

STATE OF MICHIGAN
DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
OFFICE OF FINANCIAL AND INSURANCE REGULATION
Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX

Petitioner

v

File No. 117941-001

Blue Care Network
Respondent

**Issued and entered
this 30th day of June 2011
by R. Kevin Clinton
Commissioner**

ORDER

I. BACKGROUND

On November 5, 2010, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.*

Respondent Blue Care Network (BCN) was notified of the request and on November 9, 2010, furnished the information it used in making its final adverse determination. On November 12, 2010, after a preliminary review of the material submitted, the Commissioner accepted the request for external review.

The issue in this external review can be decided by an analysis of the contract that defines the Petitioner's health care benefits. The Commissioner reviews contractual issues under MCL 500.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

The Petitioner is a member of BCN, a health maintenance organization. Her health care benefits are defined in the BCN 10 Certificate of Coverage (the certificate).

The Petitioner was diagnosed with type I diabetes in 1984 at age 13. Over the years, it has become more challenging for her to maintain proper blood glucose levels. As a result, the Petitioner's physician recommended an insulin pump and glucose monitor, which are durable medical equipment (DME) items.

BCN requires 50% coinsurance for DME and the Petitioner says she cannot afford it. When she asked BCN to waive or reduce the 50% coinsurance, BCN denied the request.

The Petitioner appealed the denial through BCN's internal grievance process. At its conclusion, BCN affirmed its decision in its final adverse determination dated October 22, 2010.

III. ISSUE

Was BCN correct when it declined to waive or reduce the Petitioner's copayment for DME?

IV. ANALYSIS

Petitioner's Argument

In her August 23, 2010, appeal letter to BCN the Petitioner explained:

Unfortunately my insurance contract only covers 50% of durable medical equipment. The cost of the pump alone ranges from \$6,000 to \$11,000. Not including the supplies, insulin, and blood sensors to flag low and high blood sugar. **I cannot afford to pay the out-of-pocket costs associated with these life saving items.**

* * *

I am asking Blue Care Network to consider covering my insulin pump and blood sugar sensor durable (medical) equipment at a higher percentage or covering in full. . . .

. . . My husband had to call 911 because he was unable to revive me from an episode of low blood sugar. If I would have had the insulin pump and blood sensors, this would not have happened. The sensors would have rang a bell that would have alerted me of the oncoming low blood sugar.

If BCN helps her to acquire the diabetes DME by paying for it entirely or at a higher percentage, the Petitioner believes her health care costs will be reduced; for example, she has had to summon emergency services three times because of hypoglycemic episodes. She says the DME will eliminate the need for emergency care and help her live a longer, healthier life.

Respondent's Argument

In its October 22, 2010, final adverse determination, BCN declined to accede to the Petitioner's request that it completely cover the DME she needs or reduce her coinsurance percentage:

The [grievance] Panel maintained the denial; as our members are responsible for the applicable copayments¹ that are applied per their benefits.

The certificate (p. 9) contains the following provision regarding DME:

1.15 Durable Medical Equipment

Durable medical equipment (DME) is equipment that must be used primarily for medical purposes. It must be intended for repeated use and be useful primarily as a result of illness, injury and congenital defect.

Coverage: Rental or purchase of durable medical equipment is limited to the basic equipment. Any special features that are considered medically necessary must be preauthorized by BCN to be covered.

Copayment: 50% of the fee for the equipment

BCN says 50% coinsurance for DME is a requirement of the certificate and is the Petitioner's responsibility.

Commissioner's Review

BCN is a health maintenance organization (HMO). Under Section 3406p(3) of the Insurance Code, MCL 500.3406p(3), HMOs are required to cover certain diabetes equipment and supplies, including glucose monitors and insulin pumps:

¹ Section 3515 of the Insurance Code (MCL 500.3515) now says that "coinsurance" is stated as a percentage and "copayment" is stated as a dollar amount. BCN uses the terms interchangeably in this case.

(3) An expense-incurred hospital, medical, or surgical policy or certificate delivered or issued for delivery in this state and a health maintenance organization contract shall include coverage for the following equipment, supplies, and educational training for the treatment of diabetes, if determined to be medically necessary and prescribed by an allopathic or osteopathic physician:

(a) Blood glucose monitors and blood glucose monitors for the legally blind.

(b) Test strips for glucose monitors, visual reading and urine testing strips, lancets, and spring-powered lancet devices.

(c) Syringes.

(d) Insulin pumps and medical supplies required for the use of an insulin pump.

(e) Diabetes self-management training to ensure that persons with diabetes are trained as to the proper self-management and treatment of their diabetic condition.

Section 3406p(6) also imposes limitations on cost sharing for mandated diabetic equipment and supplies:

(6) Coverage under this section is not subject to dollar limits, deductibles, or copayment provisions that are greater than those for physical illness generally.

The Commissioner concludes that it was permissible for BCN to establish a 50% coinsurance for diabetic DME. Under the terms of the certificate, *all* DME is subject to the 50% coinsurance requirement. The coinsurance² requirement for diabetic DME is no greater than that for DME necessitated by any other physical illness and it therefore satisfies the limitation in Section 3406p(6).

In finding that BCN's 50% coinsurance requirement for diabetic DME is permissible, the Commissioner further finds nothing in the certificate or state law that requires BCN to waive or reduce the coinsurance in this case. The certificate is clear: there is a 50% coinsurance for all DME, including DME required under Section 3406p.

² As noted in footnote 1, Section 3515 now makes a distinction between "copayment" and "coinsurance." However, at the time Section 3406p was added to the Insurance Code (2000 PA 425, effective March 28, 2001), Section 3515 referred to copayments as a percentage, not a dollar amount. Thus, for the purposes of this analysis, the Commissioner considers the word "copayment" in Section 3406p(6) to include coinsurance as well.

V. ORDER

The Commissioner upholds BCN's October 22, 2010, final adverse determination. BCN is not required to waive or reduce the 50% copayment for Petitioner's diabetic DME.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

R. Kevin Clinton
Commissioner