TESTIMONY

HB2461 HD2

LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
P. O. Box 339
Honolulu, Hawaii 96809-0339

March 15, 2010

MEMORANDUM

TO: Honorable Dwight Y. Takamine, Chair
Senate Committee on Labor

Honorable Suzanne Chun Oakland, Chair
Senate Committee on Human Services

Honorable David Y. Ige, Chair
Senate Committee on Health

FROM: Lillian B. Koller, Director

SUBJECT: **H.B. 2461, H.D. 2 – RELATING TO INSURANCE**

Hearing: Monday, March 15, 2010, 2:50 P.M.
Conference Room 016, State Capitol

PURPOSE: The purpose of this bill is to require EUTF health benefits plans to allow enrollees to continue the same prescription drug coverage for current enrollees, and applies this provision retroactively to the 2009 EUTF open enrollment period. This bill also would prohibit the Department of Human Services from requiring its approval for a Medicaid or QUEST health plan to deliver services through telehealth, and from requiring in-person health care visits to qualify telehealth services for coverage under these health plans.

DEPARTMENT'S POSITION: The Department of Human Services (DHS) strongly opposes Part II of this bill regarding telehealth services for Medicaid and

QUEST health plan patients. Part II of this bill potentially jeopardizes patient safety and exploits a low-income vulnerable population.

Any service provided by a contracted health plan that has not been authorized by DHS will not be reimbursed. Any service not approved by the federal Centers for Medicare and Medicaid Services will not be eligible for federal funding. This bill would require a new service despite DHS voiced opposition, would be state-only funded, and would require a new appropriation.

The provisions for telehealth in this bill eliminate DHS authority for oversight of an emerging technology. As with any new technology there are risks and benefits, and DHS has the responsibility to ensure the safety of its recipients. It is critical for DHS to be able to review scientific evidence in order to make informed decisions about patient safety.

Telemedicine does have an important and growing role, when done in a safe and coordinated manner. A report by the federal Agency for Healthcare Research and Quality found that “studies of office/hospital-based telemedicine suggest that telemedicine is most effective for verbal interactions, e.g., videoconferencing for diagnosis and treatment in specialties like neurology and psychiatry.” DHS has an ongoing telepsychiatry program through the University of Hawaii’s John A. Burns School of Medicine Department of Psychiatry. DHS requires an initial face-to-face visit and then ongoing care occurs remotely. Requiring an initial face-to-face visit is important to establish the provider-patient relationship for ongoing care.

DHS supports the use of telemedicine that has been demonstrated to be safe and effective, and we are quite willing to review data on safety, effectiveness, and cost-effectiveness for any new telemedicine technology. To date no data that demonstrate the safety and effectiveness of a new telemedicine technology have been shared with

DHS. Although data have been shared by one health plan on an emerging technology, those data raised concerns rather than reassurances.

Through QUEST and QUEST Expanded Access, DHS medical assistance programs adhere to the concept of managed or coordinated care. The value of a primary care provider has been repeatedly demonstrated. An individual's direct consumption of healthcare resources outside of the primary care provider hamstrings efforts to coordinate care and instead further fragments healthcare. Online care is unmanaged care that allows patients to self refer to any provider available online. We would support telemedicine that enhanced managed care, but online care fragments it.

We should not be increasing access to harm. Although telemedicine can improve access, it is important that safety and quality should not be compromised. The quality of healthcare that can be provided is substantially limited in the absence of an established patient-provider relationship and without having clinical information including progress notes, laboratory data, and the ability to perform a physical examination. Given patient expectations and providers potentially being evaluated, there is a risk for increased prescribing and thereby an increased risk for adverse drug events. Unmanaged telemedicine could also increase inappropriate utilization and increase costs without improving outcomes.

DHS would be interested in pursuing the role of telemedicine to communicate with an individual's primary care provider or for a scheduled remoted consultation when referred by the primary care provider. These provisions would help ensure patient safety. Removing DHS's responsibility to ensure patient safety under this bill is dangerous.

Thank you for this opportunity to provide testimony.

