Chairman Holmberg and members of the committee, thank you for the opportunity to appear before you today. For the record, 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 1012.

I want to begin by thanking you, legislators, for your longstanding support for and focus on healthcare needs in our state. Your work has had an incredibly positive impact for our people.

This afternoon you will hear testimony on various aspects of Medicaid Expansion, and in my comments, I would like to focus on the historical underpinnings of our program in North Dakota.

This committee has heard prior 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 doesn't hold up when we look at the facts.

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 advisable to implement 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 and beyond.

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, legislators were concerned, both about the long-term sustainability of the program and whether the federal share of funding would remain true to the initial representations.

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 on the other, 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, by contrast, 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 in 2013, not been successful in getting Expansion authorized and implemented in any "red state". It was highly motivated to do so, and willing to do what was needed to get it going in North Dakota. The bottom line is that in these negotiations, they agreed to terms that would provide a rate of payment for services in North Dakota that would not have to be cross subsidized by other patients, as they do in other states. This was a major victory 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, health care will be put at great risk. That move would result in only a small relative benefit (10%) to our state coffers, while turning away well over $100 million from our economy every year. $100 million dollars *every year.* I think of what we do in North Dakota to bring any enterprise into the state that brings with it $100 million in revenues annually. Think what a loss it would be to send $100 million out of the state every year.

It's important to remember that over half 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. 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, my community and yours.

I want to emphasize that this is an issue that impacts all providers of care and does so in equal proportion in every community in our state, those in our rural areas and larger cities alike. I'm confident that if asked, health care leaders in any community, small or large, they would tell us the loss of this reimbursement would be a devastating blow. For many of our institutions, the reduction would be larger than their entire bottom line.

Study after study after study has shown that in other states *the payment for services under their Medicaid programs are less than the cost providers' incur 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 reimbursement reductions advocated by the DHS would cut payments by 40% or in some cases, nearly in half. Given historically low margins of hospitals in our State, it doesn't take any complex actuarial formula to conclude that if you reduce the payment for any

type of service by 40-50%, that service would then 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 we do that? Why would we want to 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 then 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. I would further encourage you to remove the "sunset" provision in the bill as unnecessary. This is an important component of our state's budget and would receive the needed scrutiny without sunsetting the entire authorization every biennium.

Chairman Holmberg, I'll close where I started. I thank the members of this committee for their selfless efforts on behalf of our citizens. As we move into the future, we're eager to discuss how we might continue to build toward a healthier and more productive State.