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2003 HOUSE HUMAN SERVICES

HB 1462

2003 HOUSE STANDING COMMITTEE MINUTES

BILL/RESOLUTION NO. HB 1462

House Human Services Committee

☐ Conference Committee

Hearing Date February 5, 2003

Tape Number	Side A	Side B	Meter #
1	x		21.8 -61.7
		x	0.0 - 31.8
Committee Clerk Signature	Sharon Renfrew		

Minutes:

Rep. Scott Kelsh appeared as prime sponsor stating the reason for this bill as a message of giving a patient an option, if they are denied coverage by an HMO for a medically necessary procedure as determined by the primary care physician. This bill gives the patient an option of a second opinion.

Rep. Devlin noted that many things he's asking for in this bill are already in law.

John Risch, United Transportation Union Railroad Workers across the State appeared in support stating this is a good effort to reduce health costs and gives the option of a second opinion.

John W. Breen Jr. on behalf of himself appeared in support with written testimony as well as a copy of a Supreme Court Bench Opinion.

Rep. Porter asked about patient confidentiality and asked if he asked any patients that have talked to him about this for a medical release so that you could discuss the situations so we could get a better understanding if there truly is a problem. Answer: No, feels its client confidentiality.

Questions of the committee on what HMO's are involved. Answer: didn't ask. Did he know of anyone who has specifically brought a case or grievance against HMO's? Answer: Yes, but didn't bring any information. Also if the problem wouldn't go directly to the Insurance Commission and if that avenue was pursued. Answer; Didn't know, he directed them to the doctor.

Bruce Levi, ND Medical Assoc. appeared in support stating our association wasn't involved in the introduction of this bill, but we have a keen interest in the concept of independent review and expect to provide a couple of observations.

Rep. Price asked if what we have in law now, is it working?

Answer: Can't say whether there are specific problems now, but this would encourage physicians to be stronger advocates for patients in trying to address these issues.

Rep. Porter stated there is nothing here to pay back the HMO if after review of an appeal and found in favor of HMO. Answer; Doesn't know.

Rep. Porter also stated that you may have to go out of State to find a same type of doctor and that could be expensive, and wanted to know who pays for this?

Rep. Weisz: Could the Insurance Commissioner ask for an independent review? Answer: doesn't know.

Allan Matties, Heart of America HMO appeared in opposition with written testimony stating they have approx. 2300 membership.

Rep. Amerman asked sits on his grievance committee and can he bring an attorney to the hearing.

Answer: 7 members made up a surgeon, administrator of the hospital in Rugby and 5 consumer members and they can bring whoever they want to the hearing.

Rep. Porter asked about the number of grievances they've had in past years and what they consisted of: Answer: 2001 - no grievances, 2000 - 3 complaints and 1999 - 1 grievances

Vance Magnuson, ND Insurance Dept. appeared not opposing the concept for solving grievances, however as far as the bill is concerned I feel there are already procedures in place that currently provide for safeguards to members of HMO's. The way the bill is written it would not pertain to specialists, like cardiologists, radiologists, etc. There currently are procedures in place to address the concerns raised in this bill. Medical records are typically provided to the insurance department, we do get a release from the insured if they file a complaint with us and regulators are authorized to review these medical records, they are confidential under both federal and state law. For any appeal, those are required to be reviewed by a like physician (outside physician). Under HIPAA, applies to all new health group benefit plans and in certain instances it will supersede our utilization review. The utilization review in ND would still pertain to individuals if there were individuals that had HMO coverage, however, the HMO's in ND do not actively write individual business.

Questions of the committee on if it could be costly to go through the grievance procedure and whether it was better to have legal counsel present with the individual. Also, how many complaints were filed with Medica.

Answer: no additional cost to go through grievance procedure, its up to the individual if they want to retain counsel and only 2 complaints with Medica, 1 in 2002 and 1 in 2001.

Closed the hearing.

Rep. Porter states this bill was a solution seeking a problem and feels Mr. Magnuson gave examples of how the process worked, we all got a good basis review of the patient protections

already in place and I can't disagree with the gentleman from Heart of America HMO that its discriminatory towards their organization, that its not dealing with other insurance companies and sees no purpose of having this legislation and moves a DO NOT PASS, second by Rep. Kreidt.

Rep. Price noted that HIPAA is going to regulate this.

Rep. Amerman & Rep. Sandvig disagrees and feels it should be given a do pass.

