Michigan Civil Service Commission

REGULATION

SPDOC No.:	Effective Date:	Index Reference:	Regulation Number:
~~13-09~~	~~September 15, 2013~~	Group Insurance Benefit Complaints	**5.18**
Issued By: Employee Benefits	**Rule Reference:** Rule: 5-11 (Group Insurance Plans)		**Replaces:** Reg. 5.18 (SPDOC ~~12~~13-~~03~~09, ~~March~~ September ~~4~~15, ~~2012~~2013)
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

This regulation provides the exclusive procedures for all classified employees to file (1) complaints about benefits under group insurance plans and (2) 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 the following:
   a. The group insurance plans authorized in the compensation plan for employee health, 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. ***Qualified pretax plan*** means medical and dependent care spending accounts and qualified 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. Complaints ~~Regarding~~ About Third-Party Administrator (TPA) Decisions.

Several state group insurance plans have a TPA that processes claims on behalf of the State. The State, however, retains responsibility 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.

1. **Plans and Third-Party Administrators.** The following table lists the TPAs (as of the date of this regulation) whose decisions, if challenged, must be appealed under this regulation:

Group Insurance Plan	Third-Party Administrator (TPA)
1. State Health Plan PPO	1. Blue Cross Blue Shield of Michigan
2. New State Health Plan PPO	2. Blue Cross Blue Shield of Michigan
3. Catastrophic Health Plan	3. Blue Cross Blue Shield of Michigan
4. State Dental Plan	4. Delta Dental Plan of Michigan
5. Preventive Dental Plan	5. Delta Dental Plan of Michigan
6. State Vision Plan	6. Blue Cross Blue Shield of Michigan
7. State Mental Health & Substance Abuse Plan	7. Magellan Behavioral Health
8. State Prescription Drug Plan	8. MedImpact
9. Group Life Insurance Plan	9. Minnesota Life
10. Long-term Disability Plan	10. Citizens Management Inc.
11. Medical Care Spending Account Plan	11. WageWorks

2. **Initial Complaints to TPA.** If an employee has a complaint about a group insurance benefit or qualified pretax plan decision made by a TPA (for example, a coverage, exclusion, or payment decision), the employee must first file a complaint with the TPA and exhaust all appeal mechanisms provided by the TPA.

3. **Appeal of TPA Decision**. After exhausting the TPA's complaint and appeal processes, an employee who disagrees with the TPA's final decision may file a written appeal, as follows:

   a. **Where to file.** An appeal under the **LTD plan** must be filed with the Office of the State Employer (OSE). An appeal under **any other insurance plan** listed above must be filed with the Employee Benefits Division (EBD) of the Civil Service Commission.

   b. **Time limit.** The appeal must be **received** by the appropriate division (EBD or OSE) within ~~14~~ 28 calendar days after the date of the TPA's final decision.

   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 TPA, and (c) any other relevant information and evidence needed to consider the appeal. This appeal is the last opportunity for the appellant to submit new medical documentation supporting a claim of eligibility for group insurance benefits.

   d. **Review and decision.**

      (1) **Staff review and decision.** The EBD or OSE, as appropriate, shall conduct a staff review of the appeal and issue a written staff decision.

      (2) **Request for full review.** After the staff decision is issued, an employee may request a full review by the State Personnel Director. The request must be in writing and must be **received** by the OSE for LTD appeals or the EBD for all other TPA appeals within ~~14~~ 28 calendar days after the date of the staff decision. The OSE or EBD will forward the request together with the full administrative record to the director. ~~The~~ A request must ~~explain~~ demonsrate why the staff decision ~~is~~ was incorrect. If ~~the~~ an employee fails to timely object ~~to the staff decision~~, the staff decision is final and cannot be further appealed. If a timely request is filed, the ~~State Personnel D~~director or ~~the~~ a ~~Director's~~ designee shall review the record for error, obtain any other information necessary to evaluate the appeal, and issue a written decision.

B. Direct Complaint to Civil Service.

An employee with a complaint about a group insurance benefit or qualified pretax plan decision made by someone other than a TPA (for example, a plan enrollment decision), must file any complaint directly with the EBD under the exclusive procedures provided in this regulation.

1. **Complaint.** The employee must file a complaint in writing directly to the **EBD**. The EBD must **receive** the direct complaint 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.

2. **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.** The EBD shall conduct an administrative staff review of the appeal and issue a final written decision.

C. Further Appeal to Commission.

An employee who disagrees with 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 Regulation 8.05 [Employment Relations Board Appeal Procedures].

D. HMOs, DHMOs, and VBPs.

Health Maintenance Organizations (HMOs), Dental Health Maintenance Organizations (DHMOs), and Voluntary Benefit Plans (VBPs) are not 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 HMOs, DHMOs, or VBPs are responsible for a group insurance benefit decision, an employee ~~with a complaint~~ must file any complaint directly with the applicable HMO, DHMO, or VBP carrier. The carrier's ~~F~~final decisions ~~of HMOs, DHMOs, or VBPs~~ cannot be appealed to the EBD, State Personnel Director, or Civil Service Commission.

E. Complaints ~~Regarding~~ About Qualified Pretax Plans.

Complaints ~~regarding~~ about 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.

F. Complaints ~~Regarding~~ About Involuntary Payroll Deductions by Civil Service.

Complaints against Civil Service ~~regarding~~ about 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. Complaints against an agency ~~regarding~~ about involuntary payroll deductions must be filed under the grievance process.

G. Privacy Complaints.

1. **Complaint Filing.** An eligible classified employee enrolled in a self-insured health insurance plan administered by the EBD who believes that personal health information has been improperly used or disclosed by the plan may file a complaint with the plan's Privacy Official. 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 website, www.mi.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 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 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 Civil Service Privacy Official ~~for Civil Service~~ at the same address and phone numbers or ~~to~~ MCSC-HIPAA@mi.gov.