Internal Grievances and External Review for Service Denials in Covered California Plans

Managed Care in California Series
Issue No. 5

Prepared By: Abbi Coursolle

Introduction

Federal and state law and the Constitution ensure that enrollees in publicly-funded health care plans receive notice, grievance and appeal rights when they are denied access to medical services. Enrollees in Covered California plans have the right to a notice when their plan denies access to a service, and have several avenues to contest the plan's decision through a grievance or appeal. Frequently, however, enrollees fail to receive the required notice, get an inadequate notice, or do not understand their right to appeal the plan's decision. This fact sheet will describe the legal protections available to consumers in California and how to enforce these rights.

I. California Knox-Keene Licensed Plan Rules

Most—but not all—Covered California plans are licensed by the California Department of Managed Health Care (DMHC) and are subject to a set of consumer protection laws called the California Knox-Keene Act (KKA).[1] The KKA sets forth very detailed requirements on DMHC-licensed plans with respect to internal grievances and external appeals.

a. Notice

When a DMHC-licensed plan denies, delays, or modifies all or part of a requested service it must provide the enrollee with written notice within two business days.[2] DMHC-licensed plans must make decisions about service requests within a reasonable time after receiving all necessary information from the enrollee and provider considering the enrollee's health condition, not to exceed 72 hours for cases involving an imminent threat to health (or shorter if required by the insured's health), five business days

for prior or concurrent authorization requests, and 30 days for post-service (reimbursement) claims.[3] The written notice provided to the enrollee by DMHC-licensed plans must specify the particular service at issue; provide an explanation of the reasons for the decision (including clinical reasons for cases concerning medical necessity) and the criteria used to reach the decision; and must give the enrollee information about grievance rights and timeframes to file an internal grievance.[4] DMHC-licensed plans are also required to give the requesting provider notice by phone or fax within 24 hours of a decision, whether it is favorable or unfavorable to the enrollee; the initial notice to the provider must include contact information for the person who made the decision, and should be followed by written notice.[5] In cases where a plan is concurrently reviewing an existing service or course of treatment, it may not reduce, suspend, or modify the service until the plan has consulted the treating provider and the provider and plan have agreed upon an alternative care plan to meet the medical needs of the enrollee.[6]

The enrollee notices described above are considered “vital documents” for the purposed of California’s Language Access law, and must be translated into certain non-English languages for enrollees who have indicated that they prefer to receive information in those languages rather than English.[7] DMHC-licensed plans must also provide oral interpretation in any language to the enrollee at no cost.[8]

b. Internal Review

DMHC-licensed plans must have an internal process for handling enrollee grievances.[9] There are no specific rules that govern what issues a DMHC-licensed plan enrollee may present to the plan for resolution. As described above, DMHC-licensed plans must inform enrollees about the internal grievance process whenever they deny, delay, or modify all or part of a requested service, or reduce or terminate an existing service.[10] Enrollees may file grievances themselves, or may authorize a provider, family member, or advocate to file one on their behalf.[11] In addition, DMHC-licensed plans must ensure that their internal grievances procedures are reasonable and adhere to several specific requirements.[12]

Pursuant to the KKA, DMHC-licensed plans must provide forms and a toll-free number through which enrollees can file a grievance.[13] Plans must help enrollees to file a grievance when necessary, including by providing language assistance and reasonable accommodations for enrollees with disabilities.[14] When an enrollee files a grievance, DMHC-licensed plans must acknowledge the receipt of most internal grievances within five days.[15] The plan must ensure that all internal grievances are reviewed by management level staff responsible for the operations or services at issue.[16] Enrollees may file a grievance for any reason, and they may authorize an advocate or provider to assist them in the process.[17] Enrollees may file a grievance up to 180 days after the incident.[18]