Rep. Wieland, Potter & Kreidt felt there was no demonstrated need for this and no evidence was produced stating there was a need.

Rep. Weisz stated this bill doesn't catch the fall through the cracks people because they have a grievance procedure & appeal process.

10 - 3 - 0 Rep. Pollert will carry the bill.

Date: February 5, 2003
Roll Call Vote #:

2003 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. HB 1462

House HUMAN SERVICES Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken DNP

Motion Made By Rep Porter Seconded By Rep Kreidt

Representatives	Yes	No	Representatives	Yes	No
Rep. Clara Sue Price - Chair	✓		Rep. Sally Sandvig		✓
Rep. Bill Devlin, Vice-Chair	✓		Rep. Bill Amerman		✓
Rep. Robin Weisz	✓		Rep. Carol Niemeier		✓
Rep. Vonnie Pietsch	✓		Rep. Louise Potter	✓	
Rep. Gerald Uglem	✓				
Rep. Chet Pollert	✓				
Rep. Todd Porter	✓				
Rep. Gary Kreidt	✓				
Rep. Alon Wieland	✓				

Total (Yes) 10 No 3

Absent 0

Floor Assignment Rep. Pollert

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE (410)
February 5, 2003 12:22 p.m.

Module No: HR-22-1705
Carrier: Pollert
Insert LC: . Title: .

REPORT OF STANDING COMMITTEE

HB 1462: Human Services Committee (Rep. Price, Chairman) recommends **DO NOT PASS** (10 YEAS, 3 NAYS, 0 ABSENT AND NOT VOTING). HB 1462 was placed on the Eleventh order on the calendar.

2003 TESTIMONY

HB 1462

717 Williams St.
Bismarck, ND 58501

February 5, 2002

Representatives of the North Dakota Legislature

Re: **Health care access and medical necessity**

Testimony of John W. Breen Jr.

Gentlemen and Gentlewomen,

I am pleased to testify in support of the bill introduced by Representative Kelsh. I am an attorney in Bismarck, but appear before you only as a citizen and a patient who holds a health care insurance policy.

Presently health care insurance policies in North Dakota can unilaterally deny patients in ND medical coverage on this basis, that is, while the treatment is covered under the health policy, the health policy administrator can unilaterally find the recommended treatment is not medically necessary, and deny coverage.

The United States Supreme Court, recently, in **Rush Prudential HMO vs. Morgan** (June 2002) has changed this, but only if the state legislature enacts a statute that requires the independent medical review. **In Rush Prudential**, The Supreme Court upheld an Illinois statute, which requires an independent review, binding on the health insurer when the health insurer or HMO denies medical coverage as not medically necessary.

The residents of North Dakota do not have this protection, simply because it in not required by a state statute.

The Illinois statute 215 ILCS125/4/10 is a model and provides essentially as follows:

1. Each Health Maintenance Organization shall provide for timely review by an independent physician, jointly selected by the patient, the primary care physician and the H. M. O., in the event of a dispute regarding the medical necessity of a covered service.

2. In the event the independent reviewing physician determines the covered service is medically necessary, the Health Maintenance Organization is required to provide the covered service.

3. The primary car physician who makes referral to an independent review is protected from adverse action based on this conduct from the HMO.

Presently North Dakota does not provide such statutory protection for its constituents. Indeed a national carrier, which is required to provide such protection to a resident in Illinois, is not required to provide such protection to a resident of North Dakota. Are North Dakotans to be second class citizens in access to health care?

The legality of this regulatory statute has been upheld by the United States Supreme Court despite a challenge by Prudential. The court clearly recognizes that health insurers are protected under law, for example from antitrust law, but are subject to this specific protection as enacted by the state legislatures.

Patient privilege properly protects my discussion of any patient medical record and treatment or lack of treatment. Accordingly I am properly barred from discussing specific numbers or examples before this committee. However I assure the committee that this is not a hypothetical remedy. There is a genuine need for this protection.

The mechanism of this review is efficient and simple and imposes a deminimus expense. Most of these reviews will be done on review of films and a medical chart. The review is also efficient as it eliminates unnecessary costs of an arbitration or legal process, and focuses on prompt efficient review by fellow physicians in the appropriate specialty. The focus is on prompt independent review and prompt medical treatment if appropriate. This decision on review is binding on the carrier and patient. This method also protects the health insurer from any claims or criticism about the decision.

