POS Complex

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF ALAMEDA

WENDY GALLIMORE, **Plaintiff,** **vs.** **KAISER FOUNDATION HEALTH PLAN, et al.,** **Defendants.**	**No. RG12-616206** **TENTATIVE RULING & PROPOSED STATEMENT OF DECISION**

In the above-captioned case, the parties appeared through counsel for a court trial on March 16 to 19, 23 to 26, 30 and April 1 to 3 and 8 to 10, 2015. Post-trial briefing was concluded on May 29, 2015. In the interim, Kaiser filed a Motion for Judgment ("MFJ") pursuant to Code of Civil Procedure ("C.C.P.") section 631.8, which was submitted on June 3, 2015, and a Motion to Decertify the Class ("MDC"), which was submitted on July 10, 2015 – both without oral argument. Having considered the evidentiary record, the briefing by the parties and the argument

of counsel, the court rules on the MFJ and MDC and provides the following explanation of the factual and legal basis of its Decision on the principal controverted issues. Unless within 10 days of service hereof a party specifies further issues or proposes additional provisions per CRC 3.1590(c)(4), this tentative ruling and proposed statement shall become the Decision of the court in this matter.[1]

A. BACKGROUND

1. In her First Amended Complaint filed on March 29, 2013 ("Complaint"), plaintiff Wendy Gallimore ("Gallimore" or "Plaintiff") alleges that she is a member of defendant Kaiser Foundation Health Plan, Inc. ("Kaiser" or "Defendant") under an evidence of coverage ("EOC") issued to the Twin Rivers Unified School District. Plaintiff alleges that she underwent bariatric surgery for treatment of morbid obesity and subsequently experienced massive weight loss leaving her with large amounts of excess skin. Plaintiff further alleges that she was advised by Kaiser personnel that surgery for removal of excess skin was not included in her coverage but was only available to her on a fee-for-service basis. She claims that such denial of coverage for this surgery violates Health and Safety Code section 1367.63 ("HS 1367.63" or "the Statute"), which requires coverage of "reconstructive surgery" to "correct or repair abnormal structures" to "improve function" or "create a normal appearance, to the extent possible." The Complaint contains causes of action for (1) Violation of Business and Professions Code section 17200 ("UCL") and (2) Declaratory Relief, and it is pled as a class action.

[1] Apart from substantive objections and proposal per CRC 3.1590(c)(4), the court welcomes typographical and technical corrections, proposed record citations and the like. If the parties need more time to review the above and formulate their objections, suggestions, etc., they may file a stipulation extending the time.

2. On December 23, 2013, the court granted Plaintiff's class certification motion, and in doing so relied heavily on *Arce v. Kaiser Foundation Health Plan, Inc.* (2010) 181 Cal.App.4th 471 ("*Arce*"). There the appellate court reversed a denial of class certification where it was alleged defendant breached its health plan contract and violated the Mental Health Parity Act by categorically denying coverage for behavioral therapy and speech therapy to plan members with autism spectrum disorders. (*Id.,* at 496.) The Court of Appeal found that there was a reasonable probability that plaintiff could establish the requisite community of interest because there were legal issues that were common to all class members – e.g., whether defendant categorically denied coverage for particular types of treatment and, if so, whether categorical denials were permissible under the Mental Health Parity Act. It further found that resolution of the UCL claim would not require the trial court to, inter alia, make individualized determinations of medical necessity. (*Id.*, at 488.) Plaintiff's allegations here are similar to those in *Arce* in that she alleges that Kaiser systematically denies requests to cover reconstructive surgery "to correct or repair abnormal structures of the body to create a normal appearance to the extent possible" and, more specifically, that it "has a pattern and practice of systematically denying requests for reconstructive surgery for excess skin following bariatric surgery for morbid obesity and systematically ignores" the applicable statute. (Compl., ¶ 21.)

3. The class as certified is defined as follows:

> "All California Members of Kaiser Foundation Health Plan, Inc. who underwent bariatric surgery at any time from February 7, 2006 to the present. Excluded from this definition are members covered under federal plans, such as ERISA or FEHBA, and Medi-Cal plans."

Defendant has consistently argued throughout the case that this class definition is overbroad for several reasons – e.g., it includes patients who never sought or wanted excess skin removal surgery, patients who for independent medical reasons do not qualify for such surgery and

patients who are no longer Kaiser members. In certifying the above class and in subsequent orders, this court repeatedly rejected Kaiser's over-breadth arguments as conflating the issue of who may have been subject to the challenged pattern and practice with those who, but for such an alleged pattern and practice, were actually entitled to excess skin removal surgery under the Statute. The court also made it clear that adjudicating Plaintiff's claims would not require the court to review Kaiser's medical criteria for such surgery – e.g., the requirement that patients have a body mass index ("BMI") below a certain number or be non-smokers. Plaintiff did not claim that such criteria were unlawful or being used as a pretext to deny patients surgery they were otherwise entitled to have under the Statute.

4. During the trial Plaintiff presented extensive evidence of the various iterations of Kaiser's policies and procedures as reflected in the Surgical Guidelines and Referral Guidelines developed by Kaiser's two affiliated medical groups – the Permanente Medical Group ("TPMG") and Southern California Medical Group ("SCPMG"), collectively with Kaiser referred to a "Plan" – and in training materials, in web-based summaries of the criteria for excess skin surgery and in the orientation materials used with prospective bariatric surgery patients. It also presented evidence from various physicians, Plaintiff and another Kaiser member, Sandra Gonering ("Gonering"), to support her theory of liability – namely, that Kaiser required a functional impairment and/or used the length of the pannus as an appearance substitute for functional impairment. Plaintiff also challenged Kaiser's use of primary care physicians ("PCPs") to screen potential candidates for excess skin removal surgery on the grounds that the special expertise of plastic surgeons is required to adequately address whether a patient's individual circumstance warrants not only a panniculectomy but perhaps other kinds of excess

skin removal surgery – i.e., abdominoplatsy ("tummy tuck"), circumferential body lift (360 lift), thighplatsy (thigh lift), brachioplatsy (arm lift) and/or breast lift.

