Michigan Civil Service Commission

Regulation 5.18

Subject: Complaints About Benefits		
SPDOC No.: 22-04~~20-13~~	**Effective Date:** July 25, 2022~~October 1, 2020~~	**Replaces:** Reg. 5.18 (SPDOC ~~19~~20-13~~1~~, October 1, 20~~19~~20)

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 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~~shall implement and ~~administering~~administer ~~the~~ approved 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~~over group~~-~~-insurance benefits. The director's ~~administrative review~~ process is the exclusive procedure for ~~reviewing~~ employee complaints ~~regarding~~over group~~-~~-insurance ~~plan~~ benefits. An employee aggrieved by ~~a~~ the director's final ~~administrative~~ decision may appeal ~~the decision~~ to the ~~civil service~~ commission as provided in the civil service rules and regulations.*

* * *

3. Definitions

A. CSC Rule Definition.

~~1.~~ ***Group insurance benefits*** *means eligibility, enrollments, premiums, coverages, exclusions, costs, reimbursements, payments, copayments, deductibles, coinsurance, out-of-pocket maximums, 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, and life for which the State retains the responsibility to pay the cost of ~~all~~ eligible claims.

b. COBRA and other insurance continuation programs authorized by law or the compensation plan.

2. **Qualified pretax plan** means health-care and dependent-care flexible spending accounts and qualified transportation fringe benefits reimbursement plans authorized by law and the commission.

3. **Third-party administrator (TPA)** means an organization under contract with the State to administer 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. A TPA processes claims for the state for some state group-insurance plans, but the state retains responsibility to review these decisions. A classified employee with a complaint over a group-insurance-plan benefit must complain under the exclusive procedure in this regulation.

1. **Plans and third-party administrators.** As of this regulation's effective date, the following TPAs are responsible for the corresponding plans:

Plan	Third-Party Administrator (TPA)
State Health Plan PPO	Blue Cross Blue Shield of Michigan
State High Deductible Health Plan with HSA	Blue Cross Blue Shield of Michigan
Catastrophic Health Plan	Blue Cross Blue Shield of Michigan
State Dental Plan	Delta Dental Plan of Michigan
Preventive Dental Plan	Delta Dental Plan of Michigan
State Vision Plan	EyeMed
State Behavioral Health & Substance ~~Abuse Plan~~Use Disorder	Blue Cross Blue Shield of Michigan
State Prescription Drug Plan	OptumRx
Group Life Insurance Plan	Securian Financial Group
Long-term Disability Plan	Sedgwick

Plan	Third-Party Administrator (TPA)
Health-Care or Dependent-Care Flexible Spending Account Plan	~~WageWorks~~HealthEquity

2. **Initial complaints to TPA.** If an employee has a complaint about a plan decision made by a TPA (e.g., 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 that an employee wants 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 final TPA decision.** After exhausting the TPA's complaint and appeal process, an employee who disagrees with a TPA's final decision must file any appeal in writing to the EBD as follows:

   a. **How to file**. The appeal must be filed with the EBD by email to MCSC-EBDAppeal@mi.gov.

   b. **Time limit.** The EBD must **receive** the appeal within 28 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. **Contents.** An appeal must include (a) a clear and concise statement of the relief sought and why the TPA's decision is in error and (b) a copy of the final TPA decision 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 the EBD deems necessary to evaluate the appeal. The EBD shall then issue a written decision.

B. Direct Complaint to Civil Service. If an employee has a complaint about a group-insurance-benefit or qualified-pretax-plan decision made by someone other than a TPA (e.g., a plan enrollment decision), the employee must file any complaint in writing directly with the EBD by email to MCSC-EBDAppeal@mi.gov.

1. **Complaint.** The EBD must **receive** the complaint within 28 days after the employee knew of or, in exercising reasonable diligence, should have known of the circumstances giving rise to the complaint.

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

3. **Review and decision.** The EBD shall review the appeal and issue a written decision.

C. Further Appeal to Commission. An employee who disagrees with a decision of the EBD, either as an appeal of a TPA decision or after a direct complaint, may appeal the decision to the commission 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 accident, accidental death & dismemberment, identity theft, 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 or commission.

E. Qualified Pretax Plans. Complaints about qualified pretax plans arising under or related to regulation 5.16 must be filed with Civil Service exclusively under §§ 4.B or 4.C.

F. Involuntary Payroll Deductions by Civil Service. Complaints against Civil Service about involuntary payroll deductions to recover overpayments 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 may file a complaint with the plan's privacy official. The complaint must be filed on the HIPAA Privacy Complaint Form (CS-1782). The complaint must identify the alleged violation of privacy rights with sufficient specificity to allow review. Privacy complaints over HMOs, DHMOs, VBPs, long-term-disability plans, or life-insurance plans must be directed to the plan's TPA or carrier.

2. **Privacy official review.** Under the plan's privacy policies, the privacy official or a designee shall review the complaint and make written findings on the alleged violations. This decision is final. The privacy official shall send the complainant and any other relevant party copies of the written findings. The privacy official shall continuously evaluate complaints to seek improvements to existing 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; 1-800-505-5011; or MCSC-EBDAppeal@mi.gov. Questions on privacy complaints may be directed to the privacy official at the same address and phone number or MCSC-HIPAA@mi.gov.