HGEA
AFSCME
LOCAL 152, AFL-CIO

888 Mililani Street, Suite 601
Honolulu, Hawaii 96813-2991

Telephone: 808.543.0000
Facsimile: 808.528.4059

www.hgea.org

The Twenty-Fifth Legislature, State of Hawaii
Hawaii State Senate
Committee on Labor
Committee on Human Services
Committee on Health

Testimony by
Hawaii Government Employees Association
March 15, 2010

H.B. 2461, H.D. 2 – RELATING TO INSURANCE

The Hawaii Government Employees Association, AFSCME Local 152, AFL-CIO, supports the purpose and intent of H.B. 2461, H.D. 2 with certain amendments. The purpose of H.B. 2461, H.D. 2 is to require health insurers who issue prescription drug coverage to offer those insured at least the same prescription drug coverage they had through their previous health insurance plan. The need for this type of legislation is because the trustees of the Employer-Union Health Benefits Trust Fund (EUTF) approved a prescription drug benefit plan which requires employees to fill their prescriptions for maintenance drugs with a company in Florida.

In addition to the complaints from our members about poor service and delays in receiving medications, this same company initiated reference-based pricing in January 2010 for three drug classes: statins (cholesterol lowering drugs), proton-pump inhibitors (anti-heartburn and ulcer medications) and low or non-sedating antihistamines (allergy medications). Under reference-based pricing, the most cost effective FDA-approved drug is designated by the company within these drug categories. Referenced-based pricing is used in Canada and certain European countries, but there are no jurisdictions in the United States that have used this program for an extended period.

If employees take the preferred drug, participants pay a generic co-payment of $5-$10. However, if a patient cannot tolerate the generic drug, then the co-payment for one of these three drug classes is no longer be a fixed amount, but is based on the difference in price of the preferred (low cost) drug and the more costly drug.

According to the company, co-payments for the non-preferred drug could be as high as $143 for statins, $142 for proton-pump inhibitors and $89 for certain types of antihistamines. It is important to note that all medicines within a specific drug class are not the same. Medications intended to treat the same condition may have different active ingredients and work differently. They also may have different side effects, dosages and risks.

We oppose reference-based pricing because it can interfere with a physician's ability to tailor treatments to individual patients, and the potential to cause differential access to care based upon a patient's ability to pay. Most people cannot afford these expensive co-payments and may go without medication resulting in more expensive hospitalization and emergency room visits.

Under these circumstances, we believe the bill should be amended by suspending the referenced-based pricing policy for a three-year period while the EUTF conducts a comprehensive study on the policy and its effects on its members. Although we support ways to reduce health care costs, we cannot support a policy that forces our members to use a less effective drug because of financial considerations. Thank you for the opportunity to testify on H.B. 2461, H.D. 2 with the suggested amendment.

Respectfully Submitted,

Kevin Mulligan

for Nora A. Nomura
Deputy Executive Director

Written Testimony Presented to the
Senate Committees on Labor, Human Services and Health
Monday, March 15, 2010, 2:50 p.m.
Re: House Bill 2461 Relating to Insurance

Aloha Chairs Takamine, Chun Oakland, Ige and members of the Senate Committees on Labor, Human Services and Health.

My name is Jerris R. Hedges, and I am writing to you as a longtime physician and academic medicine program administrator, including where I currently serve as Dean of the University of Hawai‘i at Manoa’s John A. Burns School of Medicine

My intent is to offer some constructive suggestions regarding language which currently exists in Section 3. As we understand the bill, it states that the goal is to expand -- or not limit -- the different plans in deployment of telemedicine/telehealth services.

This would be accomplished by NOT requiring approval for state plans to conduct their own telemedicine programs. Specifically, (1) state\department approval is not required for the use of telemedicine services, and (2) in-person visits are not required for coverage under these plans.

To clarify (2), initially all telehealth reimbursement was limited by the standard that to be a billable event, the visit must be in-person. Therefore, telemedicine can not be reimbursed, since by definition, telemedicine is not in person. Even video teleconferencing is not technically in person. This statement is perhaps helpful, as it provides guidance to plan administrators that an in-person visit is not required.

Perhaps a more direct statement would be that the State of Hawai‘i will simply follow Centers for Medicare and Medicaid Services (US Department of Health and Human Services) guidelines.

Mahalo for this opportunity to testify.