5. In response, Kaiser has consistently challenged Plaintiff's standing to bring this action because Kaiser contends that – the challenged practices aside – she did not satisfy the medical prerequisites for excess skin removal surgery due to her high BMI, does not have an "abnormal structure" that could be restored to a "normal condition," was not denied a consultation with a plastic surgeon and suffered no loss of money or property as a result of the challenged practices. For all of these reasons Kaiser has filed its MFJ. In addition, Kaiser contends that it is regulated by the Department of Managed Health Care ("DMHC"), which has investigated the very practices at issue here and, after requiring some corrective measures, eventually found Kaiser to be in compliance. Kaiser further contends that, even if its written materials were at some times and in some facilities not strictly Code-compliant, it has always allowed its physicians to use their clinical judgment. Thus, for example, PCPs have always been allowed to refer to reconstructive surgeons patients who did not exactly fit the criteria and those surgeons, in turn, had the discretion to exercise their independent clinical judgment as well. Given these actual practices, Kaiser argues that there is no pattern and practice common at all times at all facilities on this subject and, indeed, Plaintiff cannot point to any patient who was entitled under the Statute to the kind of reconstructive surgery at issue here but did not receive it.

6. Presented with these widely divergent positions, the court begins with the Statute and then turns to examine the evidentiary record as to Kaiser's policies and practices and those of the two medical groups and how those policies and practices played out for Plaintiff and one other Kaiser member who testified at trial. Significantly, each of the medical groups has its own Surgical Guidelines ("SG") and Referral Guidelines ("RG"), and these have changed over time.

In addition, in both Northern and Southern California Kaiser members have at times been required to attend classes before undergoing bariatric surgery, and one of the topics in these classes has been the possibility of excess skin following massive weight loss and the circumstances under which excess skin removal surgery is or is not available at Kaiser on a covered basis. Complicating matters is the fact that these various written materials are, in some instances, ambiguous or applied in varying manners by the PCPs and plastic surgeons. Some of these materials were the subject of the DMHC inquiry, and the more recent changes were to some extent made in response to that inquiry. The court will summarize the evidence on all of these issues and then rule on the issues presented by the two pending motions and then the case as a whole. For the reasons set forth more fully below, the bottom line is that Plaintiff prevails on all issues related to Kaiser's miscommunications regarding coverage, while Kaiser prevails on all issues related to the clinical judgments of Plan physicians.

B. THE STATUTORY FRAMEWORK

7. To understand the evidence, it is helpful to start with the statutory framework and how excess skin removal procedures may fit within it. The Statute reads in relevant part:

> (a) Every health care service plan contract ... *shall cover reconstructive surgery*, as defined in subdivision (c) ... *Nothing in this section shall be construed to require a plan to provide coverage for cosmetic surgery*, as defined in subdivision (d).
> (b) No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section...
> (c) (1) "Reconstructive surgery" means surgery performed to *correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease* to do either of the following:
> (A) To improve function.
> (B) *To create a normal appearance, to the extent possible.*
> ...
> (d) "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.

(e) In interpreting the definition of reconstructive surgery, a health care service plan may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following:

...

(2) *Denial of the proposed surgery or surgeries if the procedure* or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, *offer only a minimal improvement in the appearance of the enrollee.*

[Emphasis added.]

The key components relevant to this case are (a) the absolute coverage distinction between reconstructive and cosmetic surgery, (b) the definition of "reconstructive" to include that which corrects or repairs an "abnormal structure," (c) the proviso that that structure is caused by "congenital defects, developmental abnormalities, trauma, infection, tumors, or disease," (d) the further proviso that the surgery will *either* improve function *or* create a "normal appearance to the extent possible," and (e) the option to deny coverage if the surgery will "offer only a minimal improvement in ... appearance." Each of these concepts comes into play in the following ways.

8. First, Kaiser has always and consistently maintained that excess skin removal procedures are typically cosmetic because in the view of most plastic surgeons excess skin hanging from the body is not an "abnormal structure" but common as people lose weight and/or age. Furthermore, the excess skin that may develop after bariatric surgery is not the result of "congenital defects, developmental abnormalities, trauma, infection, tumors, or disease." If one were to argue that pre-surgery obesity justifying the bariatric surgery is the "disease" within the meaning of the Statute, Kaiser would argue that obesity is not a disease but a condition that in individual cases may result from a disease or not. Finally, there must always be a judgment as to whether the proposed surgery will only minimally improve appearance. Kaiser argues that all of these factors have been considered and folded into the various guidelines published by the two

medical groups to inform both PCPs and plastic surgeons as to when excess skin removal surgery may be provided as a covered benefit.

9. Plaintiff, on the other hand, contends that Kaiser's guidelines and actual practices historically have always required some functional impairment (e.g., rashes, trouble walking, etc.) so as to read the "normal appearance to the extent possible" prong out of the Statute and avoid any assessment of whether a given patient has an "abnormal structure" that reconstructive surgery could address so as to create a "normal appearance to the extent possible" and would offer more than "a minimal improvement in ... appearance." As for the requirement that the abnormal structure be caused by "congenital defects, developmental abnormalities, trauma, infection, tumors, or disease," Plaintiff notes that in assessing whether a post-bariatric surgery patient is a candidate for excess skin removal surgery Kaiser has never considered the underlying cause of the pre-surgery obesity and not relied on that to deny a covered procedure. Thus, as Plaintiff sees it, that criterion is not relevant to the case.

C. NORTHERN CALIFORNIA POLICIES AND PRACTICES AT TPMG

10. Both medical groups have multiple facilities with a plastic surgery department. Each such facility has a chief of plastic surgery, and there is a "chairman of chiefs" or "chief of chiefs" for each group, who supervises the medical group's plastic surgery practice as a whole through, inter alia, periodic meetings and interim email communications. Among the issues addressed among the chiefs in each group is the distinction between covered (reconstructive) and non-covered (cosmetic) plastic surgery procedures. Both medical groups have developed Surgical and Referral Guidelines that address these distinctions. With respect to cosmetic

surgery, both medical groups have a cosmetic surgery practice in which members may receive cosmetic surgery on a fee-for-service basis.

11. **Surgical Guidelines:** In Northern California, the 2005 SG are the earliest in this record. (Exh. 5.) Those guidelines have a cover page setting forth as "Guiding Principles" the distinction between "Medical" and "Cosmetic." "Surgical treatment is medically indicated" to (a) treat lesions that are, inter alia, harmful or may become harmful or impair function, (b) "more than minimally improve appearance by correcting or repairing abnormal structures" caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. While not explicit, the foregoing is most reasonably read in the disjunctive and the second prong on its face is framed solely in terms of appearance. In contrast to that definition, "cosmetic and not medically necessary" is surgery to treat (a) "normal structures" in order to augment, lift, reduce, reshape body parts or counter normal aging, (b) "structures (may be abnormal) not due to congenital defects, developmental abnormalities, trauma, infection, tumors or disease." Again, this is implicitly disjunctive.

