July 14, 2009

Chairman George Miller
Education & Labor Committee
US House of Representatives
2181 Rayburn House Office Building
Washington, DC 20515

Chairman Charles Rangel
Ways and Means Committee
US House of Representatives
1102 Longworth House Office Building
Washington, DC 20515

Chairman Henry Waxman
Energy & Commerce Committee
US House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairmen Miller, Rangel and Waxman:

As CEO and Chairman of Molina Healthcare, I write to express my strong support for enacting comprehensive health reform this year. Like you, Molina believes that every person should have access to basic health coverage. The cost to achieve this goal is a shared responsibility among all Americans. Molina advocates for a solution that is fair for all stakeholders in the healthcare system.

Molina Healthcare is a multi-state health care organization that arranges for the delivery of health care services to persons eligible for Medicaid, CHIP, Medicare, and other government-sponsored programs for financially vulnerable individuals. Molina Healthcare's subsidiaries in California, Florida, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, Virginia, and Washington currently serve nearly 1.4 million low-income members. Molina Healthcare has six health plans accredited by the National Committee for Quality Assurance and has been consistently ranked by the US News and World Report among the top Medicaid health plans in the nation. Further, we offer a significant added value to local communities by operating 20 primary care clinics in predominately economically disadvantaged and underserved areas. Our clinics not only treat Molina members, but the uninsured as well. With nearly 30 years of caring for Medicaid and uninsured patients, Molina Healthcare is one of the most experienced organizations in the country.

As the legislative process continues, there will be substantial discussion and debate regarding the final shape of health care reform in the United States. We look forward to your continued leadership and vision in that process. I will use the remainder of this letter to outline our recommendations for health care reform.

Health Care Reform Provisions:

Public Plan Option: Molina Healthcare opposes the creation of a new government-run "public" health insurance plan. Such a public plan option would give the government-run plan an unfair

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advantage. The federal government would "compete" with private health insurers while establishing and enforcing rules and regulations governing the marketplace. It is imperative that all plans—public and private— be subject to the same standards and state regulations, particularly with respect to licensure, insurance regulations, benefit options, and provider network. As a federal government program, the public plan would have the unfair advantage of setting prices and could pay lower rates to providers. We feel that it is impossible to act fairly as a regulator while simultaneously competing against other health plans.

Individuals Covered: Molina Healthcare strongly supports universal coverage for every eligible person, while building on the existing health insurance structure. As a health care organization with a 30-year history in the Medicaid program, we have seen firsthand the value that existing Medicaid services offer our beneficiaries and understand the importance of such health coverage. We strongly support expanding the existing Medicaid program to cover more individuals and we appreciate your efforts in this area. Innovative outreach programs should be put into place to help identify and enroll every eligible persons. We applaud your efforts in this regard in the draft legislation unveiled in June.

Individual Mandate and Guaranteed Coverage: An individual mandate and guaranteed coverage are interdependent; one cannot successfully exist without the other. The only viable way to ensure that universal coverage occurs on a responsible basis is to establish an individual mandate that makes every person a responsible participant in his or her health care coverage. We believe it will be critical to aggressively enforce the individual mandate to achieve the universal coverage goal. At the same time, Molina Healthcare strongly supports requiring health plans to provide coverage on a guaranteed issue basis and supports the market and other insurance reforms in the draft legislation. Guaranteed issue must accompany the individual mandate. The two items are inextricably linked.

Medical Cost Ratios: We are extremely concerned about the inclusion of a minimum Medical Cost Ratio (MCR) in the House Tri-Committee legislation. While we support the principle that an appropriate amount of the health care dollar should be spent on medical costs, we oppose setting a federal mandatory minimum MCR on health plans. Little information is typically provided about how an appropriate minimum MCR is determined and there is no evidence that any numerical MCR correlates to better or higher quality care. Mandating a MCR will also not lower the cost of health care and in fact will discourage efficiency in the short and long term. It may be possible to mitigate some of the efficiency issues by allowing plans with appropriate quality measures and low medical cost ratio to reinvest the "savings" into health care improvement efforts or health-related community programs.

