

REGULATION

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Issued By: Employee Benefits	Rule Reference: Rule: 5-11 (Group Insurance Plans)	Replaces: Reg. 5.18 (SPDOC 05-1107-14, June 19, 2005 October 7, 2007)	
Authority: Regulations are issued by the State Personnel Director under authority granted in the Michigan Constitution and the Michigan Civil Service Commission Rules. Regulations are subordinate to the Commission Rules.			
Subject: COMPLAINTS ABOUT BENEFITS			

TABLE OF CONTENTS

1. PURPOSE	1
2. CIVIL SERVICE COMMISSION RULE REFERENCE	2
3. DEFINITIONS	2
4. STANDARDS	3
A. Complaints Regarding Third-Party Administrator (TPA) Decisions.	3
B. Direct Complaint to Civil Service.....	5
C. Further Appeal to Commission.	6
D. HMOs, DHMOs, and VBPs.....	6
E. Complaints Regarding Qualified Pretax Plans.....	6
F. Complaints Regarding Involuntary Payroll Deductions by Civil Service.....	6
G. Privacy Complaints.....	6

1. **PURPOSE**

This regulation provides exclusive procedures for classified employees to file (1) complaints ~~regarding about~~(1) benefits under group insurance plans, and (2) ~~qualified pretax plans, and (3) decisions by Civil Service to require involuntary payroll deductions to recover overcompensation~~HIPAA privacy complaints involving self-insured state health insurance plans.

2. CIVIL SERVICE COMMISSION RULE REFERENCE

Note: This Section 2 reprints only selected Commission Rules for quick reference by the reader. Additional Rules (that are not reprinted below) may apply. The complete, current version of the Rules can be found at www.michigan.gov/mdcs.

Rule 5-11 Group Insurance Plans

5-11.1 Types of Group Insurance Plans

* * *

(e) Administration. The state personnel director is responsible for implementing and administering the group insurance plans approved by the civil service commission.

(1) Complaints. The state personnel director shall provide an expedited administrative review of employee complaints regarding group insurance benefits. The director's administrative review process is the exclusive procedure for reviewing employee complaints regarding group insurance plan benefits. An employee aggrieved by a final administrative decision may appeal the decision to the civil service commission as provided in the civil service rules and regulations.

* * *

3. DEFINITIONS

A. Civil Service Commission Rule Definition

1. *Group insurance benefits means eligibility, enrollments, premiums, coverages, exclusions, costs, reimbursements, payments, copayments, deductibles, coordination of benefits, or other benefits authorized under the group insurance plans.*

B. Additional Definitions as used in this Regulation

1. **Group insurance plans** means all ~~of~~ the following:
 - a. The group insurance plans authorized in the compensation plan for employee health (medical, dental, vision), disability, life, and accidental death for which the State retains the responsibility to pay the cost of all claims.
 - b. COBRA and other insurance continuation programs authorized by law or the compensation plan.

~~2. **Improper reimbursement** means a reimbursement under a qualified pretax plan that is not authorized under applicable law or properly documented by the employee.~~

~~32. **Qualified pretax plan** means any of the following:~~

~~a. **M**edical and dependent care spending accounts authorized by law.~~

~~b. **D**ependent care spending accounts authorized by law.~~

~~e. **Q**ualified parking reimbursement plans authorized by law.~~

3. **Third-party administrator (TPA)** means an organization under contract with the State to provide day-to-day administration of claims under a group insurance plan.

4. **Voluntary benefits plan (VBP)** means a benefit or insurance plan for which (1) the State does not pay any portion of the costs or benefits and (2) the employee pays all premium costs.

4. STANDARDS

~~A. Exclusive Procedures.~~

~~A classified employee with a complaint regarding a group insurance benefit or qualified pretax plan may complain under the exclusive procedures provided in this regulation.~~

BA. Complaints Regarding ~~Self-funded Plans~~ Third-Party Administrator (TPA) Decisions.

~~A several state self-funded group insurance plans is a plan where have a contract plan administrator TPA that processes claims on behalf of the State, but t~~ The State, however, retains final responsibility for the cost of all claims to review these decisions. A classified employee with a complaint over a group insurance plan benefit must complain under the exclusive procedures provided in this regulation.