12. The SG then provide more specific guidance for various procedures. The 2005 SG for TPMG categorize panniculectomy as cosmetic with an "exception," which provides that the procedure "is appropriate to relieve uncontrolled interriginous dermititis, difficulty walking and occasionally actual skin necosis as deemed appropriate by a Permanente surgeon." (*Id.*, at 17.) The same guidelines categorize abdominoplasty as cosmetic with an "exception," which provides that it "may be considered reconstructive when performed to correct or relieve significant symptoms due to structural defects or relieve significant symptoms due to structural defects and incompetence of the anterior abdominal wall as deemed appropriate by a Permanente surgeon." (*Id.*, at 16.) Both the panniculectomy and abdominoplasty pages have under the

exception note a statement that both procedures "may be considered for a subset of massive weight loss patients whose back pain is recalcitrant to all reasonable standard treatments, as deemed appropriate by a Permanente surgeon who is familiar with the current literature ... [and] based on an appropriate risk/benefit analysis." The page on brachioplasty classifies that procedure as cosmetic with an exception recognized where "excess skin becomes significantly infected or interferes with function." (*Id.,* at 18.) In all of the pages covering the specific procedures at issue in this case, the procedure is generally categorized as cosmetic, the exceptions are all tied to some kind of functional impairment (i.e., rash, infection, problems with ambulation, etc.), and no provision is made for or example given of the second prong of the "Guiding Principles" – i.e., where the procedure would "more than minimally improve appearance by correcting or repairing abnormal structures" caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

13. In November 2011 TPMG issued revised SG. (Exh. 8.) The relevant "Guiding Principles" were not changed, and panniculectomy and abdominoplasty remained classified as cosmetic; however, the exceptions for the two procedures were modified. For panniculectomy, a paragraph was added stating that "[a] pannus would need to extend significantly below the pubis in order to interfere with function." An additional paragraph stated that "[o]besity is a relative counterindication. Surgery for patients with a BMI greater than 35 is appropriate only if the Plan surgeon determines the pannus is out of proportion to body size, *causes symptoms*, and the benefits of surgery outweigh the increased risks." (*Id.,* at 18 [emphasis added].) For abdominoplasty, the SG was restructured so that abdominoplasty "to contour and sculpt the abdomen is cosmetic and is never reconstructive" but "abdominal wall reconstruction ... to correct or relieve significant symptoms due to structural defects" was defined as medical. None

of these changes may fairly be read to expand the availability of these procedures, and again the details for the various procedures in the 2011 SG do not reflect any implementation of the concept expressed in the second prong of the "Guiding Principles" – i.e., where the procedure would "more than minimally improve appearance by correcting or repairing abnormal structures" caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease. This reading of the 2005 and 2011 SG for TPMG was confirmed by Dr. Harold Mancusi-Ungaro ("Mancusi-Ungaro") – the person designated as Kaiser's PMQ on excess skin removal guidelines, practices and procedures – namely, that some functional impairment such as a rash or problem with walking rather than a mere appearance issue was required before any of the excess skin removal procedures at issue in this case would be considered medically indicated rather than cosmetic. (RT 228:25 – 229:24.)

14. **Referral Guidelines:** Since at least early 2012, TPMG has employed a web-based RG system called "e-Consult" for use by PCPs in referring their patients to surgeons. By using e-Consult, a PCP can navigate to a screen for a particular procedure, find a summary of criteria and contact information, make a query to a surgeon, provide information to the surgery department and refer the patient to a surgeon. The details of the e-Consult screens vary by facility but until very recently had certain common features. For panniculectomies, for example, up until April 2015 the Santa Rosa facility's e-Consult system stated that a referral "is indicated if pannus hangs below thighs and causes significant problems with ambulation." (Exh. 149, at 2.) The San Leandro facility's relevant e-Consult screen stated "panniculectomy is a covered benefit only in extreme cases of functional impairment." (Exh. 148.) Other facilities' e-Consult pages did not attempt to re-state the criteria for panniculectomies but simply provided a link to the relevant SG. (E.g., Exh. 150.) The same kinds of variations are found in the former e-Consult

pages addressing other excess skin removal procedures such as abdominoplasties, but common to all the criteria found on e-Consult before 2015 is the requirement of some kind of functional impairment to indicate a surgical referral and the absence of any reference to the second prong of the "Guiding Principles." As discussed below in more detail, beginning sometime in early 2015 TPMG started to make material changes in the relevant e-Consult pages.

15. **Bariatric Patient Orientation:** Potential bariatric surgery patients are offered (and in some instances required to attend) classes regarding the surgery and what they may expect. The written materials for training class instructors cover the issue of the possibility of excess skin following bariatric surgery and whether it is covered or not. The 2006 materials state "[t]his surgery is not (as of January 2006) a covered benefit ... It is, however, available for a fee at several Kaiser Permanente surgery centers." (Exh. 70, at 11.) The 2012 instructor training materials contain a Frequently Asked Questions ("FAQ") section with the following:

> **Q. What about cosmetic surgery to remove the extra skin?**
>
> **A:** Significant weight loss can lead to extensive amounts of excess skin on the legs, thighs, arms, stomach, breasts and buttocks. This skin may not be elastic enough to shrink back down after weight loss. Many patients chose cosmetic surgery to remove excess skin. While cosmetic surgery may help some people after surgical weight loss, **it is not a benefit of Kaiser Health Plan.** It is a free-for-service option at several Kaiser Permanente medical centers in northern California and you are responsible for paying for the surgery, should you decide you want it. For more information, you can visit the cosmetic surgery website at ...." [Exh. 71, at 5 (emphasis original).]

The PowerPoint and other materials used in these classes vary by location but all contain a statement to the effect that excess skin removal surgery is cosmetic and thus not covered. (E.g., Exhs. 66, at 16; 67, at 11; 68, at 15; 69, at 7.) In addition, TPMG has a "My Doctor Online" website with a set of pages entitled "Living With Weight Loss Surgery/" As of the October 2014 close of discovery, a visitor to the latter pages was advised: "After weight loss, you may be left

with loose hanging skin on your arms, face, breasts, stomach, buttocks, and thighs. Removal of this loose skin is not a covered medical benefit." (Exh. 106, at 3.)

