# Michigan Civil Service Commission

# Regulation 5.18

| Subject: Complaints About Benefits | | |
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| **SPDOC No.:** | **Effective Date:** | **Replaces:** |
| 147-091 | DRAFT | Reg. 5.18 (SPDOC 134-09, ~~September~~ March 153, 20134) |

## 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~~ about self-insured state health--insurance plans.

## 2. CSC Rule References

### *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.*

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## 3. Definitions

**A. CSC Rule Definitions.**

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. Definitions 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 About Third-Party Administrator (TPA) Decisions.** Several state group insurance plans have a TPA that processes claims on ~~behalf of~~ the ~~S~~state's behalf. The ~~S~~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 procedure~~s provided~~ in this regulation.

1. **Plans and ~~T~~third-~~P~~party ~~A~~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 ~~&~~and Substance Abuse Plan | ~~7.~~ Magellan ~~Behavioral~~ Healthcare |

| Group Insurance Plan | Third-Party Administrator (TPA) |
|---|---|
| ~~8.~~ State Prescription Drug Plan | ~~8. MedImpact~~OptumRx |
| ~~9.~~ Group Life Insurance Plan | ~~9.~~ Minnesota Life |
| ~~10.~~ Long-term Disability Plan | ~~10. Citizens Management Inc.~~York Risk Services Group |
| ~~11.~~ Medical Care Spending Account Plan | ~~11.~~ WageWorks |

2. **Initial ~~C~~ccomplaints to TPA.** If an employee has a complaint about a group ~~-~~insurance ~~-~~benefit or qualified ~~-~~pretax ~~-~~plan decision made by a TPA (~~for example~~e.g., ~~a~~ coverage, exclusion, or payment decisions), the employee must first file a complaint with the TPA and exhaust all appeal mechanisms provided by the TPA. All documentation to be considered in any appeal must be provided by the final appeal available with the TPA; records newly submitted with an appeal to the Employee Benefits Division (EBD) will not be considered.

3. **Appeal of TPA ~~D~~decision.** After exhausting the TPA's complaint and appeal process~~es~~, an employee who disagrees with ~~the~~ a TPA's final decision ~~may~~ must file any ~~written~~ appeal in writing, as follows:

   a. **Where to file**. ~~An~~ The 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 EBD ~~appeal~~ must ~~be~~ **receive~~d~~** the appeal ~~by the appropriate division (EBD or OSE)~~ within 28 ~~calendar~~ days after the date of the TPA's final decision. If an employee fails to timely appeal, the TPA's decision is final and cannot be further appealed.

   c. ~~**Documents**~~**Contents.** ~~The~~ An appeal must include (a) a clear and concise statement of the relief sought and ~~reasons~~ why the TPA's decision is in error~~,~~ and (b) a copy~~ies~~ of ~~all~~ the final TPA decision~~s 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~~ being appealed. The EBD will obtain the record from the TPA for its review.

   d. **Review and decision.** If a timely appeal is filed, the EBD shall review the record from the TPA, the employee's filing, and any other information necessary to evaluate the appeal.

~~(1) **Staff review and decision.**~~ The EBD ~~or OSE, as appropriate,~~ shall then ~~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 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. A request must demonstrate why the staff decision was incorrect. If an employee fails to timely object, the staff decision is final and cannot be further appealed. If a timely request is filed, the director or a 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.** If an ~~An~~ employee ~~with~~ has a complaint about a group-insurance-benefit or qualified-pretax-plan decision made by someone other than a TPA (~~for example~~e.g., a plan enrollment decision), the employee must file any complaint in writing 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~~ exercising ~~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 EBD~~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 C~~commission~~, as provided in~~ under regulation 8.05.

**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 must file any complaint directly with the applicable HMO, DHMO, or VBP carrier. The carrier's final decision cannot be appealed to the EBD~~, State Personnel Director,~~ or ~~Civil Service C~~commission.

**E. Complaints About Qualified Pretax Plans.** Complaints about qualified pretax plans arising under or related to regulation 5.19 must be filed with Civil Service exclusively under §§ 4.B or 4.C.

**F. Complaints About Involuntary Payroll Deductions by Civil Service.** Complaints against Civil Service about involuntary payroll deductions to recover overpayments ~~as authorized in~~ under regulation 5.16 must be filed with Civil Service under § 4.B. Complaints against an agency 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 the plan has improperly used or disclosed 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~~-~~ HIPAA Privacy Complaint Form (CS-1782)~~, 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~~ over HMOs, DHMOs, VBPs, long-term~~-~~ disability plans, or life~~-~~insurance plans ~~should~~ must be directed to the plan's TPA or carrier ~~for the plan~~.

2. **Privacy Official Review.** ~~Pursuant to~~ Under the plan's privacy policies, the Privacy Official or a designee shall review the complaint and make written findings ~~of fact regarding~~ on the alleged violations ~~of privacy policies~~. This decision is final. The Privacy Official shall send the complainant and any other relevant party 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 on this regulation may 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; or to MCSC-EBDAppeal@mi.gov.

Questions on privacy complaints ~~can~~ may be directed to the Civil Service Privacy Official at the same address and phone numbers or MCSC-HIPAA@mi.gov.