MCR requirements can potentially penalize health plans that provide effective quality health care for patients and better manage utilization of services. Medicaid health plans have been working to implement case management strategies such as disease management, care coordination, prevention and wellness programs, and other service programs that improve care and health outcomes. However, these additional services often increase administrative costs which may lead carriers to eliminate or reduce these important services. Setting a mandatory minimum MCR may risk the use of such important services as disease management, utilization management, quality assurance and improvement initiatives, or improved health information technology.

Medicaid Provisions:

Drug Rebate Equalization: The Medicaid prescription drug rebate program ensures that State Medicaid programs receive the best price for prescription drugs for their beneficiaries through pharmaceutical manufacturer rebates. However, under current law, states are not eligible to receive

these rebates for beneficiaries enrolled in Medicaid health plans. Molina supports H.R. 904 *the Drug Rebate Equalization Act* (DRE), introduced by Representative Bart Stupak, that would extend the federal drug rebate program to beneficiaries enrolled in Medicaid managed care organizations. Accessing these rebates will achieve important savings for states in the Medicaid program. In fact, the Congressional Budget Office has estimated that applying the fee-for-service Medicaid drug rebate purchased for Medicaid managed care enrollees would result in approximately $11 billion in federal savings over ten years. We fully support Section 1843 of the draft legislation which extends the rebate provision to Medicaid managed care enrollees.

Out-Of-Network Services: Any health care reform proposal should promote efficiency and prevent cost-shifting to government programs. Limiting the amounts health plans must pay when Medicaid beneficiaries need care outside their networks is an important component of any proposal that ensures adequate provider access for beneficiaries and provides appropriate incentives for providers to participate in these programs.

The passage of the Rogers Amendment in the Deficit Reduction Act of 2005 was a positive step in limiting the amounts that Medicaid managed care plans pay to non-contracted providers for emergency care. This amendment has encouraged many providers to engage in negotiations with health care organizations in order to provide quality care to low-income individuals at a reasonable price. However, this amendment does not go far enough—it is critical that the Rogers Amendment is expanded to include all services, not just emergency care. States, such as Texas and New Mexico, have addressed Medicaid contracting rates which have lowered program costs while increasing access to services for Medicaid beneficiaries. We strongly urge you to amend your legislation and extend this policy to all provider contracts under the Medicaid and CHIP programs.

MCO Medicaid Provider Taxes: Molina also strongly supports extending a provision of the Deficit Reduction Act of 2005 that allows for the continuation of provider taxes on Medicaid managed care organizations (MCOs) that states enacted before December 8, 2005. Several states have been relying on taxes on Medicaid MCOs to generate revenues for their state Medicaid programs. We support the extension of this provision beyond September 2009, so states can continue to sustain vital Medicaid services.

Including Medicaid in the Exchange: Molina is concerned about implementing an Exchange or connector, particularly with regard to its effect on the coverage received by those in the Medicaid program. We support increased coverage through the current Medicaid structure – and applaud you for increasing eligibility to 133% of FPL – but have serious reservations about providing coverage through an Exchange.

Unlike many health insurance organizations, Molina focuses exclusively on serving the vulnerable people that rely on government health programs. As such, we are better equipped to provide the specialized care and services this population requires. By using an Exchange to cover Medicaid beneficiaries in the fifth year after enactment of the draft legislation, we are concerned that involving traditional health insurance plans may compromise the quality of care for low-income populations. Health plan participation in Medicaid or CHIP should be conditional. Plans must demonstrate that they have the necessary experience and expertise to meet the particular needs imposed by these programs. Many not-for-profit and Medicaid-specialized health plans like Molina (that do not offer commercial products) may be pushed from the marketplace as they will not be able to compete through broker networks against larger, multi-line plans, thereby jeopardizing the quality of care and access provided to these vulnerable Medicaid populations.