16. **Testimony of Actual Physicians Practices at TPMG:** The foregoing presents a consistent portrait of the terms and conditions under which excess skin removal surgery was made available as a covered benefit to Kaiser members in Northern California through at least 2014. In addition to the foregoing documentary record, however, there was some evidence as to how the above documents were actually implemented. Kaiser presented the testimony of Mancusi-Ungaro and the chief of Kaiser plastic surgery in the Sacramento area, Dr. Kenneth Phillips ("Phillips"), to the effect that the SG were only guidelines and that every physician was allowed to use his or her own clinical judgment as to what was appropriate for a given patient. Phillips testified that he had provided a panniculectomy to a patient with a pannus "to the mons or just below but really had no functional concerns" and would do so for patients who reported only slight discomfort; however, that was as specific as he could be and he had no documented example to illustrate his testimony and allow it to be tested on cross-examination. There were two more specific TPMG examples. First, Mancusi-Ungaro recalled an unnamed patient for whom he had provided an excess skin removal surgery, but he was clear that the reason for doing so was the presence of the kind of functional problem that under the existing SG made the procedure medically indicted. (RT 189:21 – 191:4.) The second example was that of Plaintiff and how her inquiry was handled by her PCP, Dr. Cristina Solis ("Solis"). As discussed in greater detail below, it is clear that Solis reviewed Plaintiff's medical records and the RG and offered a referral to the fee-for-service cosmetic surgery department rather than for a reconstructive (covered) surgery consultation. Both of these examples illustrate the application of the SG and RG as written.

17. **The Discovery Issue:** At this juncture, it is important to note a significant discovery dispute that bears on the issue of TPMG's actual practices. Throughout the discovery process Kaiser resisted discovery of individual patient records on grounds of privacy, relevancy and burden. On May 20, 2014, Plaintiff filed a motion to compel that included Requests #26 and #27, which respectively sought all documents supporting Kaiser's contention that it did not refuse excess skin removal surgery absent a functional problem and/or that medical group physicians did not consistently follow the group's SG on this subject. Kaiser promised to produce such documents with patient identifying information redacted, and on June 12, 2014, the court *ordered* that production. Thereafter Kaiser identified 318 class members who had received a panniculectomy and produced medical records for a sample of that population. That evidence is discussed in more detail in the next section and relates almost exclusively to SCPMG patients,[2] but the important point to note at this juncture is that Kaiser had available to it the records from which corroborating documentation could have been obtained to support the testimony of any medical group physician who said he or she had, for example, performed panniculectomies outside the parameters of the SG based on the exercise of clinical judgment. Kaiser chose not to do that even after being ordered to do so. Given the history of the discovery disputes in this case and the importance of the issue, the court draws an adverse inference from Kaiser's decision not to produce such corroborating evidence. (See CACI 203 and authorities cited therein.)

18. **Response to DMHC Survey:** As discussed in Part I below, DMHC conducted a survey of various Plan practices and issued a report in 2011 and then a follow-up report in 2014. (Exh, 525, 543.) "Deficiency #4" in the 2011 report related to DMHC's concerns that Kaiser was not doing enough to ensure that the medical groups were providing reconstructive surgery in

[2] There was only one TPMG patient, and the records for that patient reflected a functional problem, namely, a yeast infection. (Exh. 605, at 85-96, 150-155.)

accordance with the statutory mandate. In response to the 2011 report, Kaiser worked with its medical groups through a designated Plan Physician Advisor ("PPA") to address the identified deficiencies. Dr. James Glauber ("Glauber"), a pediatrician by training, was the Kaiser PPA who from mid-2012 to October 2014 (when he left) was tasked with working with TPMG. As the PPA, Glauber's role with respect to Deficiency #4 was not to re-do the SG or any other document but work with the chiefs, and particularly the chief-of-chief (Mancusi-Ungaro) to see that the issues were being addressed. As of the time Glauber left in 2014, the SG had not been changed; however, before he left Glauber had developed and TPMG had deployed a tool known as "Smart Phrase" to help physicians document their consideration of the relevant statutory criteria.

19. Smart Phrase was a page on the internal Kaiser net that plastic surgeons would see whenever they decided that a patient was not a reconstructive surgery candidate. The page recited the statutory language and then provided five statements to which the surgeon could answer "yes" or "no" so as to document that he or she had considered of the relevant factors:

- 1. The structure is abnormal (Yes/No)
- 2. The structure is the result of infection, developmental abnormality, congenital defect, trauma, tumor, or disease defect (Yes/No)
- 3. Surgery is necessary to restore function (Yes/No)
- 4. If no functional limitation, surgery will restore a normal appearance, to the extent possible (Yes/No)
- 5. The surgical benefit in terms of improved appearance or function outweighs the surgical risks (Yes/No)

[Exh. 551.]

Smart Phrase was completed in the Fall of 2013, presented to the TPMG plastic surgery chiefs and then rolled out in Northern California in 2014.

20. **Conclusions as to TPMG Practices:** Based on all of the foregoing evidence, the court concludes that prior to 2014 there was a consistent set of SG, RG and orientation materials

used across TPMG facilities, and there is no credible evidence that these policies were not relied upon by PCPs in deciding who should be referred to plastic surgery and by surgeons in deciding who qualified for such surgery on a covered basis. Those policies as reflected in the SG and RG clearly state that in order to qualify for a panniculectomy, abdominoplatsy or brachioplatsy a patient must, among other things, report or manifest a functional problem and all other excess skin removal procedures are considered per se cosmetic. The patient materials were even more restrictive: all such procedures were classified as cosmetic without exception. While the SG, RG and orientation materials did not change in 2014 (or before the trial of this case in 2015), TPMG did introduce the Smart Phrase tool in 2014 so as to alert surgeons who may have been in the process of rejecting a candidate for reconstructive surgery to the statutory requirements; however, prior to trial no corresponding changes were made in the RG or the orientation materials, and thus there is no reason to conclude that either patients or PCPs were aware that in some circumstances excess skin removal surgical procedures might be available to a patient without a functional problem.

21. **Most Recent Revisions:** Finally, the court must address evidence of very recent changes in TPMG's written policies that Kaiser presented late in the trial through a custodian of records (Anne Feder) and later Dr. Phillips and has attempted to expand upon even after the close of the evidence in the trial. The records introduced through the custodian on April 2, 2015, consisted of Exhibits 695 and 696 and reflect changes in the "My Doctor Online – Living with Weight Loss Surgery" website pages. The new exhibits show changes in the coverage description previously found on those pages regarding excess skin removal surgery from an absolute bar to "may not be a covered benefit." These two exhibits were conditionally admitted subject to Kaiser producing all of the emails discussing these changes. The latter were not

provided to Plaintiff until well after the close of evidence in the case on April 10, 2015. Plaintiff has since moved to exclude these exhibits based on Kaiser's failure to satisfy the condition subsequent, and that motion is GRANTED.[3]