Jerris R. Hedges, MD
(808) 692-0881

HAWAII MEDICAL ASSOCIATION
1360 S. Beretania Street, Suite 200, Honolulu, Hawaii 96814
Phone (808) 536-7702 Fax (808) 528-2376 www.hmaonline.net

Monday, March 15, 2010, 2:50 p.m., Conference Room 016

To: COMMITTEE ON LABOR
Senator Dwight Y. Takamine, Chair
Senator Brian T. Taniguchi, Vice Chair

COMMITTEE ON HUMAN SERVICES
Senator Suzanne Chun Oakland, Chair
Senator Les Ihara, Jr., Vice Chair

COMMITTEE ON HEALTH
Senator David Y. Ige, Chair
Senator Josh Green, M.D., Vice Chair

From: Hawaii Medical Association
Robert C. Marvit, MD, President
Gary A. Okamoto, MD, Legislative Co-Chair
Linda Rasmussen, MD, Legislative Co-Chair
April Donahue, Executive Director
Lauren Zirbel, Government Affairs
Dick Botti, Government Affairs

Re: HB2461 RELATING TO INSURANCE

Chairs & Committee Members:

Hawaii Medical Association would like to provide comments on HB2461 Relating to Insurance.

We support the intent of Part I that allows continuity of drug benefits and would help protect EUTF patients, particularly those with chronic conditions. HMA would like to point out, however, that continuity of drug benefits is an issue that affects more patients in Hawaii than just EUTF, and while these provisions are a step in the right direction, they do not adequately address the entire situation.

Allowing patients to retain coverage of their current life-saving medications when they are forced to change from one health plan to the next will protect those who may suffer from interrupted care. Health insurers may consider it worthwhile to make their prescription drug benefits proprietary and a part of their competitive positioning. However, when a patient's health coverage changes, new formularies can be very disruptive to their care, sometimes with life threatening implications. Expecting providers to go through a new round of prior authorization requests and demands to switch drugs due to differing formularies can be very time consuming and burdensome for busy practitioners, and may lead providers to refuse to accept patients who are moved to plans with overly restrictive policies.

Please note that it may not be appropriate to require a health insurer or like entity to offer the same prescription drug benefits to insured individuals who voluntarily elect to change plans.

HMA would like to suggest amendments to Part II, which relates to telehealth. The language is currently unclear and too broad, and we recommend the committee review the Centers for Medicare and Medicaid Services (CMS) policy on telehealth for appropriate wording. Please see attached. Using this as a basis for Medicaid will ensure parity with national policies.

Thank you for this opportunity to provide comments.

The official CMS policy reads as follows:

The use of a telecommunications system may substitute for a face-to-face, "hands on" encounter for consultation, office visits, individual psychotherapy and pharmacologic management. These services and corresponding current procedure terminology (CPT) codes are listed below. [1]

- Consultations (CPT codes 99241 - 99275).
- Office or other outpatient visits (CPT codes 99201 - 99215).
- Individual psychotherapy (CPT codes 90804 - 90809).
- Pharmacologic management (CPT code 90862).
- Psychiatric diagnostic interview examination (CPT code 90801).
- End stage renal disease related services (HCPCS codes G0308, G0309, G0311, G0312, G0314, G0315, G0317, and G0318).
- Individual Medical Nutrition Therapy (HCPCS codes G0270, 97802, and 97803).
- Neurobehavioral status exam (CPT code 96116).

Only the following health professionals may claim reimbursement for remote telehealth services:[2]

- Physician;
- Nurse practitioner;
- Physician assistant;
- Nurse midwife;
- Clinical nurse specialist;
- Clinical psychologist,*
- Clinical social worker;* and
- Registered dietitian or nutrition professional.

* Clinical psychologists and clinical social workers cannot bill for psychotherapy services that include medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for the following CPT codes: 90805, 90807, and 90809.

Only the following facilities are eligible to be an originating site under the rules of the program:[3]

- The office of a physician or practitioner.
- A hospital.
- A critical access hospital.
- A rural health clinic.
- A federally qualified health center.
- A Skilled nursing facility (as of January 1, 2009).
- A hospital-based dialysis center (as of January 1, 2009).
- A community mental health center (as of January 1, 2009).

Remote Non Face-to-Face Services[4]
A service may be considered to be a physician's service where the physician either examines the patient in person or is able to visualize some aspect of the patient's condition without the interposition of a third person's judgment. Direct visualization would be possible by means of x-rays, electrocardiogram and electroencephalogram tapes, tissue samples, etc.

