

**Health Care Reform Review Committee
64th North Dakota Legislature Interim
Testimony of Dr. Don Warne, MD. MPH
May 18, 2016**

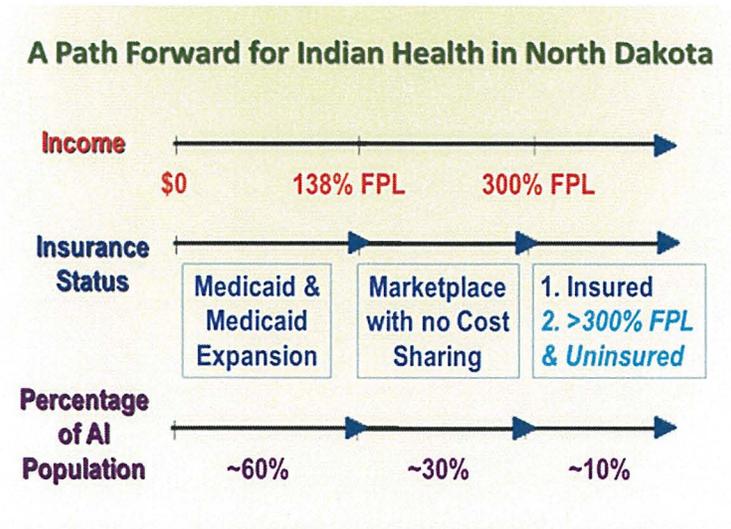
Hau. Pilamaye Yelo. Mitakuye Pi. Hello and Thank You to All My Relations, Chairman Keiser, Members of the Committee, my name is Dr. Don Warne. I am the Chair of the NDSU Department of Public Health, and a family practice physician, as well as a Master of Public Health. I am here today to provide information regarding the positive impact the Patient Protection and Affordable Care Act and North Dakota's Medicaid Expansion has had in North Dakota, with an emphasis on tribal communities.

While it is too soon to know what the exact impact has been, there have been concerns voiced in several arenas regarding the high cost of the Medicaid Expansion. It is estimated to be \$6 million over expected cost. However, prior to the Affordable Care Act and Medicaid Expansion, there were 70,000 North Dakotans without any health insurance (healthinsurance.org, 2015), 35,000 who were Medicaid Expansion eligible (healthinsurance.org, 2016). While the extent of the health needs of North Dakota's uninsured and the number of eligible North Dakotans who would take advantage of the Marketplace and Expansion was under estimated, thousands of North Dakotans are getting first time care for many costly chronic diseases such as diabetes and high blood pressure.

The investment in the health of all North Dakotans does have potential for large fiscal impact long term. For example, the cost of care for a person having a stroke and living another decade is \$87,000 (NIH, 2013, Stoke, October 2014). The cost of treating a person with high blood pressure and reducing the risk of stroke is \$7, 733 over a decade (USHHS, 2013). When we provide health coverage for a male under 65 with high blood pressure, who's employer does not offer insurance and cannot afford it personally, ND Medicaid potentially saves \$80,000 it would likely have incurred when a stroke left him uninsured and disabled. This does not take into account the cost savings for other public assistance programs the individual may require, cost to business when an employee is lost and the various other fiscal impacts of sudden disability.

The Affordable Care Act and Medicaid Expansion has particular implications for American Indians. The Affordable Care Act is the "Largest Expansion of Indian Health in our Generation". It permanently reauthorizes the Indian Health Care Improvement Act, the legal authority for the provision of health care to American Indians. American Indian health care provision is a federal obligation, however, there are implications for the North Dakota Medicaid system. There are an estimated 36,591 enrolled American Indians living in North Dakota, 40% live below the poverty level and are eligible for traditional Medicaid (US Census, 2010). Under Medicaid Expansion, the