22. As for Dr. Phillips, in December 2014 he succeeded Mancusi-Ungaro as chairman of the chiefs of plastic surgery for TPMG. Before that time he was not aware of any proposed changes to the SG or RG, but when he became chairman he worked with Kaiser and its attorneys on such changes and admitted that the current lawsuit was a factor contributing to that effort. None of the documentation relating to the development or implementation of the changes was included on Kaiser's trial exhibit list (much less produced in discovery); rather, on April 8, 2015, Phillips was recalled to the witness stand to testify to his most recent efforts to bring TPMG into compliance and to sponsor a number of supporting exhibits. Among these new documents is Exhibit 243, which contains the minutes of the March 13, 2015 meeting of TPMG's plastic surgery chiefs, reflects work on the new policies and attaches drafts of the new policies. (Exh. 243, at 5, 9-11.) Also presented through Phillips was a draft of an e-Consult page reflecting new RG and examples of such pages subsequently implemented at various facilities; these new documents show a change in the coverage descriptions more consistent with the Statute. The draft SG introduced through Phillips include express reference to the second prong of the "Guiding Principles" in the exception section of the portions for panniculectomies, abdominoplasties and other body contouring procedures. Since the close of evidence Kaiser has sought to introduce two new exhibits of additional revisions to e-Consult pages and attempted to

[3] Kaiser has argued that there is no prejudice because the subsequently produced emails do not help Plaintiff, and, in any event, it would stipulate to the re-opening of the record if Plaintiff wanted to explore any issues raised by the late-produced emails. The prejudice, however, is palpable: Plaintiff vigorously pursued these issues throughout discovery and prepared its case in good faith, while Kaiser was aware of the changes underway after the close of discovery, did not reveal these developments through its exhibit lists or otherwise, and then sprung the exhibits on Plaintiff late in the trial without notice.

authenticate them through declarations dated June 22, 2015. Plaintiff has objected on multiple grounds to the new exhibits and the related foundational declarations. Those objections are SUSTAINED.[4]

D. SOUTHERN CALIFORNIA POLICIES AND PRACTICES AT SCPMG

23. As noted in the previous section, the two medical groups have to the extent relevant to this case a similar structure and mode of operation; however, the format and details of the SG, RG and various patient orientation materials differ in certain respects, which may be summarized as follows.

24. **Surgical Guidelines:** For Southern California, the record contains three iterations of SG dated May 2006, August 2011 and March 2014. (Exh. 22, 23, 86, respectively.) All of them start with a "Guiding Principles" page that is identical to those in the TPMG SG. The specific guidelines for panniculectomies in all three state that it is cosmetic, that uncomplicated superficial infections responding to conservative treatment are *not* a basis for an exception but that the procedure is appropriate to relieve uncontrolled rashes, difficulty in walking and occasionally actual skin necrosis, and that "[p]annus should completely cover the mons pubis." In all three abdominoplatsy is defined as cosmetic without any exception.

25. The three vary in certain details regarding the specific guidance on panniculectomies. The 2006 SG state with respect to panniculectomies that "[p]annus should completely cover the mons pubis; BMI should be less than 35 and weight stable for 1 year."

[4] As noted in connection with the other late exhibits presented by Kaiser, it is extremely prejudicial to Plaintiff to have Kaiser attempt to come into compliance mid-trial and submit purported proof thereof without any notice to Plaintiff or opportunity for discovery or cross-examination. Rather than reflecting a good faith effort to achieve compliance, this looks more like an effort to manufacture a defense a minute before (and several minutes after) midnight. This evidence also demonstrates the relative ease of addressing the compliance issues in this case. It is unfortunate that it has taken more than three years of litigation and the actual commencement of trial to motivate Kaiser to address the obvious.

There is then a discussion of "[f]unctional problems," and the statement, for example, that "[i]f a patient has a pannus that extends more than half the distance from the perineum to the patella, they will automatically be considered to have a functional problem and they will not be required to provide addition documentation of a functional problem." The section ends: "Patients who do not meet criteria but who still wish to see a plastic surgeon should be seen upon request since nay [sic] particular patient may be an appropriate candidate for surgery if the treating physician feels that the risks outweigh the benefits." (Exh. 22, at 17.) The revised 2011 SG delete the above, insert a set of risk assessments that vary by BMI, and then end with the following:

> Functional problems include difficulty with walking, or transfers. A pannus that covers the genitalia does not represent a functional problem per se.
> All consults for panniculectomy should be seen if they meet the above criteria. Patients who do not meet criteria but who still wish to see a plastic surgeon should be seen upon request.
> [Exh. 23, at 20.]

The revised 2014 SG retain the BMI risk assessment paragraph from the 2011 SG but delete the ending language quoted above, and Dr. Cissy Tan ("Tan") – SCPMG's and Kaiser's PMQ on these issues, SCPMG's San Diego chief of plastic surgery since 1992, and SCPMG's chief-of-chiefs since 2010 – testified that the modifications to the 2014 SG were intended to eliminate any requirement that there be a rash.

26. As previously noted, all three versions of the SG contain the "Guiding Principles" on the first page, and as noted in the context of the TPMG discussion, the second prong of the "Guiding Principles" contains the "more than minimally improve appearance" language; however, the latter concept is not reflected in the specifics for panniculectomies, abdominoplatsies or any other procedure. Rather there is an emphasis on functional problems, and, where there is a reference to the length of the pannus, it is in a context that is linked to functional issues. Further, Dr. Tan admitted that nowhere in the 2006 or 2011 SG's description

of the indications for panniculectomies is there any statement that the procedure may be appropriate based solely on appearance issues. (RT 559:19-561:4.) While the 2014 SG deleted language from the earlier version which emphasized functional problems, the 2014 version does not clearly add an alternative appearance requirement. The statement that "Pannus should completely cover the mons pubis" follows a functional requirement and may be read as an additional rather than alternate criterion.

27. The significance of the 2014 SG formulation is further complicated by the fact that, in the of view Dr. Tan, Dr. Neal Gorlick ("Gorlick") and other SCPMG plastic surgeons, a pannus that completely covers the mons pubis typically is a condition that causes functional problems such as rashes. Thus it is unclear whether the length of the pannus criteria is an appearance standard under the second prong of the "Guiding Principles" or simply a marker that there is likely a functional problem. If the length of the pannus criteria is only a marker for the likelihood of rashes, then Plaintiff argues it is a de facto functional requirement and not a bona fide attempt to allow panniculectomies when the procedure would "more than minimally improve ... appearance" by correcting or repairing "abnormal structures." In any event at best the 2014 change only related to panniculectomies and not to other excess skin removal procedures.