For example, the interpretation by a physician of an actual electrocardiogram or electroencephalogram reading that has been transmitted via telephone (i.e., electronically rather than by means of a verbal description) is a covered service.

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[1] CMS Internet Only Manual 100-02, Medicare Benefit Policy Manual, Chapter 15-Covered Medical and Other Health Services, Part 270.02 - List of Medicare Telehealth Services
[2] Ibid, Part 270.4 – Payment – Physician/Practitioner at a Distant Site
[3] Ibid, Part 270.01 – Eligibility Criteria
[4] Medicare benefit policy manual, Part 15 – Covered Medical and Other Health Services, 30-Physician Services pp 10-11.

Use of Telehealth in Delivery of Home Health Services
(Rev. 1, 10-01-03)
PM A-01-02, HHA-201.13

Section 1895(e) of the Act governs the home health prospective payment system (PPS) and provides that telehealth services are outside the scope of the Medicare home health benefit and home health PPS.

This provision does not provide coverage or payment for Medicare home health services provided via a telecommunications system. The law does not permit the substitution or use of a telecommunications system to provide any covered home health services paid under the home health PPS, or any covered home health service paid outside of the home health PPS. As stated in 42 CFR 409.48(c), a visit is an episode of personal contact with the beneficiary by staff of the home health agency (HHA), or others under arrangements with the HHA for the purposes of providing a covered service. The provision clarifies that there is nothing to preclude an HHA from adopting telemedicine or other technologies that they believe promote efficiencies, but that those technologies will not be specifically recognized or reimbursed by Medicare under the home health benefit. This provision does not waive the current statutory requirement for a physician certification of a home health plan of care under current §§1814(a)(2)(C) or 1835(a)(2)(A) of the Act.[5]

[5] Medicare Benefit Policy Manual Chapter 7 Home Health Services, Part 110

Neuropathy Action Foundation
Awareness ▪ Education ▪ Empowerment

March 12, 2010

The Honorable Takamine, Chun-Oakland and Ige
Hawaii State Capitol
415 South Beretania Street
Honolulu, HI 96813

RE: H.B. 2461 - SUPPORT

Dear Senators,

The Neuropathy Action Foundation (NAF), which is dedicated to ensuring neuropathy patients obtain the necessary resources and tools to access individualized treatment to improve their quality of life, strongly supports HB 2461. HB 2461 requires EUTF health benefits plans to allow enrollees to continue the same prescription drug coverage for current enrollees, and applies this provision retroactively to the 2009 EUTF open enrollment period.

HB 2461 is very important for the thousands of Hawaiians who suffer from neuropathy. Many Hawaiians affected by neuropathic pain are oftentimes high users of the health care system as they search for relief from persistent pain. However, once a medication or treatment that actually works is discovered many patients are able to live normal lives. Patients and providers alike expect to be protected by having continuity of medically necessary drugs when they switch from one health plan to another or when they renew plans during open enrollment periods.

The NAF receives a lot of calls from Hawaiians informing us that they are not allowed to continue to use their prescribed medications after they switch or re-enroll in their health plans. Oftentimes these treatments are limb saving like plasma derived IVIG. Many patients have been successfully taking these drugs and/or treatments for years and depend on them to function and take care of their families. HB 2461 would allow Hawaiians to continue using medically necessary medications and treatments prescribed prior to enrollment in their plan, whether or not the drug is covered by the plan, until the prescribed therapy is no longer prescribed by the patient's provider.

Please help neuropathy patients and others who suffer from chronic illnesses by supporting this patient protection bill that directly strengthens the doctor patient relationship. Should you have any questions please contact me at 877-512-7262.

Regards,

James D. Lee
Treasurer and Public Affairs Chair

Neuropathy Action Foundation ▪ 1304 S. Roxbury Drive #303 ▪ Los Angeles, California 90035 ▪ (877) 512-7262 ▪ www.neuropathyaction.org

1100 New York Avenue, NW Suite 630 Washington, DC 20005 (202) 331-2196

Honorable Senators
Hawaii State Capitol
415 South Beretania Street
Honolulu, HI 96813

RE: H.B. 2461 - SUPPORT

Dear Senators,

The Alliance for Plasma Therapies, a national non-profit organization established to provide a unified, powerful voice of patient organizations and healthcare providers to educate about the diseases that rely on plasma derived therapies and advocate for fair access to plasma therapies for patients who benefit from their lifesaving effects, strongly supports HB 2461. HB 2461 requires EUTF health benefits plans to allow enrollees to continue the same prescription drug coverage for current enrollees, and applies this provision retroactively to the 2009 EUTF open enrollment period.