We have serious concerns about how a broker-dependent exchange system will work for the Medicaid program. For example, if Medicaid beneficiaries are enrolled through an exchange using health insurance brokers, how will the brokers be paid for Medicaid enrollment and who will pay them? Currently it is illegal for health plans to pay a broker to refer or enroll Medicaid beneficiaries. Such a system may give traditional health insurance plans with long-standing broker relationships, a distinct advantage over Medicaid-only plans which cannot utilize brokers. Furthermore, Medicaid premiums do not include funding for this type of marketing.

Increased Funding of Medicaid: The Medicaid program is substantially under-funded, and payments to physicians, hospitals, and health plans must be increased in order to maintain access to care. It is critical that as the federal and state governments attempt to manage health care costs in the Medicaid program that these attempts not undermine access to care. In an effort to improve quality and provide more cost-effective care, many states have contracted with health plans that seek to improve access to coordinated health care services, including preventive care, and to control health care costs. In fact, a newly released Lewin Group study found that the Medicaid managed care model typically yields cost savings of up to 20 percent.

We urge you to consider the importance of maintaining adequate payments to Medicaid providers and health plans caring for Medicaid patients. We certainly appreciate the importance you have placed in your legislation on increasing Medicaid provider payments. Health plans such as Molina Healthcare have a demonstrated record of improving health care access and quality for their Medicaid enrollees. It is critical that any Medicaid funding increases include protections for the millions of beneficiaries who rely on Medicaid health plans. Molina also strongly supports the enforcement of requirements that state Medicaid programs must establish health plan payment rates in an actuarially sound manner. Actuarial soundness is a critical protection for Medicaid and CHIP beneficiaries and allows sustainability of coordinated care programs.

The Elderly and Disabled: The elderly and disabled make up about a quarter of all beneficiaries but account for 70% of all Medicaid costs. These are the persons most in need of coordinated care and a Medical Home. Over the past decade, the federal government has expanded the ability of state Medicaid agencies to explore, and in many cases, to mandate the use of managed care for Medicaid beneficiaries, including the aged, blind, and disabled (ABD) population, a concept that we strongly support.

Medicare Provisions:

Dual Eligibles: Molina Healthcare serves the dual-eligible population through its Special Needs Plans (SNPs) in seven states under the Medicare Advantage Program. The beneficiaries we serve are poor and often disabled Medicare beneficiaries who also are eligible for Medicaid. These patients often have physical, behavioral and cognitive disabilities to go along with multiple, serious medical conditions, including behavioral health issues, which impact all interactions with the health care system. They are significantly challenged in self-care knowledge and many have experienced compromised medical and related care over a lifetime (dental is an example which has a significant impact on overall health). Dual eligibles are dispersed across geography and treatment settings. Unlike chronically ill or institutionalized SNP members, dual eligible members can't be accessed by the plan across a small set of providers or a specific treatment setting. Therefore, highly specialized care (some mandated, some voluntary) is necessary for this vulnerable population.

SNPs for dual eligible beneficiaries provide an opportunity for coverage to be designed for the specific needs of these beneficiaries under the Medicare Advantage (MA) program. For example, Molina designs its SNP benefit packages to coordinate Medicaid benefits in each state. We provide case management and care coordination, disease management services, utilization management, transportation, and 24-hour access to licensed medical personnel for our members. We work with providers to educate and encourage willingness to provide services to these members, creating greater access to care. As such, we believe the current SNP program is an effective and efficient method to improve care for dual eligibles. We, therefore, support a three-year extension for all SNPs.

We also support allowing states to recognize savings from coordinating care for dual eligibles in meeting the Medicaid 1915(b) waiver's cost-effectiveness test and to give states the option of using these waivers to increase contracting with SNPs. Establishing a program or office within CMS specifically dedicated to Medicaid and Medicare integration, as proposed in the House Tri-Committee draft legislation, is especially critical.

Furthermore, we urge Congress to provide for presumptive eligibility for Medicaid beneficiaries who are 65 and older and who have been eligible for Medicaid for twelve consecutive months, provided that states conduct random audits and provide beneficiaries and their plans at least 30 days notice prior to disenrollment for loss of Medicaid eligibility.