28. **Referral Guidelines:** Like TPMG, SCPMG had RG for PCPs to use when considering whether to refer a patient to a plastic surgeon. Exhibit 29 dated as last reviewed/revised in January 2011 is apparently the only RG in use at SCPMG during the relevant time period until August 2013. The 2011 RG states in relevant part for panniculectomies and abdominoplatsies that referral to a plastic surgeon is appropriate where:

ALL of the following criteria are met prior to referral:

- Recommended BMI below 30

- Pannus covers ENTIRE mons pubis
- Patient must have recurrent rashes recalcitrant to conventional medical treatment (nonresponsive to conservative treatment for more than 6 month)
- Bariatric surgery/weight loss patients should AT goal weight and stable for at least 6 months before consideration for panniculectomy
- ...

**Panniculectomy only excises the overhanging fold*
***Panniculectomy may be medically indicated (and therefore covered) when the following conditions exist: significant, documented fold rash, ulcers, and/or recalcitrant panniculitis not responsive to local care*
****A tummy tuck or abdominoplatsy is cosmetic and not covered*
[Exh. 29, at 6 (emphasis added).]

In August 2013 the above RG was revised to read in relevant part:

Refer to Health Education for Weight Management if:

- Large significant pannus covering the entire mons pubis AND BMI > 30 within the past 6 months

Refer to Plastic Surgery if:

- Large significant pannus covering the entire mons pubis AND BMI <= 30 within the past 6 months

**Panniculectomy only excises the overhanging fold*
*** A tummy tuck abdominoplatsy, breast lift, thigh lift, brachioplatsy arm lift, mons lift is not medically indicated*
****Patient may have significant fold rash, ulcers, and/or recalcitrant panniculitis not responsive to local care*
...
[Exh. 87, at 5-6.]

The intent of the August 2013 revision was to remove the rash requirement for panniculectomies. There was no attempt to reference the second prong of the SG's "Guiding Principles" more broadly or change the unqualified cosmetic designation for other excess skin removal procedures.

29. **Bariatric Patient Orientation:** Like TPMG, SCPMG conducted classes for prospective bariatric surgery patient and provided materials for the instructors and for attendees. The attendee materials used in some of these classes (called "Options") do not refer at all to the potential for excess skin problems after surgery, while other materials do. For example, Plaintiff

introduced instructional materials dated "6/28/2012" and stating that the only covered procedure for post-bariatric patients is a panniculectomy, for which there must be "evidence of recurring rashes, which have been photographically documented by a Kaiser Permanente physician on several occasions." (Exh. 55, at 2.) Some patient materials used in these classes have "frequently asked questions" ("FAQs") sections, which contain similar statements. For example:

> **If a person wants plastic surgery after having a by-pass, will Kaiser pay for it?** The only procedure that is covered by Kaiser after massive weight loss is a panniculectomy (a surgery to remove fatty tissue and excess skin from the lower section of the abdomen). Abdominoplatsy (a complete tummy tuck), thighplatsy (thigh lift), brachioplatsy (arm lift), and breast lifts are not covered. In addition, even for a panniculectomy, a person has to satisfy three criteria. 1) You reach your goal weight with a BMI below 30 and maintain that weight for a period of time. 2) The pannus (hanging abdominal skin) must be completely covering the pubic area. And 3) *there must be evidence of recurrent rashes*, which have been photographically documented by a Kaiser physician on several occasions.
> [Exh. 52, at 4 (emphasis added).]

Bariatric patients execute an informed consent form for the surgery and that form includes an acknowledgement of the same Kaiser coverage policies. For example:

> After I lose weight from surgery, there may be complications associated with excess, sagging skin. I understand that Kaiser Permanente does not perform cosmetic surgery for excessive skin.
>
> Note: In rare cases, Kaiser does perform the surgery if there is a serious medical condition. Usually the only procedure that is covered after massive weight loss is a panniculectomy. A panniculectomy is performed if 1) you are not still morbidly obese (your BMI has to be below 30), 2) your pannus (the vascular, fibrous tissue of the stomach) is of a functionally significant size which means it completely covers the pubic bone, and 3) *you have evidence of recurrent rashes* (This requires photographic documentation on several occasions.). Abdominoplatsy, thighplatsy, brachioplatsy and breast lift are not covered.
> [Exh. 53, at 2 (emphasis added).]

While there were some variances in the materials based on the particular facility and date, at least until mid-2013, all of the materials mentioning excess skin problems and possible surgical solutions are consistent with the above excerpts on the issue of the extent and conditions under

which Kaiser would provide excess skin removal surgery for post-bariatric patients. After mid-2013, there is some variation as to the panniculectomy criteria, but other excess skin removal procedures continue to me classified as cosmetic per se.

30. **Testimony of SCPMG Physicians as to Actual Practices:** Dr. Tan testified that there was an effort among the chiefs to achieve consistency in the application of the SG, that the latter were reviewed at the plastic surgeons' annual meeting to ensure that they were being followed, that she and the local chiefs reviewed and approved the panniculectomies RG that made rashes or other functional impairments a requirement for referral and that based on those RG prior to August of 2013 she would expect the PCPs to understand there was a rash requirement. (TR 569:3-11.)[5] Dr. Gorlick, chief of plastic surgery at Woodland Hills, agreed that his facility used a rash requirement for panniculectomies at least through July of 2013, although in practice the patient only had to say they were experiencing rashes. After July 2013 potential panniculectomy patients were still asked about rashes but only because the presence or absence of a rash and its severity might factor into the overall risk/benefit analysis. The testimony of Dr. Charlotte Resch and Melissa Poh (SCPMG plastic surgeons in Fontana and West Los Angeles, respectively) was consistent with the foregoing. Further, as discussed below in greater detail with respect to Gonering, Dr. Vinod Dasika ("Dasika") was her PCP at SCPMG, and his 2012 decision not to refer her to a plastic surgeon for evaluation for a panniculectomy was based on his reading of the rash requirement set forth in the RG in use at that time.

[5] Dr. Tan did testify that, when the rash requirement was dropped from the RG in 2013 and the SG in 2014, this did not reflect a change in actual practice because prior to that time SCPMG plastic surgeons had stopped using that criteria and relied instead on the length of the pannus. While this may have been true by the time the SG were changed in 2014, the court rejects this testimony in so far as it relates to pre-August 2013 practices because of the weight of the other evidence and the fact that, as explained elsewhere, the length of the pannus criteria was for some just an indicator that there was a likely rash or other functional issue.