On an annual basis, the Alliance receives approximately 250 insurance cases from patients who have been denied access to their lifesaving therapy intravenous immune globulin therapy (IVIG) throughout the U.S. IVIG is a plasma-derived therapy used to treat patients with autoimmune diseases, cancer, primary immune deficiencies and neuropathies. HB 2461 is very important for the thousands of Hawaiians who suffer from these diseases. Many Hawaiians affected by rare and chronic disorders, when diagnosed and receiving lifesaving therapies such as IVIG are put in danger when they do not receive their therapy on a timely basis. Patients and providers alike expect to be protected by having continuity of medically necessary drugs when they switch from one health plan to another or when they renew plans during open enrollment periods.

The Alliance receives a lot of calls from Hawaii residents informing us that they are not allowed to continue to use their prescribed medications after they switch or re-enroll in their health plans. Oftentimes these treatments are lifesaving from severe and chronic infections for primary immune deficient patients to paralysis for autoimmune and neuropathy patients when relying on therapies such as IVIG. Many patients have been successfully taking these drugs and/or treatments for years and depend on them to function and take care of their families. HB 2461 would allow Hawaiians to continue using medically necessary medications and treatments prescribed prior to enrollment in their plan.

Please help all patients who suffer from chronic and rare disorders by supporting this patient protection bill that directly strengthens the doctor patient relationship. Should you have any questions please contact me at 888-331-2196.

Regards,

Michelle Vogel
Executive Director

The Official Sponsor of Birthdays

March 13, 2010

Committee on Labor
Senator Dwight Takamine, Chair
Senator Brian Taniguchi, Vice Chair

Committee on Human Services
Senator Suzanne Chun Oakland, Chair
Senator Les Ihara, Jr., Vice Chair

Committee on Health
Senator David Ige, Chair
Senator Josh Green, M.D., Vice Chair

Hearing:
2:50 P.M. Monday, March 15, 2010
Hawaii State Capitol, Room 016

RE: HB2461, HD2 – Relating to Insurance

Testimony in Support with Recommendations

Chairs Takamine, Chun Oakland, and Ige, and members of the committees. Thank you for the opportunity to testify in support of HB2461, HD2. This bill requires EUTF health benefits plans to allow enrollees to continue the same prescription drug coverage for current enrollees, and applies this provision retroactively to the 2009 EUTF open enrollment period. It would also prohibit the Department of Human Services from requiring its approval for a Medicaid/Quest health plan to deliver services through telehealth, and from requiring in-person health care visits to qualified telehealth services for coverage under these health plans.

The American Cancer Society is limiting our testimony and recommendations to those portions of the bill that address the continuity of drug coverage. The original intent of this bill and Senate bill SB2494 would ensure prescription drug coverage for patients who, through no fault of their own, would experience a change in their health insurance plan and may not be able to obtain the same medications that they were on with their previous health plan provider.

The Cancer Society believes it is crucial that patients, actively undergoing chemotherapy, retain their prescribed treatment regimen, and depending upon the type of cancer, may require a specific cocktail of anticancer drugs consisting of both brand name and generic drugs; as well adjunct medications that treat the uncomfortable side effects of chemotherapy. To change a patient's drug treatment regimen to adhere to the prescription formulary of a new insurance carrier could be life-threatening.

American Cancer Society Hawai'i Pacific, Inc., 2370 Nu'uanu Avenue, Honolulu, Hawaii 96817-1714
●Phone: (808) 595-7500 ●Fax: (808) 595-7502 ●24-Hour Cancer Info: (800) 227-2345 ●http://www.cancer.org

We would also like to point out to the committee members of the possible financial consequence that this may cause by forcing cancer patients to pay full price for critical medications at a time when their financial resources are limited. A similar situation may also occur for EUTF members. Our understanding is that current EUTF policy limits access to some medications used to treat the side effects of chemotherapy such a gastric reflux.

We would strongly recommend that the committees reinsert the language of the Senate passed measure, SB2494, SD2, to include all insured individuals and also retain the amended language regarding EUTF members.

