although the measure is anticipated to have an impact on the expenditures required by state resources—specifically related to OHP—it is not anticipated to have a direct impact on revenue generated by the General Fund or other state revenue sources.

b. Federal revenue: Given the estimated cost increases for OHP and WIC, additional federal revenue would be received by state government for the federal government's share of funding for these programs.

- OHP federal revenue: Of the estimated increased costs of $21,000,000, an estimated $13,299,300 is assumed to come from federal revenue. This amount is based on the current average federal Medicaid matching rate of 63.33 percent available to support the given OHP/CAWEM population. Under current federal statute and rules, the additional federal revenue to support Medicaid is "guaranteed," such that any additional individuals who are eligible for OHP are entitled to those services.

- WIC federal revenue: WIC is a federally funded and does not require a state match, resulting in the entire estimated increase in WIC costs of $1,229,283 to be supported by federal revenue. Although WIC is not an "entitlement" program like OHP, the current federal WIC allotment available to Oregon is more than sufficient to support the estimated increase in WIC caseload.

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4. **Potential Future Costs Beyond Year 1**: Additional births related to this measure are expected to result in annual recurring costs in terms of: 1) the potential on-going OHP costs for those individuals who continue receiving OHP services—whether continuously or intermittently—after their assumed first year of receiving infant health care under OHP; and 2) the additional births that may occur year after year as a result of the measure. The proposed draft statement did not quantify the recurring annual costs for the following reasons:

    a. OHP caseload fluctuations: The OHP caseload fluctuates over time, with many individuals dropping off the program for one or more months during a given year only to rejoin the program later on. These fluctuations make it difficult to anticipate with confidence how a certain OHP population will impact expenditures in the long-term. The Oregon Health Authority is able to determine average "ons" and "offs" for a given OHP caseload at a certain point in time; however, this is not analogous to tracking and projecting the number of months of program service utilized by one group of clients over a defined amount of time, e.g. infants born at point 0 over the next 5 years.

    b. Unclear correlation between prior OHP experience and future experience: The estimate regarding the 1-year of infant health care costs included in the proposed draft financial statement is based on the assumption that most, if not all, women on OHP who have a newborn will maintain eligibility based on the unlikelihood they would fail to submit required annual renewal information or their income would increase beyond the eligibility threshold within this relatively short period of time. The Oregon Health Authority validated this assumption by providing data showing the continuous months of coverage for infants born under OHP from June 2016 through May 2017.

    If this same approach were to be used for future years, data from prior years would need to be evaluated. For instance, to determine how many estimated months of OHP services would be utilized by a group of infants over the next 5 years, data from a group born 5 years ago would need to be analyzed and tracked over time. The proposed draft financial statement did not pursue this possibility out of concerns regarding the potential disconnect between prior year and future year experience, which likely becomes more problematic as the timeline grows given the various factors that determine how long an individual remains on OHP.

    c. Data limitations: Caseload data from Oregon's Medicaid information system dates from the year 2000 and may limit estimated program utilization over long periods of time.

5. Additional Background on Assumptions

a. Reproductive Health Equity Act abortion services: The estimated support of approximately 900 abortions on a full calendar year basis subsequent to 2018 represents five months of program expenditures of $86,919 from February through June of 2018 and the ongoing increase in program utilization as the RHEA becomes fully implemented. The increase in utilization reflects the continued work of the Oregon Health Authority to expand the number of participating community health care providers and program participants. The estimated trend is also consistent with current estimates for the program roll-up costs upon full implementation and remains in line with abortion rate statistics from the Centers for Disease Control and Prevention and the number of low-income undocumented immigrants who give birth in Oregon.

b. Services for Reproductive Health Equity Act participants: The Reproductive Health Equity Act (RHEA) reimburses specific reproductive health services for women who would be eligible for the Oregon Health Plan (OHP) except for their immigration status. Although these women are not eligible for the full array of OHP services, they are eligible for limited Medicaid services, including childbirth delivery, under the Citizen Alien Waived Emergent Medical (CAWEM) program. CAWEM funds the cost of delivery at the same federal matching rate as those women who receive delivery services under OHP. Because of this, the average cost of delivery was included in the analysis for the total estimated additional RHEA and OHP women who would carry their pregnancy to term should the initiative pass.

   To meet the residency requirement for the Women, Infants, and Children (WIC) program, women must demonstrate that they live in Oregon, but are not required to provide documentation regarding immigration status. Since undocumented women must reside in Oregon to be eligible for RHEA services, they would also meet the residency requirement for the WIC program.

c. Oregon Health Plan abortion services: The estimated 4,100 abortions funded by the Oregon Health Plan included in the analysis represents the approximate average number of abortions for the following state fiscal years, as reported by the Oregon Health Authority:

   - 2016 – 4,181 procedures
   - 2017 – 4,086 procedures

   State fiscal year 2018 data was not used because it would not represent a full fiscal year of experience due to the timing of the data analysis.