31. **Kaiser's Sampling of Patient Records:** As previously noted, Kaiser identified a set of class members who received panniculectomy or other excess skin removal surgeries as a member benefit and produced the medical records (personal identifying information redacted) for a 16 of those patients – all but one of which were SCPMG patients. Of the selected sample, Kaiser characterizes the records as reflecting 3 instances where there is no indication of a rash or other functional problem, 9 where there were only patient-reported rashes in the patient history and only 4 had rashes that the surgeon examined. From this Kaiser argues that in practice there was considerably more flexibility than reflected in the written guidelines and that such flexibility is consistent with medical group physicians exercising their clinical judgment on a case-by-case basis such that class adjudication is unwarranted.

32. In response Plaintiff points out that the sample size determination, random selection process and the analysis were all done by counsel without the kind of expert support one would expect in any serious effort to present a statistical study. (See, e.g., *Duran v. U.S. Bank Nat'l Assoc.* (2014) 59 Cal.4th 1, 43 ["the court here chose a sample size of 20 ... without input from either side's statistical experts"].) Further, of the 16 selected, one was not even a panniculectomy case and another was an apparent duplicate. Of the remaining 14, at least 12 patient files reflect the presence of a rash, and the 2 remaining files are silent on the subject. The problem with assigning any weight to those 2 is the fact that counsel selected the portion of the files to be culled, reviewed and produced, and thus there is no way to determine whether the conclusions Kaiser would draw are based on an examination of all the relevant material in the file. In addition, by definition the records of patients who actually underwent a panniculectomy can shed no light on the number of members who were dissuaded from inquiring about such a procedure because of the information disseminated in their orientation class or asked their PCP

about the procedure but were told it was unavailable on a covered basis. The *most* that can be concluded from Kaiser's record sampling is that, to the extent SCPMG's policies had a rash *documentation* requirement (e.g., a photograph or direct observation by the physician), that particular requirement may not have been consistently followed. This evidence does not support a reasonable inference that the SR and RG were not otherwise followed at least until August of 2013.

33. **Response to DMHC Survey:** As discussed in connection with TPMG and in Part I below, DMHC conducted a survey of various Kaiser practices and issued a report in 2011 and then a follow-up report in 2014. (Exh, 525, 543.) "Deficiency #4" in the 2011 report related to DMHC's concerns that Kaiser was not doing enough to ensure that the medical groups were providing reconstructive surgery in accordance with the statutory mandate. In response to the 2011 report, Dr. John Brookey ("Brookey) was designated as the PPA for SCPMG. On Deficiency #4 he worked with Tan and others to ensure that SCPMG materials no longer contained a rash requirement for panniculectomies. There is email traffic from July of 2013, for example (Exh. 76), reflecting communications among Drs. Brookey, Tan, Glauber and others about panniculectomy class materials, the RG and the presence or absence of the rash requirement. It is clear that the changes to the RG in August 2013 and the SG in 2014 were the result of Brookey's efforts to make sure that SCPMG physicians no longer used a rash requirement for panniculectomies but that he did not address the function-versus-appearance issue more broadly than that particular procedure.

34. **Conclusions as to SCPMG Practices:** Based on all of the foregoing evidence, the court concludes that Plaintiff has presented convincing evidence of a consistent set of written policies across SCPMG facilities prior to August 2013, and there is no credible evidence that

these policies were not relied upon by PCPs in deciding who should be referred to plastic surgery and by surgeons in deciding who qualified for such surgery on a covered basis. Those policies clearly state (a) that in order to qualify for a panniculectomy a patient must, among other things, report or manifest a functional problem such as a rash and (b) that all other excess skin removal procedures are considered per se cosmetic. Exceptions, if any, were rare. In 2013 there was a change in the RG, which was not reflected in the SG until 2014, and that change was intended to remove any rash requirement for panniculectomies but was no broader than that. Thus even after the 2013 change in the RG and the 2014 change in the SG, all excess skin removal procedures other than panniculectomies continued to be classified as per se cosmetic. Further, the patient orientation materials that addressed the issue were generally consistent with the criteria reflected in the SG and RG. Put another way, with the exception of having but then deleting the rash requirement for panniculectomies, SCPMG policies and practices have consistently treated all excess skin removal procedures as per se cosmetic except for panniculectomies.

E. PROFESSIONAL STANDARDS

35. During the testimony of the various medical group doctors referenced above, both parties developed evidence regarding what is and is not considered an "abnormal structure," the range of "normal appearance" and the distinction between reconstructive and cosmetic surgery. Among the Kaiser plastic surgeons who testified on this subject were Drs. Tan, Gorlick and Resch. In addition, Plaintiff called Dr. John Katzen ("Katzen") as an expert witness. Katzen is a board certified plastic surgeon in private practice who specializes in excess skin removal surgery. He has performed thousands of such surgeries, mostly for post-bariatric surgery patients.

36. What emerged from the testimony of Tan, Gorlick and the other medical group plastic surgeons who testified is a general understanding that, if a particular excess skin removal procedure is for the sole purpose of improving appearance, it is considered cosmetic. The origin of this understanding is not any SG but their professional training. For excess skin removal surgery to be "medically indicated" there must be some functional problem such as a rash, skin infection, problems walking or toileting, etc. The length of the pannus is a relevant indicator for a panniculectomy because a pannus of a certain length will typically cause functional problems. In Tan's view, use of a length of the pannus standard is not only an easy one for surgeons and general practitioners alike to apply but assures consistency and is fairer. She noted that a rash might not always manifest itself when a patient sees the physician; further some patients could simply use a brillo pad to cause a rash and thus trigger coverage, while a less sophisticated patient would not think of doing that. Tan and other plastic surgeons may view a pannus of a certain length to be an "abnormal structure," but apart from that example none of them had a definition of that term that could be applied more broadly to other types of excess skin conditions.

37. Katzen testified that the length of the pannus standard was far too narrow to capture all the ways in which a hanging pannus might constitute an "abnormal structure." He presented a number of photographs of persons from his practice or the literature where, for example, the pannus was, in his opinion, an "abnormal structure" but did not fit the Kaiser length of the pannus standard. For example, whereas the Kaiser standard required the pannus to completely cover the mons, Katzen presented a photo of a patient of his with a hanging pannus in a "W" shape such that it did not cover the mons but hung down below each side of the mons. (Exh. 189.) He also presented a photo of a patient whose pannus, even though it extended down,

did not cover the mons because the mons was also hanging. (Exh. 191.) When shown such photographs, Tan or other Kaiser plastic surgeons would often agree that the photo presented an "abnormal structure" even though it did not cover the mons; however, they would also say that they had never seen a patient with the condition in the picture and that they had the discretion to use their clinical judgment to decide that a given patient with an unusual condition might well present an abnormal structure justifying reconstructive as opposed to cosmetic surgery. Katzen also presented photographs of patients from his practice who had what he considered excess skin conditions apart from the pannus and significant enough to be considered an abnormal structure. Thus he criticized Kaiser guidelines that classified as cosmetic per se all excess skin removal surgeries other than panniculectomies.