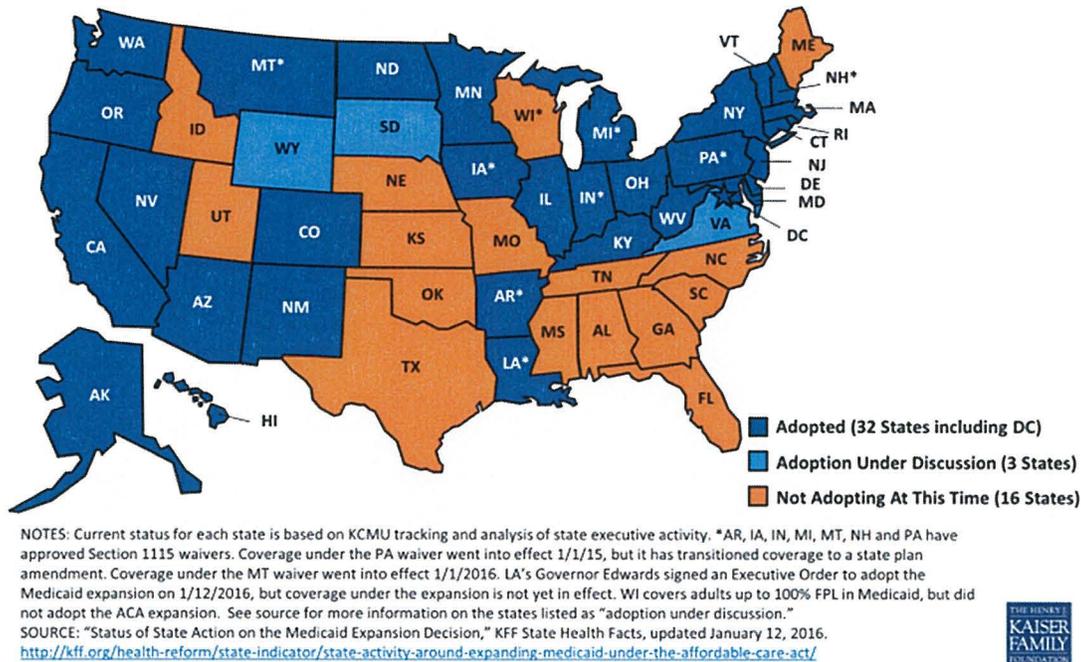
percentage of American Indians eligible increases to 60%, and another 30% are eligible for insurance in the Marketplace with no cost sharing.



IHS is the principle health care provider for American Indians and Alaskan Natives. It is not health insurance, it is a health service provider. It is also not an entitlement program. As a discretionary program, funding is dependent on Congress, not guaranteed to increase with inflation and cost of care increases. The system truly runs out of funds long before the year ends, leaving elderly, adults and children with limited to no access to care. “Don’t get sick after June” has long been an unwritten rule of care through Indian Health Services (IHS). The IHS system currently operates on less than 50% of the funds fully needed to serve 1.8 million AI/AN through 638 facilities.

When North Dakota joined 32 other states, including the District of Columbia in expanding Medicaid, it offered the opportunity for eligible American Indians to not only have access to care year round, but have access to more preventative care, coverage for care provided through referrals to specialists and other services not always available with in IHS’s limited budget. Non-IHS healthcare providers, such as hospitals and clinics, now have opportunity to see more IHS referred patients and receive payment from Medicaid or private insurance through the marketplace for it. It has been estimated that if all ND Medicaid eligible enrolled members of the Standing Rock Sioux tribe were to enroll in Medicaid and utilize preventative care services alone, it would generate \$10.9 million dollars in Medicaid revenue annually. (Warne, 2016)

Current Status of State Medicaid Expansion Decisions



Next year the federal government will begin to decrease the amount of Federal Medical Assistance Percentages or FMAP, to states who have expanded Medicaid. For North Dakota that means the federal government will match 90% vs 100%. Not bad when you think of taking in \$9 for every \$1 spent. However, this does not apply to enrolled American Indians. The federal government will continue to pay 100% of the state's FMAP for Medicaid eligible, enrolled American Indians, an estimated 14,640 citizens.