DMHC-licensed plans must ordinarily resolve internal grievances within 30 days.[19] Plans must, however, resolve an internal grievance within three days when it involves an “imminent and serious threat” to the enrollee’s health.[20] When a DMHC-licensed plan resolves an internal grievance, plans must provide the enrollee with a written explanation of its decision.[21] If an internal grievance involves medical necessity

or coverage of a service, the plan must explain the criteria used to reach the decision, including any clinical criteria, if applicable.[22] Moreover, any time an internal grievance involving a determination that a services is not medically necessary is not resolved in the enrollees' favor, the plan must explain that the enrollee has the right to seek independent medical review (see "External Review" below).[23]

DMHC-licensed plans must establish a process to monitor and track all internal grievances.[24] Plans must keep records of all internal grievances for five years, and make them available to the applicable department for review.[25] Plans must designate an officer to oversee the internal grievance process.[26] Plans must report on internal grievances not resolved within 30 days on a quarterly basis.[27] DMHC performs periodic review of their plans' internal grievance systems for compliance, and may assess penalties for plans' failure to comply.[28]

c. *External Review*

Enrollees in DMHC-licensed plans may access two forms of external review: Independent Medical Review (IMR), and Departmental Complaints. IMR is available for an enrollee in the following three situations: (1) when the plan denies, modifies or delays health care services based on medical necessity, (2) when the plan denies reimbursement for emergency or urgent care claiming that no emergency or urgency existed, and (3) when an enrollee seeks treatment for a life-threatening or debilitating condition, and the plan denies the treatment sought as "experimental or investigational."[29] The enrollee must generally pursue an internal grievance first, and may then request an IMR within six months of an unfavorable internal grievance decision.[30] When an internal grievance is not resolved within 30 days, the enrollee may also proceed to IMR.[31] In expedited cases—those involving an "imminent and serious threat" to the enrollee's health—enrollees need only participate in the internal grievance process for three days before proceeding to IMR, and—at the Department's discretion—may sometimes forgo the internal grievance process altogether.[32] In cases involving experimental or investigational treatment, enrollees need not file an internal grievance before seeking IMR.[33]

IMR is performed by independent medical professionals who are not connected to the plan.[34] Plans contract with outside organizations to perform the review, so the insured must consent to participating in the process and sharing his or her medical records with the outside review entity.[35] Plans bear the cost of the IMR, and may not charge the insured any fee for participating in the process.[36] The reviewers must be knowledgeable with respect to the treatment or proposed treatment at issue.[37] They are charged with reviewing all documents related to the denial, along with the enrollee's medical records, relevant peer-reviewed scientific and medical evidence, national professional standards, expert opinion, and accepted standards of medical practice.[38] Enrollees may provide any information they deem relevant along with their request for IMR.[39] Insureds may use an authorized representative to make the request; in some cases, DMHC will also assist insureds in pursuing an IMR.[40]

A standard IMR must be completed within 30 days of the review organization receiving all of the documents for review, and expedited review must be completed within 3 days.[41] The review

organization must make a written decision, including an explanation of its decision in layperson's terms, and provide it to Department, enrollee, and plan. [42] If the review organization finds favor of the enrollee, the Department must adopt its decision immediately and the plan must implement it within five business days.[43] DMHC enrollees are likely to succeed in the IMR process: in 2013, 54% of IMRs filed with DMHC plans resulted in a favorable decision for the enrollee.[44]

Consumer Complaints to DMHC are the other type of external review available for matters that are not eligible for IMR.[45] While there is nothing in the law that prohibits someone from seeking both IMR and a Consumer Complaint, in practice, these two options are usually offered as alternatives to each other. Similar to the process for an IMR, DMHC plan enrollees must generally pursue an internal grievance first, and may then file a Consumer Complaint after an unfavorable grievance decision, or after waiting 30 days for the plan to resolve an internal grievance.[46] In expedited cases—those involving an "imminent and serious threat" to the enrollee's health—enrollees need only participate in the internal grievance process for three days before filing a Consumer Complaint, and may—at DMHC's discretion—forgo the grievance process all together.[47]