Lets balance the benefits and detriments of this remedy to health care access. The protection it offers is clearly beneficial, to all of us here, and all citizens of North Dakota. The burden of this review, if at all, is minimal. More importantly the remedy requested will allow the health insurance carriers and administrators to act in a manner that is above reproach and criticism, while retaining their other protections under the law. This remedy also protects the health carrier from suit for these decisions. The remedy also gives citizens of North Dakota the same protections on access to health care that have been granted by other states to their citizens. North Dakota citizens should not be second class citizens in access to health care.

May I remind you that the patients in North Dakota are unable to retain powerful lobbyists, or professional associations to represent them. I humbly ask that you consider this petition as one of their many voices.

Very truly yours,

John W. Breen Jr.

Syllabus

NOTE: Where it is feasible, a syllabus (headnote) will be released, as is being done in connection with this case, at the time the opinion is issued. The syllabus constitutes no part of the opinion of the Court but has been prepared by the Reporter of Decisions for the convenience of the reader. See *United States* v. *Detroit Timber & Lumber Co.*, 200 U. S. 321, 337.

SUPREME COURT OF THE UNITED STATES

Syllabus

RUSH PRUDENTIAL HMO, INC. *v.* MORAN ET AL.

CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

No. 00–1021. Argued January 16, 2002—Decided June 20, 2002

Petitioner Rush Prudential HMO, Inc., a health maintenance organization (HMO) that contracts to provide medical services for employee welfare benefits plans covered by the Employee Retirement Income Security Act of 1974 (ERISA), denied respondent Moran's request to have surgery by an unaffiliated specialist on the ground that the procedure was not medically necessary. Moran made a written demand for an independent medical review of her claim, as guaranteed by §4–10 of Illinois's HMO Act, which further provides that "[i]n the event that the reviewing physician determines the covered service to be medically necessary," the HMO "shall provide" the service. Rush refused her demand, and Moran sued in state court to compel compliance with the Act. That court ordered the review, which found the treatment necessary, but Rush again denied the claim. While the suit was pending, Moran had the surgery and amended her complaint to seek reimbursement. Rush removed the case to federal court, arguing that the amended complaint stated a claim for ERISA benefits. The District Court treated Moran's claim as a suit under ERISA and denied it on the ground that ERISA preempted §4–10. The Seventh Circuit reversed. It found Moran's reimbursement claim preempted by ERISA so as to place the case in federal court, but it concluded that the state Act was not preempted as a state law that "relates to" an employee benefit plan, 29 U. S. C. §1144(a), because it also "regulates insurance" under ERISA's saving clause, §1144(b)(2)(a).

Held: ERISA does not preempt the Illinois HMO Act. Pp. 6–31.

(a) In deciding whether a law regulates insurance, this Court starts with a commonsense view of the matter, *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U. S. 724, 740, which requires a law to "be specifi-

Syllabus

cally directed toward" the insurance industry, *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U. S. 41, 50. It then tests the results of the commonsense enquiry by employing the three factors used to point to insurance laws spared from federal preemption under the McCarran-Ferguson Act. Pp. 6–18.

(1) The Illinois HMO Act is directed toward the insurance industry, and thus is an insurance regulation under a commonsense view. Although an HMO provides healthcare in addition to insurance, nothing in the saving clause requires an either-or choice between healthcare and insurance. Congress recognized, the year before passing ERISA, that HMOs are risk-bearing organizations subject to state insurance regulation. That conception has not changed in the intervening years. States have been adopting their own HMO enabling Acts, and at least 40, including Illinois, regulate HMOs primarily through state insurance departments. Rush cannot submerge HMOs' insurance features beneath an exclusive characterization of HMOs as health care providers. And the argument of Rush and its *amici* that §4–10 sweeps beyond the insurance industry, capturing organizations that provide no insurance and regulating noninsurance activities of HMOs that do, is based on unsound assumptions. Pp. 9–16.

