Chairman Nelson and members of the committee, thank you for the opportunity to appear before you today. My name is Dave Molmen and it is my privilege to serve as CEO of Altru Health System. I am here to offer comments in support of HB.

You've heard testimony by several of my colleagues today, and to save the committee's time, I want to go directly to the issue of payments under Medicaid Expansion. This committee has heard testimony asserting that payments under this program are higher than other states, and as such, should be reduced to be more "in line" with those other states. While on the surface, that argument may have some appeal, it does not hold up to even a cursory review.

I would like to briefly walk you through an understanding of how North Dakota came to expand Medicaid to explain why we feel the issue has been wrongly framed, and why it would not be wise to implement those reductions.

When the Affordable Care Act was signed into law in 2010, it created the Medicaid Expansion program wherein, if states determined to extend Medicaid eligibility to those with incomes of up to 138% of federal poverty level, the federal government would provide 100% of the funding to do so in 2014, phasing down to 90% in 2020.

The question of Medicaid Expansion was debated vigorously in the North Dakota legislature in 2013. Although the program held the promise of making care available to low-income families with a large federal match, there was concern, both about the long-term sustainability of the program and whether the federal share of funding would remain true to the initial representations. There was additional apprehension about standing up a program with required state funding, even if it was only a minority share.

Ultimately, the Legislature recognized the high benefit of this program to over 20,000 North Dakota citizens and moved ahead with plans to implement. It was the right thing to do for the health and well-being of North Dakotans, and in the succeeding years Legislators' wisdom would be borne out.

It's important to recognize that, after authorization, a parallel debate was taking place among our state's health care providers. Hospitals in the US had $160 billion cut from their Medicare payments to pay for Medicaid Expansion and other components of the Affordable Care Act. On one hand, participation in this program was a way to get some of that money back, but providers had severe concerns about the stability and funding of the program and for taking on a new category of care that may pose new risks, especially the risk of cost shifting. For a time, it appeared as though we might not be able to get enough contracts with providers to cover the state for care.

Now here's the important part, and I'm going to call this the North Dakota way.

I'm sure you're all aware of many situations in which North Dakota gets treated unfairly under Federal programs in comparison to many more populous, more urban states. Medicaid

Expansion is an example where North Dakota used skill in negotiating our unique position to achieve something very good for our state.

The Obama administration had, to the time of our negotiation with them, not been successful in getting Expansion authorized and implemented in any "red states". It was highly motivated and willing to do so, and willing to do what was needed to get it going in North Dakota. In these negotiations, they agreed to terms that would provide a rate of payment for services that would not have to be cross subsidized by other patients, as they do in other states. This was a huge success and it leveraged our position as a small rural state to get terms that worked our state. As I said, we can find plenty of examples where it hasn't worked that way for North Dakota, but this is something that over the years has delivered huge benefits to our people. Nearly a decade into the program, the federal government continues to pay 90% of the cost.

Mr. Chairman and members, should the state reverse this position on the misconception that a reduction of rates is better for North Dakota's citizens, health care systems will be put at great risk. That move would result in only a small relative benefit (10%) to our state, while turning away over $100 million from our economy every year. $100 million dollars *every year.* Over $50 million of that $100 million goes to directly pay nurses, doctors, and other workers, who provide the care to our people, pay taxes, build houses, and buy groceries. $50 million dollars *every year*. That's nearly 1,000 jobs across our state. Jobs in Hettinger, and Harvey, Bismarck and Grand Forks, Mayville and Jamestown; those are jobs of people caring for their neighbors in every community, your community and mine.

I want to emphasize that this is an issue that impacts all providers of care and does so equally in every community in our state, those in our rural areas and larger cities alike. As I did last week, I would encourage you; I would ask you, to inquire of leaders of the hospitals and institutions in your local area as to its impact. I'm confident that they will tell you exactly the same thing as Mr. Delfs and Dr. Lebeau have told you today. It would be a devastating blow. For many of our institutions, the reduction would be larger than their entire bottom line.

Returning once more to the assertion that North Dakota should be more like other states, superficially that might sound appealing, but study after study after study has shown that in those other states *the payment for services under their Medicaid programs are less than the providers' costs to deliver them*. This means that in those states the burden must be shifted to commercial payors or other sources. The tab has to be picked up by their Blue Cross Blue Shield plans, other payment sources, or somehow cut out of services delivered.

Emulating other states' model does not strike me as a formula for success.

Although I do not have access to the figures for the whole state, I would speculate that, in our state, implementation of the proposed reimbursement reductions would cut payments by nearly half.

I hear actuaries and economists throw around a lot of numbers, formulas, and jargon about the costs and margins for hospital services, and I think they mostly just confuse people and cloud the issue. So here's the back-of-the-envelope way that I think about it, and it works exactly the same way as any farmer or business person would think about it for their own operation. It goes like this: operating margins for hospitals in the State of North Dakota have generally ranged between -5% and 3% over the past several years. In the case of a 3% operating margin, that means the revenue a hospital brings in would be 3 cents more on the dollar than the expenses they incur to deliver the services. Three cents. And in the case of hospitals with negative operating margins, it means they would lose several cents on every dollar of service.

With margins like that, it doesn't take any complex actuarial formula to get the idea that if you reduce the payment for any type of service by 50%, as has been suggested by some, that service would now have to now have to be subsidized by other services or payments from other sources. And I would say that for any form of payment, whether it was Medicaid, commercial insurance, or any other form of payment.

My question is, why would you do that? Why would you severely cut the payments to support the program only to send the money that could pay for it out of the State of North Dakota to Washington DC? Why would we purposely underpay services and turn away $9 to at best save 1?

The North Dakota Legislature was wise to expand our Medicaid program. It's done immeasurable good for our citizens and our state. We negotiated well and effectively to ensure the program's sustainability. Mr. Chairman and members of the committee, I ask that in your wisdom you act to protect our success and see that it not be undone