When it receives a Consumer Complaint, DMHC must analyze all documents from the enrollee and the plan and determine appropriate resolution, communicated to the enrollee in writing.[48] DMHC is charged with resolving Consumer Complaints within 30 days, and its written resolution must include an explanation of the Department's findings and reasons for the decision, a summary of any discussion the Department undertook with any medical provider or independent expert (and that expert's qualifications), and information about any corrective action taken.[49] For any Consumer complaint that involves delayed, denied or modified medically necessary health care services that should have been covered, the plan must promptly provide or reimburse for the service.[50]

II. California Department of Insurance Plan Rules

For 2015, the Health Net's EPO / PPO Covered California plan, offered in in some counties, is regulated by the California Department of Insurance (CDI), and subject to the California Insurance Code.[51] The Insurance code tends to be much less specific in terms of what plans must provide regarding notice, grievances and appeals. Thus, plans have significant—though not unbounded—discretion to design their policies governing review of service denials.

a. *Notice*

Like its DMHC-licensed counterpart, when a Covered California CDI-licensed plan denies, delays, or modifies all or part of a requested service, or reduces or terminates an existing service, it must provide the insured with written notice.[52] This written notice must specify the particular service at issue; provide an explanation of the reasons for the decision (including clinical reasons for cases concerning medical necessity) and the criteria used to reach the decision; and must give the enrollee information about grievance rights and timeframes.[53] CDI-licensed plans are also required to give the requesting

provider notice by phone or fax within 24 hours of reaching a decision, whether it is favorable or unfavorable to the insured; the initial notice to the provider must include contact information for the person who made the decision, and should be followed by written notice.[54] CDI-licensed plans are required to provide notice to the insured within the same timeframes as DMHC-licensed plans.[55] They must also follow the same rules regarding written translation and oral interpretation of these notices.[56]

b. *Internal Review*

CDI-licensed plans must provide insureds with an internal process for handling grievances.[57] There are no specific rules that govern what issues an insured may present to the plan for resolution, or the timeline for making a request. But as described above, plans must inform insureds about the internal grievance process whenever they deny, delay, or modify all or part of a requested service, or reduce or terminate an existing service.[58] Insureds may file internal grievances themselves, or may authorize a provider, family member, or advocate to file one on their behalf.[59] CDI-licensed plans must ordinarily resolve internal grievances within 30 days.[60] For grievances that involve an "imminent and serious threat" to the insured's health, however, plans must resolve a grievance within three days.[61]

c. *External Review*

Like their counterparts in DMHC-licensed plans, insureds in CDI-licensed plans may access two forms of external review: Independent Medical Review (IMR), and Departmental Complaints. The rules governing IMR for CDI-licensed plans are identical to the rules for DMHC-licensed plans.[62] Insureds frequently succeed in the IMR process: in 2014, 48% of IMRs filed with CDI plans had favorable results for the insured.[63]

Departmental Complaints by CDI provide external review of matters that are not eligible for IMR.[64] While there is nothing in the law that prohibits someone from seeking both IMR and a Departmental Complaint, in practice, these two options are usually offered as alternatives to each other. CDI rules do not specify the amount of time that an insured has to file a complaint with the department, or whether the insured must participate in the plan's internal grievance process before CDI will entertain a Departmental Complaint.[65] When it receives a Departmental Complaint, CDI must analyze all documents from the enrollee and the plan and determine appropriate resolution, communicated to the enrollee in writing.[66] CDI has 60 days to resolve Departmental Complaints, and must notify the insured of its decision within 30 days of reaching it.[67] The notice must explain the reason for the decision.[68]

III. Multi-State Covered California Plans

In addition to the plans described above, in all counties, Covered California enrollees may choose a "multi-state plan" offered by Anthem Blue Cross. That plan is partly regulated by DMHC, but is also regulated by the federal Office of Personnel Management.[69] While the rules that apply to DMHC-

licensed plans apply in some cases, "adverse benefits determinations" are subject to OPM's federal rules, described in more detail below.