(2) The McCarran-Ferguson factors confirm this conclusion. A state law does not have to satisfy all three factors to survive preemption, and §4–10 clearly satisfies two. The independent review requirement satisfies the factor that a provision regulate "an integral part of the policy relationship between the insurer and the insured." *Union Labor Life Ins. Co.* v. *Pireno*, 458 U. S. 119, 129. Illinois adds an extra review layer when there is an internal disagreement about an HMO's denial of coverage, and the reviewer both applies a medical care standard and construes policy terms. Thus, the review affects a policy relationship by translating the relationship under the HMO agreement into concrete terms of specific obligation or freedom from duty. The factor that the law be aimed at a practice "limited to entities within the insurance industry," *ibid.*, is satisfied for many of the same reasons that the law passes the commonsense test: It regulates application of HMO contracts and provides for review of claim denials; once it is established that HMO contracts are contracts for insurance, it is clear that §4–10 does not apply to entities outside the insurance industry. Pp. 16–18.

(b) This Court rejects Rush's contention that, even though ERISA's saving clause ostensibly forecloses preemption, congressional intent to the contrary is so clear that it overrides the statutory provision. Pp. 18–30.

(1) The Court has recognized an overpowering federal policy of

Syllabus

exclusivity in ERISA's civil enforcement provisions located at 29 U. S. C. §1132(a); and it has anticipated that in a conflict between congressional polices of exclusively federal remedies and the States' regulation of insurance, the state regulation would lose out if it allows remedies that Congress rejected in ERISA, *Pilot Life*, 481 U. S., at 54. Rush argues that §4–10 is preempted for creating the kind of alternative remedy that this Court disparaged in *Pilot Life*, one that subverts congressional intent, clearly expressed through ERISA's structure and legislative history, that the federal remedy displace state causes of action. Rush overstates *Pilot Life*'s rule. The enquiry into state processes alleged to "supplemen[t] or supplan[t]" ERISA remedies, *id.*, at 56, has, up to now, been more straightforward than it is here. *Pilot Life*, *Massachusetts Mut. Life Ins. Co.* v. *Russell*, 473 U. S. 134, and *Ingersoll-Rand Co.* v. *McClendon*, 498 U. S. 133, all involved an additional claim or remedy that ERISA did not authorize. In contrast, the review here may settle a benefit claim's fate, but the state statute does not enlarge the claim beyond the benefits available in any §1132(a) action. And although the reviewer's determination would presumably replace the HMO's as to what is medically necessary, the ultimate relief available would still be what ERISA authorizes in a §1132(a) suit for benefits. This case therefore resembles the claims-procedure rule that the Court sustained in *UNUM Life Ins. Co. of America* v. *Ward*, 526 U. S. 358. Section 4–10's procedure does not fall within *Pilot Life*'s categorical preemption. Pp. 20–24.

(2) Nor does §4–10's procedural imposition interfere unreasonably with Congress's intention to provide a uniform federal regime of "rights and obligations" under ERISA. Although this Court has recognized a limited exception from the saving clause for alternative causes of action and alternative remedies, further limits on insurance regulation preserved by ERISA are unlikely to deserve recognition. A State might provide for a type of review that would so resemble an adjudication as to fall within *Pilot Life*'s categorical bar, but that is not the case here. Section 4–10 is significantly different from common arbitration. The independent reviewer has no free-ranging power to construe contract terms, but instead confines review to the single phrase "medically necessary." That reviewer must be a physician with credentials similar to those of the primary care physician and is expected to exercise independent medical judgment, based on medical records submitted by the parties, in deciding what medical necessity requires. This process does not resemble either contract interpretation or evidentiary litigation before a neutral arbiter as much as it looks like the practice of obtaining a second opinion. In addition, §4–10 does not clash with any deferential standard for reviewing benefit denials in judicial proceedings. ERISA itself says nothing

Syllabus

about a standard. It simply requires plans to afford a beneficiary some mechanism for internal review of a benefit denial and provides a right to a subsequent judicial forum for a claim to recover benefits. Although certain "discretionary" plan interpretations may receive deference from a reviewing court, see *Firestone Tire & Rubber Co.* v. *Bruch*, 489 U. S. 101, 115, nothing in ERISA requires that medical necessity decisions be "discretionary" in the first place. Pp. 24–30.

230 F. 3d 959, affirmed.

SOUTER, J., delivered the opinion of the Court, in which STEVENS, O'CONNOR, GINSBURG, and BREYER, JJ., joined. THOMAS, J., filed a dissenting opinion, in which REHNQUIST, C. J., and SCALIA and KENNEDY, JJ., joined.

Heart of America HMO

Keeping you healthy for life

Madam Chairman and Members of the Committee,

I appear before this committee to offer testimony against House Bill 1462. The Heart of America HMO sees this bill as being discriminatory, as HMOs alone are being identified, costly, and of no value to our membership.