Far greater than the financial benefit is the ability for Medicaid expansion to decrease health disparities for American Indians living in ND. North Dakota ranks 21st in US infant mortality rates (CDC, 2010). The infant mortality rate for American Indian infants is over twice that of North Dakota's average, and nearly double the US average (NDDoH, 2012). The charts below show infant mortality rates per 1,000 births. Medicaid expansion has meant more access to prenatal care, a major factor in reducing infant deaths from low birth weight (Derbyshire, 2007). As 40% of North Dakota's American Indian population is under the age of 19, 22% of them children under the age of 9, the number of North Dakota children impacted by Medicaid Expansion is significant (NDDoH, 2012).

Deaths, American Indians and North Dakota, 2006-2010				
	American Indians		North Dakota	
	Number	Rate	Number	Rate
Infant Deaths and Rate	75	15.8	281	6.3
Child and Adolescent Deaths	65	93	285	35
Total Deaths and crude rate	1,313	718	28,984	862

American Indian* Infant Death Rates by Geograpic Area, 2000-2009

	ND	SD	US
AI Infant Mortality Rate	13.5	14	7.5

*US statistics: Identification of race may vary from state method.

The prevalence of diabetes in Indian Country has been long documented. Lack of access to care for diabetes leads to unnecessary, costly complications such as kidney damage requiring dialysis, heart disease, amputations, glaucoma, cataracts and peripheral neuropathy. American Indians are 208% more likely to die from complications of diabetes than their non-Indian counterparts (IHS, 2003). Lack of access to healthcare services has been one of the barriers in reducing not only deaths from diabetes, but also diabetes rates. Prior to the Affordable Health Care Act and North Dakota's expansion of Medicaid, many American Indian adults with diabetes did not qualify for the additional access to diabetes care and treatment that Medicaid now can provide them.

Diabetes Death Rates

(Rate/Per 100,000 Population)