a. Notice

Enrollees in a Covered California MSP are entitled to written notice any time the plan makes an "adverse benefit determination."[70] An adverse benefits determination is a rescission of coverage, a reduction or termination of existing services, a denial or modification of a request for new or continuing services, or a denial of a request for reimbursement for services already rendered.[71] The MSP must provide this notice within 24 hours for urgent cases and concurrent claims (claims involving services the enrollee is currently receiving), 15 days for pre-service claims, and 30 days for post-service (reimbursement) claims.[72]

The notice must "include[] information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning)."[73] In addition, if the decision is adverse to the enrollee, the written resolution must include the reason for the determination, including any denial code and its meaning; a description of any standard or plan provisions on which the determination is based; any internal guidelines or protocols used in making the decision; for decisions based on medical necessity, an explanation of the clinical basis as applied to the enrollee's particular circumstances; and a description enrollee's options for further review, including civil litigation, along with an explanation of how an enrollee can initiate those processes and the applicable time limits.[74] It must also provide information about available consumer assistance or ombuds services avail to assist the enrollee in contesting the plan's decision.[75]

Plans must provide notice in a non-English language upon request, and must also offer oral language assistance.[76] English-language notices must include a tagline that informs limited-English speaking enrollees about their language assistance options in other languages that are prevalent in the county where the enrollee lives.[77]

b. Internal Review

MSPs must offer an internal grievance process to contest adverse benefits determinations.[78] Enrollees may authorize a representative to present an internal grievance on their behalf.[79] Enrollees have 180 days to file an internal grievance after receiving an adverse benefits determination.[80] If an enrollee (or her representative) attempts to file an internal grievance, but doesn't follow the plans' procedures, the plan must inform the enrollee (or representative) of the proper procedures for filing the grievance.[81] Enrollees have the right to continue benefits during the internal grievance process if a plan makes an adverse benefits determination related to an "ongoing course of treatment."[82]

The internal grievance process must "contain administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants."[83] Specifically, the internal grievance process must provide enrollees with "the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits."[84] It must also ensure that enrollees receive "access to, and copies of, all documents, records, and other information relevant to the . . . claim for benefits."[85] If, during the course of considering the grievance, the plan accounts for new evidence, the plan must provide that evidence to the enrollee, and the rationale for considering it.[86]

The person who conducts a MSP's internal grievance must "not afford deference to the initial adverse benefit determination and [must be] conducted by an appropriate named fiduciary of the plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual."[87] To ensure the independence and impartiality of the decision-making, the plan must ensure that the person's compensation is not tied to the person's propensity to uphold denials.[88] In cases involving medical necessity or a question of whether treatment is experimental, the person conducting the internal grievance must consult with a health care professional with training in the appropriate field who was not involved in the plan's previous decision, and must identify any experts she consults in reaching a decision.[89]

The MSP must provide written resolution of an internal grievance to the enrollee as follows: within 24 hours for urgent cases and concurrent claims (claims involving services the enrollee is currently receiving), 15 days for pre-service (prior authorization) claims, and 30 days for post-service (reimbursement) claims.[90] The written resolution of an internal grievance must include the same information required to be included on the initial notice, described above. MSPs may not require enrollees to complete more than one level of appeal within its internal grievance process before rendering a final determination.[91] If the MSP fails to comply with any of the applicable requirements related to the internal appeals process (other than *de minimus* violations), the enrollee will be deemed to have exhausted the internal grievance process and may proceed directly to external review.[92]

c. External Review

OPM offers external review for MSP enrollees to contest adverse benefits determinations.[93] The standards for external review are set forth in a series of regulations and OPM guidance letters.[94] External review is free to enrollees, and there is no minimum dollar threshold required.[95]