In my seven years as Chairman of the Grievance Committee for the Heart of America HMO we have had only nine cases come before us for a determination. Of these nine cases, five were also sent to the State Insurance Department for their determination. In all cases the Insurance Department agreed with our determination. The HMO has never had a case in which the primary care physician (PCP) and the HMO were in disagreement regarding the medical necessity of a covered service.

Within the content of the bill it states " that the reviewing physician must be jointly selected by the primary care physician (PCP), the health maintenance organization, and the patient". We believe that it would be very difficult to achieve this purpose as each party has their own separate agenda.

The bill does not address the party responsible for paying for the independent reviewer, though by the tone of the bill it appears that the HMO would absorb this cost. It would be very expensive to bring an independent reviewer to Rugby; to review the medical record, and hear pertinent testimony. Even if shared equally among the three entities involved, the review would be expensive - physician time does not come cheaply. In any event the bottom line being, the costs would need to be passed on to our membership in the form of premium increases.

Additionally, the bill does not state whether the independent reviewer would be used in either Medicare or Non-Medicare cases. Medicare has their own grievance process that they adhere to, and HMOs are mandated to follow their policies and procedures.

The Heart of America HMO, being the only functioning HMO in North Dakota, had no input into this bill - had we been contacted we believe that this bill would never had been proposed. The Heart of America HMO vigorously opposes the passage of this bill as it provides nothing for our membership.

In closing I do extend an open invitation to the members of this committee and all members of the House and Senate to visit our operations to see for themselves how an HMO functions in North Dakota. Thank you for allowing me to address this Committee.

810 S. Main Ave., Rugby, ND 58368 • 701-776-5848

Alt. Mathies

Grievances Heard in 2001
by
Heart of America HMO Hearing Committee

In 2001, there were no complaints that went before the Heart of America HMO (HAHMO) Hearing Committee.

Grievances Heard in 2000
by
Heart of America HMO Hearing Committee

In 2000, there were three complaints that went before the Heart of America HMO (HAHMO) Hearing Committee. The grievances heard are outlined below:

#1. CAUSE FOR HEARING: Request for payment for diagnostic services provided at Heart of America Medical Center rather than it being applied to their deductible, since they thought the service was a Johnson Clinic service. The Member's coverage is with the Share Option, and therefore all services other than Johnson Clinic services are applied to their deductible and then any coinsurance if applicable. Since the service was provided at HAMC, the deductible applied, thus making the Member responsible for the cost of the service.

RESULT OF HEARING: Committee voted to uphold the original decision to apply the cost of the services to the Member's deductible. The decision was based on the fact that the services received were not Johnson Clinic services, and thus all other services are applied through the Member's deductible. The Member had actually signed a form at the Heart of America Medical Center acknowledging admission as a patient to the hospital and that their insurance may not cover the services.

#2. CAUSE FOR HEARING: Request for coverage of an insulin pump for management of the Member's diabetes. Member's control of his diabetes was well within normal limits. Per HMO policy, an insulin pump would be purchased if a Member was having difficulty controlling their diabetes. Member noted that an insulin pump would be so much more convenient with his occupation and lifestyle.

RESULT OF HEARING: Committee voted to uphold the original decision to deny coverage for an insulin pump based on the fact the pump would be purchased more for convenience and not because of medical necessity in controlling the Member's diabetes.

#3. CAUSE FOR HEARING: Request for coverage for physical therapy services received by Member which were beyond the two months of coverage available. The Member had exhausted his two months of coverage that are available per injury or illness for physical therapy. The Member continued to receive therapy beyond the two months since he thought the HMO was being contacted by his therapist to arrange for continuation of therapy. The Member's condition is very unique in the fact that a number of surgeries have been performed for his medical condition. Two months of covered therapy are approved following each new surgery.

RESULT OF HEARING: Committee unanimously voted to reverse the initial determination to deny payment for physical therapy bills. The Committee agreed to cover the extended therapy since the Member was under the assumption that PT personnel were arranging for approval from HMO at the time services were being rendered, and also given the fact that HMO had previously extended his covered therapy beyond the two months.