Having reviewed testimony submitted by the opponents of this measure and SB2494, we do not fully concur that ERISA is preemptive in this situation because of our Prepaid Heath Care Act.

We believe that this measure, as **originally intended,** would be extremely beneficial for patients undergoing active chemotherapy, and will assure them that their drug regimen will not change because of changes in their health insurance carriers.

We urge you to reinsert the amended language included in SB2494, SD2, as passed earlier by the full Senate.

Thank you for your consideration.

George Massengale, J.D.
Director of Government Relations

HMSA Blue Cross Blue Shield of Hawaii

An Independent Licensee of the Blue Cross and Blue Shield Association

March 15, 2010

The Honorable Dwight Takamine, Chair
The Honorable Suzanne Chun Oakland, Chair
The Honorable David Ige, Chair

Senate Committees on Labor, Human Services and Health

Re: HB 2461 HD2 – Relating to Insurance

Dear Chair Takamine, Chair Chun Oakland, Chair Ige and Members of the Committees:

The Hawaii Medical Service Association (HMSA) appreciates the opportunity to testify on HB 2461 HD2. Part I of this measure would require EUTF to provide their members with prescription drug coverage which is identical to the prescription drug coverage they had been offered prior to changes being made to their prescription drug benefits. Part II of this measure would permit QUEST members gain access to telehealth services. We oppose Part I of this measure and support Part II.

The language contained within HB 2461 HD2 Part I seems to be problematic and would potentially constitute an Employee Retirement Income Security Act (ERISA) violation. This is because it contains a portability requirement of the drug benefit of an individual's previous health plan which is then mandated to be covered by a plan with prescription drug benefits that the member may choose. ERISA preempts any state law that relates to an employee benefit plan including "all laws, decisions, rules, regulations, or other State action having the effect of law."

There may also be issues around how the language in SB 2461 HD2 Part I could potentially interact with plans provided under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Under COBRA, plans must provide continuing coverage to qualifying participants consisting of the same benefits offered under the group plan. This bill would make it impossible to provide a summary of plan benefits offered under a group plan to COBRA participants since drug coverage would differ among members and potentially be based on a previous plans' drug coverage.

In addition to the many potential legal issues with Part I of this measure, it would end up being extremely burdensome to implement and manage and for consumers to figure out. Some other concerns we have include:

- Administering prescription drug benefits on a member-by-member basis may be impossible to manage

- Plans determine premiums based on a known set of benefits. When members choose their prior plans' prescription drug benefit, which will differ from that being offered by their plan, rates may not be adequate to cover costs

- Employers will be left to figure out how to manage employees under the same medical plan receiving differing prescription drug benefits. Issues of equity may arise

- Consumers are not adequately versed in their benefits and don't have a full understanding about which prescription drug plan would be best for them. They may make a poor choice and end up with coverage that does not suit their needs

Part II of this measure would allow health plans to offer telehealth services to QUEST members. As you are aware, the Department of Human Services (DHS) stated that due to budgetary shortfalls, they will delay payments to contracted QUEST plans, beginning in April and extending through June. This announcement has spurred discussions centered around the long term viability of the QUEST program and how to rein in costs in order to ensure it is sustainable in the future.

A project being planned on the Big Island of Hawaii may provide additional opportunities for QUEST members to access care in their communities which could help to decrease the incidence of individuals visiting the emergency room for non-emergent services. A medical van designated to operate on the Big Island has been funded and is currently in the planning stages. One large component of this effort is to enable the van to connect to specialists and other providers via telehealth services. Currently DHS will not allow QUEST members to access certain types of telehealth services such as HMSA's Online Care. We believe that the provision of services through this method could end up containing costs for the QUEST plans by ensuring that members with chronic diseases maintain their good health and those needing to see a physician are able to so instead of potentially visiting the ER. We strongly support the language in Part II which would assist in contributing to bettering the health of the QUEST population.

Despite the good intentions of this measure, we believe that Part I raises more issues than it answers and could end up contributing to increased health care cost, consumer confusion and employer frustration as well as facing legal challenges. **Due to these issues, we would respectfully request the Committees remove Part I in its entirety. We strongly support the language contained in Part II and would request the Committees see fit to pass this language as a means to increase access for QUEST members and to assist in containing cost.**

Thank you for the opportunity to testify today.

Sincerely,

Jennifer Diesman
Vice President
Government Relations