Because OPM's jurisdiction overlaps with that of DMHC, external review is trifurcated. Cases involving medical judgement are handled by an outside review entity, called an Independent Review Organization (IRO).[96] Cases involving medical judgment are those "based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational."[97] All

cases involving an adverse benefits determination not based on medical judgment are handled internally by OPM.[98] Cases not involving a specific adverse benefit determination will go through the DMHC Complaint process described above.[99]

For example, if a plan denies a request for the drug Harvoni on the basis that it is not medically necessary for the enrollee, that case involves medical judgment and a specific adverse benefits determination, so it would go to an IRO. If a plan denies a request for Harvoni on the basis that it is not a covered benefit, that case does not involve medical judgment but does involve a specific adverse benefits determination, so would go to OPM. If an enrollee is concerned that Harvoni does not appear on her plan's formulary and complains that the drug is not covered, that case does not involve a specific adverse benefits determination, so would go to DMHC. DMHC and OPM must ensure coordination so that cases that initially go to the wrong agency for review are sent on to the correct agency.[100] OPM does not have a set timeframe within which it must determine whether a case is appropriate for IRO or its internal process, but it must ordinarily issue a final decision within 30 days of a request for external review, and the IROs are given 15 days to make a decision, so in practice, OPM must determine whether to send a case to IRO or perform its own internal review within 15 days.[101]

Enrollees or their representatives must request external review in writing from OPM within one year of an adverse decision at internal grievance, unless they show a "reasonable justification" for filing later.[102] Enrollees must exhaust their plan's internal grievance process before seeking external review, except in expedited cases or in cases where the plan voluntarily waives exhaustion or where the plan's internal review process fails to comply with any of the applicable requirements related to the internal appeals process (other than *de minimus* violations).[103] Enrollees may seek internal and external review simultaneously in expedited cases.[104] Cases must be expedited when the standard time for review would "seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns . . . emergency services, but [the enrollee] has not been discharged from a facility."[105] In expedited cases, the enrollee or her representative may make an oral request for external review.[106] Expedited cases must be "resolved as quickly as possible, and within no more than 72 hours."[107]

For cases that are routed to an IRO, OPM must make an impartial choice of among its contracted IROs.[108] OPM must ensure that the IRO does not have any conflict of interest with the issuer or its employees; the enrollee and his relatives; the referring provider or her group or practice association; the facility that would provide treatment; or the developer or manufacturer of the treatment or device recommended.[109] If the IRO requests additional information from the enrollee, it must provide the enrollee with at least 20 days to respond, and may not issue a decision during that time.[110] IROs must make a final determination within 15 days of receiving the case from OPM (and the enrollee must receive the determination within 30 days total).[111]

For cases that are handled by OPM, the agency may request additional information from the enrollee, consult an independent physician, or obtain any outside information needed to make a decision.[112] If

OPM requests additional information from the enrollee, it must provide the enrollee with at least 20 days to respond, and may not issue a decision during that time.[113] OPM must make a final determination within 30 days of receiving the case.[114] OPM may reopen a case if it receives new evidence after it has issued a final determination.[115]

In cases where part of the case rests on medical judgment, but another part does not, OPM will coordinate the final decision with an IRO, but OPM will be bound by the decision of the IRO as to medical judgment.[116] The results of external review are binding on the enrollee and the plan, and the plan must implement any decision in the enrollee's favor "without delay."[117] Both OPM and its contracted IROs must maintain records of the external appeal for six years, and make those records available to enrollees and MSP issuers upon request.[118]

Conclusion

As more low-income Californians enroll in private managed care plans for the first time through Covered California, consumer advocates must ensure that enrollees receive notice when services are denied, and that enrollees can exercise their right to contest adverse decisions by their health plans. Consumer advocates should work with Covered California, DMHC, CDI, OPM, and policymakers to monitor and enforce California's strong consumer protections that aim to ensure access to services for managed care plan enrollees.