- Plans and ~~Plan~~ Third-Party Administrators.** The following table lists the ~~self-funded group insurance plans and the plan administrator for each plan~~ TPAs (as of the date of this regulation) whose decisions, if challenged, must be appealed under this regulation:

Self-funded Group Insurance Plan	Plan <u>Third-Party Administrator (TPA)</u>
1. State Health Plan PPO	1. Blue Cross Blue Shield of Michigan
<u>2. New State Health Plan PPO</u>	<u>2. Blue Cross Blue Shield of Michigan</u>
23. Catastrophic Health Plan	23. Blue Cross Blue Shield of Michigan
34. State Dental Plan	34. Delta Dental Plan of Michigan
45. Preventive Dental Plan	45. Delta Dental Plan of Michigan
56. State Vision Plan	56. Blue Cross Blue Shield of Michigan
67. State Mental Health & Substance Abuse Plan	67. Magellan Behavioral Health

78. State Prescription Drug Plan	78. Express Scripts Blue Cross Blue Shield of Michigan
8.9 Group Life Insurance Plan	89. Mutual of Omaha Minnesota Life
910. Long-term Disability Plan	910. Citizens Management Inc.
11. Medical Care Spending Account Plan	11. WageWorks

2. **Initial Complaints to ~~Plan Administrator~~ TPA.** If an [employee has a complaint about plan administrator is responsible for](#) a group insurance benefit or qualified pretax plan decision [made by a TPA \(for example, a coverage, exclusion, or payment decision\)](#), ~~an~~ the employee ~~with a complaint~~ must [first](#) file ~~the~~ [a](#) complaint ~~as follows: with the TPA~~
- ~~a. Step 1: Complaint to Plan Administrator.~~ The employee must first file a timely complaint with the plan administrator and exhaust all ~~complaint and~~ appeal mechanisms provided by the ~~plan administrator~~ TPA.
3. b ~~Step 2: Appeal of Plan Administrator's TPA Decision.~~ [After exhausting the TPA's complaint and appeal processes,](#)
- ~~(1) Where to File Appeal.~~ If an employee ~~is dissatisfied~~ [who disagrees](#) with the TPA's final decision ~~of the plan administrator, the employee may file a written appeal the plan administrator's decision,~~ as follows:
- ~~(a)a. All Plans except Long-term Disability Plan~~ [Where to file.](#) Except for ~~an~~ [An](#) appeal ~~regarding under the long-term disability LTD plan,~~ must be filed with the Office of the State Employer (OSE). ~~an~~ [An](#) appeal [under any other insurance plan listed above](#) must be filed ~~in writing~~ with the [Civil Service Employee Benefits Division \(EBD\) of the Civil Service Commission.](#) ~~The appeal must be received within 14 calendar days after the date of the final decision issued by the plan administrator.~~
- ~~(b) Long-term Disability Plan.~~ An appeal of the decision of the plan administrator for the long-term disability plan must be filed with the ~~Office of the State Employer.~~ The appeal must be received within 14 calendar days after the date of the final decision issued by the plan administrator for the long-term disability plan.
- ~~(2) Procedures.~~
- ~~(a)b. Time limit to appeal.~~ The appeal must be received by [the appropriate division \(Employee Benefits EBD or the Office of the State Employer OSE, as appropriate,\)](#) within 14 calendar days after the date of the [TPA's final decision of the plan administrator.](#)
- ~~(b)c. Documents.~~ The appeal must include [\(a\) a clear and concise statement of the reasons why the TPA's decision is in error, \(b\) copies of all decisions of the plan administrator TPA, and \(c\) any other relevant information and evidence](#) needed to consider the appeal.

(3)d. Review and decision.

(a1) Staff review and decision. ~~The Employee Benefits~~**EBD** or the ~~Office of the State Employer~~**OSE**, as appropriate, ~~may shall~~ first conduct a staff review of the appeal and ~~give~~**issue** an ~~expedited~~**written staff** decision ~~on the appeal~~.

(b2) Request for full review. ~~If an expedited~~**After the** staff decision is issued ~~and the employee disagrees, the an~~ employee ~~must~~**may** ~~notify Employee Benefits or the Office of the State Employer, as appropriate, within 14 calendar days after the date of the staff decision and~~ request a full review by the State Personnel Director. ~~The request must be in writing and must be~~ **received by** ~~or the Director's designee~~**OSE** for LTD appeals or the **EBD** for all other TPA appeals within 14 calendar days after the date of the staff decision. ~~The request must explain why the staff decision is incorrect.~~ If the employee fails to timely object to the staff decision, the ~~administrative~~ decision is final ~~and cannot be further appealed.~~ ~~If a timely request is filed,~~

~~(c) Full review and decision.~~ ~~If (1) staff does not issue an expedited staff decision or (2) an employee objects to an expedited staff decision and timely requests a full review,~~ the State Personnel Director or the Director's designee shall review the record, obtain any other information necessary to evaluate the ~~complaint and~~ appeal, and issue a **written** decision ~~on the appeal~~.

3B. Direct Complaint to Civil Service.

~~If An employee with a complaint about the a plan administrator is NOT responsible for the~~ group insurance benefit or qualified pretax plan decision, ~~made by someone other than a TPA (for example, a plan enrollment decision), an employee with a complaint~~ must file **any** complaint **directly with the EBD as follows:** ~~under the exclusive procedures provided in this regulation.~~

a1. Complaint. The employee ~~may~~**must** file a complaint in writing directly to ~~the Civil Service Employee Benefits~~**EBD**. The ~~EBD must receive the~~ direct complaint ~~must be received by Employee Benefits~~ within 28 calendar days after the employee knew of or, in the exercise of reasonable diligence, should have known of the circumstances giving rise to the complaint.

b2. Copies/Contents. The complaint must include **(1) a clear and concise statement of the relief sought and (2) copies of all relevant information and evidence** needed to consider the complaint.