Medicare Advantage: As mentioned above, as a dual-eligible SNP, Molina Healthcare has a vested interest in the Medicare Advantage program. We support the concept of linking quality to payment mechanisms but are concerned about how this will be achieved. SNPs are small plans with diverse sets of members and medical focus areas, making it difficult to gather comparative and actionable statistical information and data, particularly for dual eligibles. Any approach to measure quality must take into account the beneficiaries being served.

SNPs offer a meaningful solution for the special needs of dual eligible beneficiaries. However, 48% of Medicare beneficiaries live below 200% of the FPL but most are not dual eligible. The current MA Program fails to meet their "special needs." We support similar options and flexibility for MA plans which have enrolled a large share of subsidy-eligible individuals who are not dual-eligible.

Since SNPs differ substantially from other MA plans in the services they provide and the people they cover, it is critical that SNPs be handled differently from the MA program. SNPs present unique challenges from Medicare Advantage, in part because they involve coordination of both Medicare and Medicaid programs, so they should be subject to their own specific set of rules and regulations. This would include flexibility in network model, care model, and service area requirements to allow SNPs the ability to address specific populations within each plan.

Furthermore, we are concerned about proposed payment structure options. In recent years, rural providers have begun seeing fewer Medicare fee-for-service (FFS) patients. Without extra incentives and payments offered by MA plans, we are concerned these providers will refuse to see MA patients at all. In addition, we are concerned that the proposed benchmark reductions will encourage some providers to keep their costs high. The proposal as it stands creates a significant "advantage" for the Medicare FFS program, which does not include network restrictions or significant medical management programs. The end result of this advantage will be a significant increase in program costs unless investments are made in CMS infrastructure and programs. As the Dartmouth Atlas of Health

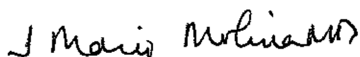
Care research indicates, there is already great disparity between regional areas and cost and quality – this approach will just magnify these differences.

Specifically, we have serious reservations about implementing a competitive bidding system for Medicare Advantage and therefore, SNPs. The current proposal is not true competitive bidding because of the ability of enrollees to decline participation and the significant administrative advantages given to the Medicare FFS program without the concomitant increase in quality of care and efficiency realized by managed care organizations. In addition, we have seen disastrous results in the Medicaid program when cost was used as the primary factor in selection of health plans and believe that these same results would translate into a cost-based bidding program for Medicare dual eligibles. We support MA payment changes assuring adequate payment for high-risk beneficiaries. This can be achieved by changing MA payment to advance improvements in risk adjustment methods for high-risk Medicare beneficiaries, requiring CMS to account for factors unique to SNPs in setting benchmarks (i.e., dual eligibility, additional plan requirements, geographic location), and establishing bonus payments to account for added clinical and administrative costs associated with MIPPA mandates and CMS rules. We would encourage a well-researched bonus system which takes into account the challenges in maintaining and raising quality measures for SNP members. Typically, it is much more difficult to gain member participation in preventive and follow-up care programs, as dual eligibles are much less able to navigate the health care system and are often reluctant to make significant behavioral changes. Longer timeframes for increases in rates, along with required participation, are needed in order to level the playing field with regard to utilization-based quality scoring systems.

Benefit Simplification: As stated earlier, SNPs work with members whose medical and related care has been compromised over long periods of time. Our position is that SNPs should be permitted flexibility in the development of benefits that compliment Medicaid benefits, increase access to care, and provide incentives for members to participate actively in addressing issues which directly and indirectly impact their health care.

Molina Healthcare supports your leadership in responding to the increasing health care crisis created by the uninsured, the rising cost of health care, and limited access to providers for government sponsored program beneficiaries. Please feel free to contact me or Ken Preede in our Washington D.C. Federal Affairs office at 202-639-9867 if we can be of assistance to you and your staff in this ambitious and critical effort.

Sincerely,



J. Mario Molina, MD
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