ENDNOTES

[1] *See generally* CAL. HEALTH & SAFETY CODE §§ 1340-1399.818.
[2] *Id.* § 1367.01(h)(3).
[3] *See id.* § 1367.01(h).
[4] *Id.*
[5] *Id.*
[6] *Id.* § 1367.01(h)(3).
[7] *See id.* § 1367.04; CAL. CODE REGS., tit. 28, § 1300.67.04.
[8] CAL. CODE REGS., tit. 28, § 1300.67.04(c)(1)(G).
[9] Grievances may be called appeals, complaints, or by another name, depending on the context. For consistency, I will refer to all internal review processes as "grievances" for the purposes of this paper.
[10] *See* CAL. HEALTH & SAFETY CODE § 1367.01(h)(4) (DMHC-licensed plans); CAL. INS. CODE § 10123.135(h)(4).
[11] *See* CAL. CODE REGS., tit. 28, §§ 1300.68(a)(1), (3) (DMHC-licensed plans); CAL. INS. CODE § § 10169 (CDI-licensed plans).
[12] *See* CAL. HEALTH & SAFETY CODE § 1368; CAL. CODE REGS., tit. 28, § 1300.68.
[13] CAL. CODE REGS., tit. 28, § 1300.68(b)(7), (4).
[14] *Id.* § 1300.68(b)(3).
[15] *Id.* § 1300.68(d)(1); see also *id.* § 1300.68(d)(8) for exceptions to the five-day requirement.
[16] *Id.* § 1300.68(d)(2).
[17] *Id.* § 1300.68(a)(1).
[18] *Id.* § 1300.68(b)(9).
[19] *See* CAL. HEALTH & SAFETY CODE § 1368.01(a); CAL. CODE REGS., tit. 28, § 1300.68(a).
[20] CAL. HEALTH & SAFETY CODE § 1368.01(b); *see also* CAL. CODE REGS., tit. 28, § 1300.68(a).
[21] CAL. HEALTH & SAFETY CODE § 1368(a)(5); CAL. CODE REGS., tit. 28, § 1300.68(d)(3).
[22] CAL. HEALTH & SAFETY CODE § 1368(a)(5); CAL. CODE REGS., tit. 28, § 1300.68(d)(4).
[23] CAL. CODE REGS., tit. 28, § 1300.68(d)(4).
[24] CAL. HEALTH & SAFETY CODE § 1368(a)(4)(B); CAL. CODE REGS., tit. 28, § 1300.68(e).
[25] CAL. HEALTH & SAFETY CODE § 1368(a)(7); CAL. CODE REGS., tit. 28, § 1300.68(d)(6).
[26] CAL. CODE REGS., tit. 28, § 1300.68(b)(1).
[27] *Id.* § 1300.68(f); *see also* CAL. HEALTH & SAFETY CODE § 1368(c).
[28] *See* CAL. HEALTH & SAFETY CODE § 1368(b)(4).
[29] *Id.*§§ 1370.4, 1374.30(j).
[30] *Id.* §§ 1374.30(j)(3), (k).
[31] *Id.* § 1374.30(j)(3).
[32] *Id.*; *id.* §§ 1368 (b)(1)(A), 1374.31(a); CAL. CODE REGS. tit. 28, § 1300.68.01(a)(4).
[33] CAL. HEALTH & SAFETY CODE § 1370.4.
[34] *Id.* § 1374.32.
[35] *Id.* § 1374.30(m)(2).
[36] *Id.* § 1374.30(l).
[37] *Id.* § 1374.32(d)(4)(A).
[38] *Id.* § 1374.33.
[39] *See id.* § 1374.30(m)(3).
[40] *See id.* § 1374.30(m); *see also* Cal. Dept. of Managed Health Care, Independent Medical Review (IMR), https://www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReview%28IMR%29.aspx (last visited May 18, 2015).
[41] CAL. HEALTH & SAFETY CODE § 1374.33(c).
[42] *Id.*
[43] *Id.* § 1374.34(a).