€3. Review and decision.

~~(1) Staff review and decision.~~ ~~Employee Benefits~~**The EBD may shall** conduct an administrative staff review of the appeal and ~~give~~**issue** a ~~final a~~ **expedited****written** decision ~~on the appeal~~.

~~(2) Request for full review.~~ ~~If an employee objects to an expedited staff decision, the employee must notify Employee Benefits within~~

~~14 calendar days after the date of the staff decision and request a full review by the State Personnel Director or the Director's designee. If the employee fails to timely object to the staff decision, the staff decision is final.~~

- ~~(3) **Full review and decision.** If (1) no staff review is given or (2) an employee objects to an expedited staff decision and timely requests a full review, the State Personnel Director or the Director's designee shall review the record, obtain any other information necessary to evaluate the complaint and appeal, and issue a decision on the appeal.~~

4C. Further Appeal to ~~Civil Service~~ Commission.

An employee ~~dissatisfied who disagrees~~ with ~~the~~a final decision of the State Personnel Director or the Director's designee, either as an appeal of a TPA decision or after a direct complaint, may appeal the decision to the Civil Service Commission, as provided in ~~the applicable rules and regulations~~Regulation 8.05 [Employment Relations Board Appeal Procedures]. ~~An expedited staff decision is not appealable to the Commission.~~

4D. ~~Complaints Regarding~~ HMOs, ~~and~~ DHMOs, ~~and~~ VBPs.

Health Maintenance Organizations (HMOs), ~~and~~ Dental Health Maintenance Organizations (DHMOs), and Voluntary Benefit Plans (VBPs) are not ~~self-funded plans covered by this regulation~~. Voluntary benefit plans include legal, term life, universal life, long-term care, critical illness, home, automobile, and other insurance programs where the employee pays the full premium cost. If ~~an~~ HMOs, ~~or~~ DHMOs, ~~or~~ VBPs ~~is~~are responsible for a group insurance benefit decision, an employee with a complaint must file a complaint directly with the applicable HMO, ~~or~~ DHMO, ~~or~~ VBP carrier. ~~A~~Final decisions of ~~an~~ HMOs, ~~or~~ a DHMOs, ~~or~~ VBPs cannot be appealed to the EBD, State Personnel Director, ~~or~~ ~~the~~ Civil Service Commission.

4E. Complaints Regarding Qualified Pretax Plans.

Complaints regarding qualified pretax plans arising under or related to regulation 5.19 [Correcting Benefit Errors] must be filed with Civil Service exclusively under standard ~~4.(B)~~, or 4.C above.

4F. Complaints Regarding Involuntary Payroll Deductions by Civil Service.

Complaints against Civil Service regarding involuntary payroll deductions to recover overpayments as authorized in regulation 5.16 [Correcting Compensation Errors] must be filed with Civil Service under standard ~~4.(B)(3)~~, above. Complaints against an agency regarding involuntary payroll deductions must be filed under the grievance process.

4G. Privacy Complaints.

- 1. Complaint Filing.** An eligible classified employee enrolled in a self-insured health insurance plan administered ~~and self-insured~~ by the ~~State of Michigan~~EBD who believes that ~~the employee's~~ personal health information ~~related to benefit eligibility or enrollment~~ has been improperly used or disclosed by the plan may file a complaint with the plan's Privacy Official ~~for~~

~~Civil Service Employee Benefits.~~ The complaint must be filed on the CS-1782 HIPAA Privacy Complaint Form, which is available at the Employee Benefits section of the Civil Service homepage, www.michigan.gov/mdcs. The complaint must identify the alleged violation of privacy rights with sufficient specificity to allow further review. Privacy complaints involving HMOs, DHMOs, VBPs, long-term disability plans, or life insurance plans should be directed to the TPA or carrier for the plan.

2. **Privacy Official Review.** Pursuant to the plan's privacy policies, ~~The~~ the Privacy Official or a designee shall review the complaint and make written findings of fact regarding the alleged violation of privacy policies. This decision is final. The Privacy Official shall send copies of the written findings to the complainant and any other relevant ~~appointing authority~~ party. The Privacy Official shall continuously evaluate complaints to seek improvements to existing health plan privacy procedures. An appointing authority shall consider all appropriate discipline of an employee found by the Privacy Official or designee to have violated privacy procedures.

CONTACT

Questions regarding this regulation should be directed to the Employee Benefits Division, Civil Service Commission, P.O. Box 30002, 400 South Pine Street, Lansing, Michigan 48909; by telephone, at 517-373-7977 or 1-800-505-5011.

Questions regarding privacy complaints can be directed to the Privacy Official for Civil Service at the same address and phone numbers or to MCSC-HIPAA@michigan.gov.