May 18, 2009

Chairman Max Baucus
Finance Committee
219 Dirksen Senate Building
Washington, DC 20510

Ranking Member Charles Grassley
Finance Committee
219 Dirksen Senate Building
Washington, DC 20510

Dear Chairman Baucus and Ranking Member Grassley:

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 over 1.3 million low-income members. Molina Healthcare's 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 taking care of 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 healthcare 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 healthcare reform.

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. As mentioned in the Finance Committee's policy options paper on coverage, we strongly support expanding the existing Medicaid program to cover more individuals.

Enrolling Everyone: One of the major problems with current government sponsored health coverage programs is that many Americans are eligible for these programs but are not enrolled. Expansion of coverage will only be effective if the individuals who are eligible are enrolled. Therefore, we recommend that steps be taken to enroll <u>all</u> persons in health care programs for which they are eligible by improving, streamlining, simplifying and enabling electronic and uniform applications and eligibility and renewal procedures and by providing continuous coverage to beneficiaries of government-sponsored programs. Innovative outreach programs should be put into place to help identify and enroll as many eligible persons as possible.

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. Guaranteed issue must accompany the individual mandate. The two items are extricably linked.

Exchange or Connector Concept – Use of Brokers: Molina Healthcare is particularly concerned about implementing an Exchange or connector. We support increased coverage through the current Medicaid structure 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 both Medicaid and Children's Health Insurance Program (CHIP) beneficiaries (such as the option included in the Finance Committee's White Paper) 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 connector system will work for the Medicaid program. For example, if Medicaid beneficiaries are enrolled through a connector 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 money for this type of marketing.

Public Plan Option: Molina Healthcare opposes the creation of a new government-run "public" health insurance plan. Such a plan public option would give the government-run plan an unfair 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, particularly with respect to such areas as licensure, insurance regulations, benefit options, and provider network. As a federal government program, the public plan would have the unfair advantage of dictating prices and could pay lower rates to providers. It is impossible to act fairly as a regulator while simultaneously competing against other health plans.

Health Care Efficiency: Any healthcare reform proposal should promote efficiency and prevent cost-shifting to government programs. Limiting the amounts health plans and insurers 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 hospitals for emergency care. This amendment has encouraged many hospitals 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 hospital contracting rates which have lowered program costs while increasing access to services for Medicaid beneficiaries. We urge you to extend this concept to all provider contracts under the Medicaid and CHIP programs.

Everyone Must Do Their Share: We are especially concerned that many tax-exempt hospitals, including government operated ones, receive much-desired tax benefits after agreeing to provide substantial amounts of charity care, yet still refuse to work with Medicaid health plans, resulting in higher costs for the Medicaid program. These "nonprofit" hospitals continue to earn large profits, often greater than their for-profit counterparts; in 2008, the Wall Street Journal reported that 77% of tax-exempt hospitals were "profitable" compared to only 61% of their tax-paying counterparts. Furthermore, we are troubled that these "nonprofit" hospitals often report exaggerated losses as they significantly increase their billed charges and write off the difference between these charges and the amount actually paid as "charity care". If these hospitals refuse to contract with Medicaid health plans at rates that are consistent with a state's fee-for-service schedule, they must be required to accept the state's fee schedule as payment in full for providing services to patients under government programs.

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 healthcare 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. 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.

Fair Payment for States: Further, we support the Committee's efforts to more appropriately formulate the Federal Medical Assistance Percentage (FMAP). In a weak economy when more individuals turn to the Medicaid program for critical healthcare services, states often reduce Medicaid services in an effort to balance their budgets. By utilizing a state's poverty level in addition to the per capita income measure to determine the formula, states would receive compensation that more fairly reflects the needs of the populations they serve. In addition, we support the option of implementing an automatic countercyclical stabilizer to ensure states receive the necessary FMAP funding during periods of national economic downturn. The states will be able to receive the funding quickly, in a more consistent manner, in order to ensure our nation's most vulnerable citizens do not lose vital healthcare services.

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.

Healthy Behavior and Preventive Care: Molina Healthcare supports steps to reduce the cost of healthcare, including the creation of programs to prevent illness and promote health. The creation of such programs will reduce the cost of healthcare by addressing the epidemic of obesity and diabetes and by providing other approaches to improving health through change in behavior.

Unnecessary Regulation: Reducing regulatory hurdles health care providers and plans must overcome to administer medical care as advocated in the Finance Committee policy options paper is something we strongly endorse. We support efforts to reduce regulatory impediments to beneficiaries' access to high quality and efficient care.

Dual Eligibles: Molina Healthcare serves the dual-eligible population through its Special Needs Plan in seven states under the Medicare Advantage Program. The beneficiaries that 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. Therefore, highly specialized care is necessary for this vulnerable population.

These Special Needs Plans (SNPs) program for dual eligible beneficiaries provides 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 and 24-hour access to licensed medical personnel for our members. As such, we believe the current SNP program is an effective and efficient method to improve care for dual eligibles. We 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.

However, since Special Needs Plans differ substantially from regular 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 different 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.

Medicare Advantage: As mentioned above, as a dual-eligible SNP plan, Molina Healthcare has a vested interest in the Medicare Advantage program. As such, we are concerned about the ramifications of some of the MA proposals put forth by the Administration and Finance Committee. We support the concept of linking quality to payment mechanisms but are concerned about how this will be achieved. SNP's are small plans making it difficult to gather statistical information and data, particularly for dual eligibles. Any approach to measure quality must take into account the beneficiaries being served.

The SNP's 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."

Furthermore, we are concerned about the payment structure options proposed by the Finance Committee. In recent years, rural providers have begun seeing fewer Medicare fee-for-service 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. 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. Finally, competitive bidding may be effective but only if done correctly. We have seen disastrous results in the Medicaid program when cost was used as the primary factor in selection of health plans.

Other Medicaid Provisions: 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, states are not eligible to receive these rebates for beneficiaries enrolled in Medicaid health plans. Molina Healthcare supports the Drug Rebate Equalization Act (DRE), introduced by Senator Jeff Bingaman in the 110th Congress, that will 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.

Molina Healthcare 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.

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

J. Mario Molina, MD
CEO and Chairman
Molina Healthcare, Inc.