[44] CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE, 2013 INDEPENDENT MEDICAL REVIEW SUMMARY REPORT REPORT OVERVIEW 1 (2013), *available at* http://www.dmhc.ca.gov/Portals/0/FileAComplaint/DMHCDecisionsAndReports/AnnualComplaintAndIMRDecisions/2013.pdf.
[45] *See* CAL. HEALTH & SAFETY CODE § 1368.02.
[46] *See id.* § 1368.03.
[47] *Id.* § 1368(b)(1)(A).
[48] *See id.* § 1368.02.
[49] *Id.* § 1368(b)(5).
[50] *Id.* § 1368(b)(6).
[51] *See, e.g.*, Cal. Dept. of Ins., Rate Filing for Health Net Life Insurance Company (2014) (Filing # HNLI-129578696).
[52] *See* CAL. INS. CODE § 10123.135(h)(4).
[53] *Id.*
[54] *Id.*
[55] *See id.* § 10123.135(h).
[56] *See id.* § 10133.8(b)(3); *see also* CAL. CODE REGS., tit. 10, § 2538.5.
[57] Grievances may be called appeals, complaints, or by another name, depending on the context. For consistency, I will refer to all internal review processes as "grievances" for the purposes of this paper.
[58] *See* CAL. INS. CODE § 10123.135(h)(4).
[59] *See id.* § 10169
[60] *Id.* § 10169(j)(3).
[61] *Id.*
[62] *See supra* notes 29 to 44 and accompanying text. For the relevant provisions of the Insurance Code, see INS. CODE §§ 10145.3, 10169, 10169.1-.3
[63] California Dept. of Ins., Interactive Independent Medical Review Statistics, https://interactive.web.insurance.ca.gov/IMR/faces/search?_afrLoop=118390488162496&_afrWindowMode=0&_adf.ctrl-state=102rsxssa7_14.
[64] *See* CAL. INS. CODE §§ 10133.661, 12921.3.
[65] *See* CAL. DEPT. OF INS., HEALTH REQUEST FOR ASSISTANCE (2015), *available at* https://www.insurance.ca.gov/01-consumers/101-help/upload/CSD002RFAHealth02112015.pdf.
[66] *See* CAL. INS. CODE § 10133.661; *see also* CAL. CODE REGS., tit. 10, § 2694.
[67] CAL. INS. CODE § 10133.661(c).
[68] *Id.*
[69] *See* 42 U.S.C. § 18054; *see also* Office of Personnel Management, Multi-State Plan Program and the Health Insurance Marketplace, http://www.opm.gov/healthcare-insurance/multi-state-plan-program/opm-multi-state-plan-program-fact-sheet/ (last visited April 17, 2015).
[70] 45 C.F.R. § 800.502 (incorporating, by reference 45 C.F.R. § 147.136(e)).
[71] *See id.* § 147.136(a)(2)(i).
[72] 29 C.F.R. § 2560.503-1(f)(2); *see also* 45 C.F.R. § 147.136(b)(3).
[73] 45 C.F.R. § 147.136(b)(2)(ii)(E)(1).
[74] *See id.* § 147.136(b)(2)(ii)(E)(3); 29 C.F.R. § 2560.503-1(g).
[75] *See id.* § 147.136(b)(2)(ii)(E)(5).
[76] *Id.* §§ 147.136(e)(2)(i)-(ii).
[77] *Id.* § 147.136(e)(2)(iii).
[78] *Id.* § 800.502(a). Note that this process is called an "internal appeal" or a "claim" in the federal rules. *See id.*
[79] *See id.* § 147.136(a)(2)(iii); *see also* 29 C.F.R. § 2560.503–1(b)(4).
[80] *See id.* § 147.136(b)(3)(ii)(C) (incorporating, by reference 29 C.F.R. § 2560.503-1(h)(3)(i)).
[81] 45 C.F.R. § 147.136(b)(3) (incorporating 29 C.F.R. § 2560.503-1(c)(1)(i)).
[82] *Id.* § 147.136(b)(3)(iii).