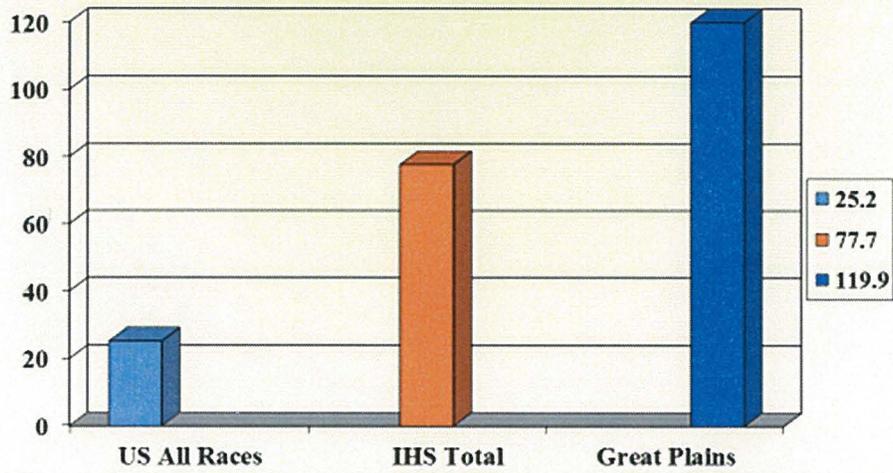
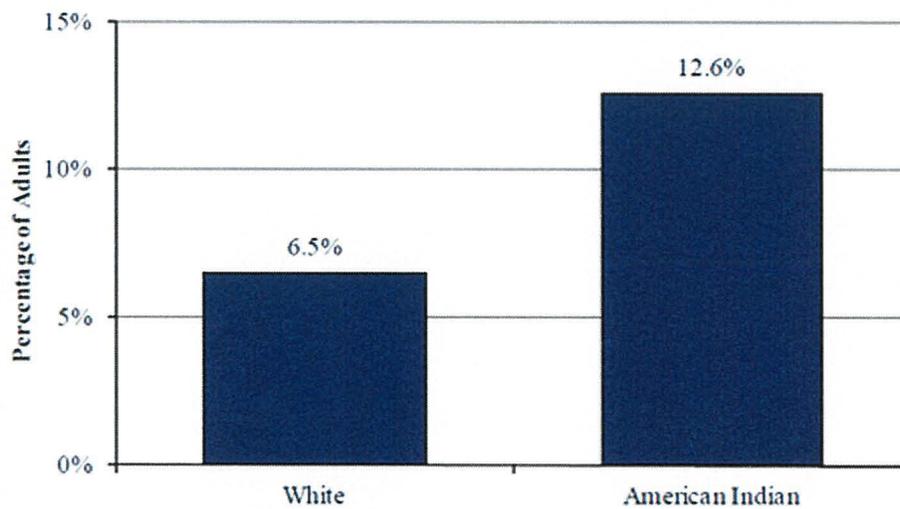
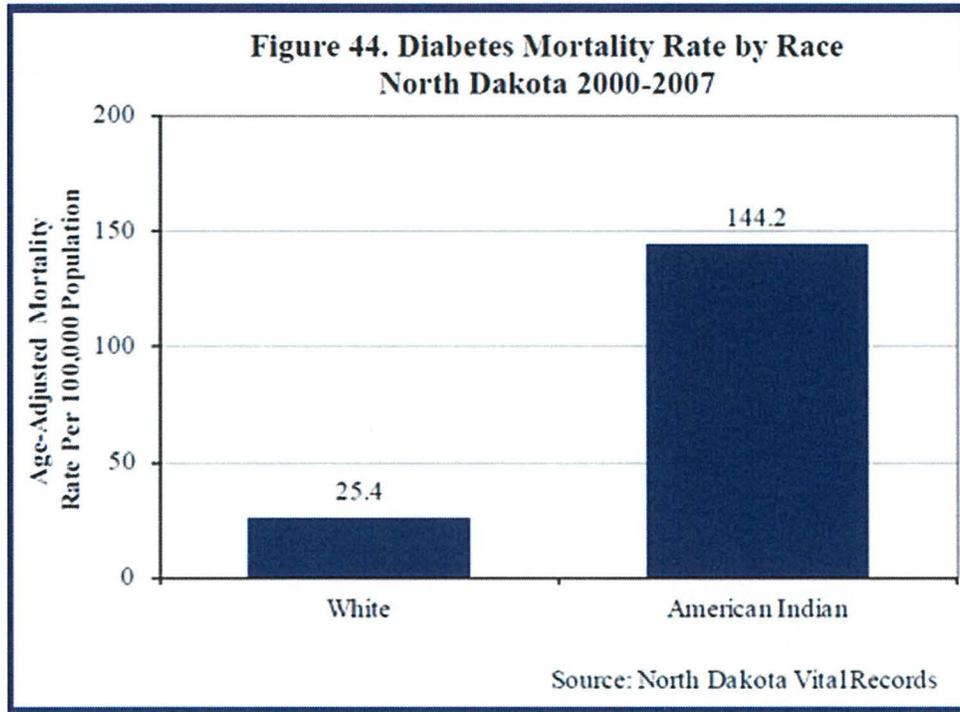


Figure 43. Diabetes Prevalence by Race
North Dakota Adults 2005-2008



Source: Behavioral Risk Factor Surveillance System



While there is still much research to be done on the fiscal and health outcomes of the Affordable Care Act and the Expansion of Medicaid in ND long term, it is one of the greatest tools in reducing the health disparity gaps for American Indians.

Philámayaye. Thank you for the opportunity to provide information regarding the positive impact the Affordable Care Act and Medicaid Expansion have had in North Dakota for.