Three complaints were filed with the ND Insurance Department that we were notified of. Of the three, two (#1 and #2 above) were previously dealt with through our grievance procedure. With #1 above, the Department upheld our decision to have the services be applied to the deductible, however it was requested that we apply it to the deductible maximum for year 2000 rather than 1999 since the services were received in late December. With grievance #2, we have heard nothing from the State since our response and thus we are assuming our initial decision was upheld. With the third complaint filed with the Insurance Department, HMO responded in May of 2000 and to date we have heard nothing further.

Grievances Heard in 1999
by
Heart of America HMO Hearing Committee

In 1999, there was one complaint that went before the Heart of America HMO (HAHMO) Hearing Committee. The grievance heard is outlined below:

CAUSE FOR HEARING: Request for coverage of services which were incurred by Member (3 months of age) through the emergency department of a non-contracted hospital located within the HAHMO's market area. The services were initially denied due to the fact that they were determined non-emergent and could have been obtained at the HAHMO's contracted primary care hospital in Rugby. The Member's grandmother had contacted the hospital in Rugby regarding recommended treatment for symptoms Member was having, grandmother was advised to seek medical attention if condition did not approve. Because of various circumstances, the grandmother chose to take Member to the non-contracted facility rather than bringing her to Rugby.

RESULT OF HEARING: Committee unanimously voted to approve the request for payment of services incurred, totaling $142.00, less the applicable $30 emergency room copayment.

There were no complaints made directly to the ND Insurance Department that we are aware, i.e. none where we were notified and needing to submit documentation.

Grievances Heard in 1998
by
Heart of America HMO Hearing Committee

In 1998, there were two complaints that went before the Heart of America HMO (HAHMO) Hearing Committee. The grievances heard are as outlined below:

#1. CAUSE FOR HEARING: Request for coverage of a Member's newborn child. Child was born December 17, 1997 and the HAHMO was informed on 1/7/98 that the child was being added to the father's policy which was not HAHMO. We were then contacted on 3/2/98 by the Member informing us that her husband's policy would not be covering the newborn's hospital and physician bills, and asked if we would cover the bills. The Member was informed that HAHMO would not be covering the bills either. It was at this point that the Member requested that the child be covered back to December 17th with HAHMO since she said she didn't know we wouldn't cover the bills.

RESULT OF HEARING: Committee unanimously voted to approve the request if the additional premium needed to update the contract to a Single Plus Dependent. The premium was paid and the child was added as of December 17th.

#2. CAUSE FOR HEARING: Request for coverage of routine services which were received by Member out-of-area from non-contracted providers. No referral was received nor was HAHMO contacted for approval of the services prior to receiving the services. Services were determined non-emergent.

RESULT OF HEARING: Committee unanimously voted to pay 50% of the charges incurred for the services received with the Member being responsible for the remaining 50%. Member agreed to the compromise.

There were no complaints made directly to the ND Insurance Department that we are aware, i.e. none where we were notified and needing to submit documentation.

Grievances Heard in 1997
by
Heart of America HMO Hearing Committee

In 1997, there was only one complaint that went before the Heart of America HMO (HAHMO) Hearing Committee. The grievance heard is as outlined below:

CAUSE FOR HEARING: Request for coverage for a panniculectomy procedure following surgery for morbid obesity.

RESULT OF HEARING: Committee unanimously voted to deny request for the panniculectomy procedure. The service was denied since the member's medical condition did not meet HAHMO guidelines for medical necessity for a panniculectomy.

There was also two complaints made directly to the ND Insurance Department rather than the members contacting HAHMO first to discuss their complaint or utilizing the grievance procedure. Information was requested by the ND Insurance Department and supporting documentation was submitted by the HAHMO in October 1997. To date, HAHMO has not received the Department's ruling with either complaint.

Grievances Heard in 1996
by
Heart of America HMO Hearing Committee

In 1996, there was only one complaint that went before the Heart of America HMO (HAHMO) Hearing Committee. Basically, the grievance dealt with a member requesting coverage for a non-covered service and is as outlined below:

CAUSE FOR HEARING: Request for coverage for reversal of a tubal ligation.

RESULT OF HEARING: Committee unanimously voted to deny request since it is a non-covered service. The service has been denied to members in the past and the service is not a covered service in general in the insurance industry.

There was also one complaint made directly to the ND Insurance Department rather than the member contacting HAHMO first to discuss their complaint or utilizing the grievance procedure. Information was requested by the ND Insurance Department and after reviewing the information provided by HAHMO, the Department's ruling was that the HAHMO acted in the correct manner and thus there was no action taken.