[83] *Id.* § 147.136(b)(3) (incorporating 29 C.F.R. § 2560.503-1(b)(5)).
[84] *Id.* (incorporating 29 C.F.R. § 2560.503-1(h)(2)(ii)).
[85] *Id.* (incorporating 29 C.F.R. § 2560.503-1(h)(2)(iii)).
[86] *Id.*§ 147.136(b)(2)(ii)(C).
[87] *Id.* § 147.136(b)(3) (incorporating 29 C.F.R. § 2560.503-1(h)(3)(ii)).
[88] *Id.* § 147.136(b)(2)(ii)(D).
[89] *Id.* § 147.136(b)(3) (incorporating 29 C.F.R. §§ 2560.503-1(h)(3)(iii)-(v)).
[90] *Id*. (incorporating 29 C.F.R. § 2560.503-1(f)(2)).
[91] *Id*. § 147.136(b)(3)(ii)(G).
[92] *Id*. § 147.136(b)(3)(ii)(F).
[93] *Id*. § 800.503(a).
[94] In addition to meeting the standards set forth in regulation, OPM's external review process must be "similar to the process set forth in the NAIC Uniform Model Act." *Id.* § 147.136(d)(2). For the NAIC Model Act see NAT'L ASS'N OF INS. COMM'RS, UNIFORM HEALTH CARRIER EXTERNAL REVIEW MODEL ACT (2010), *available at* http://www.naic.org/documents/committees_b_uniform_health_carrier_ext_rev_model_act.pdf.
[95] OFFICE OF PERS. MGMT., MULTI-STATE PLAN PROGRAM ADMINISTRATION LETTER 2013-002 at 4 (2013) [*hereafter* MSPP LETTER 13-002], *available at* http://www.opm.gov/media/4592632/pal_2013-002.pdf.
[96] OFFICE OF PERS. MGMT., MULTI-STATE PLAN PROGRAM ADMINISTRATION LETTER 2013-001 at 1 (2013) [*hereafter* MSPP LETTER 13-001], *available at* https://www.opm.gov/media/4499065/20130905_mspp_al.pdf.
[97] 45 C.F.R. § 147.136(d)(1)(ii)(A); *see also* MSPP LETTER 13-002 at 3.
[98] MSPP LETTER 13-001 at 1.
[99] *See id.*
[100] *See id.* at 2-4 (explaining the process and giving additional examples).
[101] *See* MSPP LETTER 13-002 at 8. The applicable timeframes may be extended when necessary to "ensure that sufficient information has been gathered and analyzed." *Id.*
[102] MSPP LETTER 13-002 at 5.
[103] MSPP LETTER 13-002 at 4.
[104] *Id.*
[105] 45 C.F.R. § 147.136(d)(2)(ii)(B).
[106] MSPP LETTER 13-001 at 2 n.2.
[107] MSPP LETTER 13-002 at 9.
[108] MSPP LETTER 13-002 at 5.
[109] *Id* at 6.
[110] *Id.* at 7.
[111] *Id.* at 8. The timeframe may be extended when necessary to "ensure that sufficient information has been gathered and analyzed." *Id.*
[112] *See* 45 C.F.R. § 800.503 (referring to 5 CFR 890.105(e)(2)).
[113] MSPP LETTER 13-002 at 7.
[114] *Id.* at 8. The timeframe may be extended when necessary to "ensure that sufficient information has been gathered and analyzed." *Id.*
[115] *See* 45 C.F.R. § 800.503 (referring to 5 CFR 890.105(e)(2)).
[116] MSPP LETTER 13-002 at 7.
[117] 45 C.F.R. § 147.136(d)(2)(iv); *see also* MSPP LETTER 13-002 at 7.
[118] MSPP LETTER 13-002 at 10.