38. When comparing the testimony of the Kaiser surgeons to that of Katzen it is apparent that part of the difference between them is the populations they serve. Katzen has offices in the Beverly Hills, Dubai and Singapore, sees a very large and diverse population of post-bariatric patients and some of the most extreme – e.g., he has had patients who weighed over 1000 pounds before bariatric surgery. The Kaiser surgeons have some post-bariatric patients with excess skin issues, but their surgical practice covers a broader range of reconstructive and plastic surgery cases. Thus the cover-the-mons standard generally "worked" for their patients even though it admittedly was not broad enough to cover all conceivable cases. It is not possible to draw any conclusions as to the Kaiser patient population as a whole, though, because for reasons discussed above, Kaiser's orientation materials and RG guidelines may have prevented many cases from ever being seen by a Kaiser surgeon.

39. What both the Kaiser surgeons and Katzen apparently agree on, though, is the proposition that, based on their training and experience, they all believe they can recognize an

"abnormal structure" when they see it even if they cannot articulate a standard that could be reliably applied to every post-bariatric patient manifesting an excess skin condition somewhere on the body. For this reason, Plaintiff argues that only plastic surgeons – and not PCPs – can evaluate whether a given patient presents with an "abnormal structure" that can be "corrected or repaired" so as to restore a "normal appearance" that would be more than a "minimal improvement." As opinions may vary in individual cases, Katzen even opined that ideally a *panel* of plastic surgeons would need to review some cases. Kaiser counters that such an approach is totally impractical and that PCPs can screen patients and refer to a plastic surgeon for further evaluation those who might qualify for reconstructive surgery.

40. Based on the foregoing, the court concludes that, when it comes to post-bariatric excess skin conditions, there is no bright line distinction between what would constitute reconstructive versus plastic surgery, there is general agreement that where there is a functional issue such procedures are "medically indicated," and that where there is no functional impairment the opinions of plastic surgeons may vary widely as to what constitutes an "abnormal structure" sufficient to characterize corrective surgery as "reconstructive" as that term is understood by plastic surgeons. In the latter circumstance, the decision on whether a procedure is medically indicated or not becomes part of a broader risk/benefit analysis that includes other purely medical factors such as BMI, smoking history, heart condition, etc.

F. THE EVIDENCE RE PLAINTIFF AND SANDRA GONERING

41. **Wendy Gallimore:** Plaintiff and one other Kaiser member were called to illustrate how the above policies and practices played out in the two regions. Plaintiff is a long-time Kaiser member who underwent bariatric surgery in Southern California in May of 2006.

Prior to undergoing that surgery she attended orientation classes at a Kaiser facility and was given written material similar to Exhibit 63 in which it was stated that after surgery patients may develop excess skin but the removal of such excess skin is not a covered procedure. This was also explained by the instructor. As a result of her 2006 surgery, Plaintiff's weight dropped from more than 410 pounds to approximately 282 pounds one year after surgery, but by April 2011 her weight had increased to 318 pounds, which resulted in a BMI of approximately 48. As a result of her significant weight loss Plaintiff developed excess skin that hung from her arms, on her back in rolls, around her mid-section and on her legs. She initially did not ask about removal of this excess skin because her prior experience with Kaiser was that "when they say it's not covered, it's not covered."

42. By 2011 she had relocated to Northern California, and between April and October she had had three visits with Solis, who is a board-certified family practitioner at TPMG in Roseville, California, and at the time was Plaintiff's new PCP. In December 2011 Plaintiff sent Solis an email stating in part: "I have spoken to you about getting plastic surgery for my extra skin resulting from a large weight loss by gastric bypass ... You have told me that it is not a covered service by Kaiser." (Exh. 521.) In the email Plaintiff then asks whether excess skin removal surgery is covered and asks for a referral to a plastic surgeon. Solis does not remember Plaintiff previously raising an excess skin issue, and the medical records of the previous three visits do not reflect any such inquiry even though her practice would have been to note such an inquiry if one had been made. Nevertheless Solis reviewed Plaintiff's medical records and the applicable TPMG RG (Exh. 8, at 18) and responded by suggesting Plaintiff "contact the cosmetic dermatology department to see what our plastic surgeons can do for you" and also invited her to "contact me or come in to see me." (*Ibid.*)

43. When Solis responded to Plaintiff's inquiry she did not rely on the fact that Plaintiff's BMI was higher than what the guidelines allowed, as that was an issue Solis believed would best be addressed by the plastic surgeon. By suggesting Plaintiff contact the "cosmetic dermatology department," Solis was inviting Plaintiff to "self-refer" to the department that provides fee-for-service cosmetic surgery rather than covered reconstructive surgery; however, Solis also invited Plaintiff to phone or come in to discuss the matter, which would have given Solis at least the opportunity to explore Plaintiff's situation in more detail and consult with a plastic surgeon by phone or through query feature in e-Consult. Following her email exchange with Solis, Plaintiff did not follow-up on Solis' suggestion to come in to see her or self-refer and also did not pursue an internal Kaiser grievance. Solis had had other patients file a grievance when they were not referred to a specialist and on occasion that led to a referral. Instead of pursuing any of these alternatives, Plaintiff commenced this action in February 2012. Solis testified that in her practice she has followed approximately 20 patients who have had bariatric surgery and that Plaintiff was the only one among them that she recalls having inquired about excess skin removal surgery.

44. After suit was filed, Plaintiff travelled to Ventura and with a friend accompanying her went to see Dr. Michael Pickart ("Pickart"). Pickart charged her $75 for the consultation. The friend was an attorney affiliated with her counsel, and Pickart was initially designated by Plaintiff as an expert witness to testify on her suitability for excess skin removal surgery. Pickart was never called as a trial witness. Plaintiff cites the $75 Pickart consultation fee as evidence of her injury because that fee was higher than the $50 she would have had to pay Kaiser had Solis referred her to a plastic surgeon for a reconstructive surgery evaluation. There is no evidence as to what Plaintiff would have been charged for a consultation with a Kaiser surgeon evaluating

her on a fee-for-service consultation, but presumably the charge would have been at least $50. As discussed further in the context of the MFJ, Kaiser maintains that none of Plaintiff's post-filing costs can be considered with respect to her standing and injury-in-fact arguments on that motion.

45. **Sandra Gonering:** The other Kaiser member called to recount her experiences trying to obtain excess skin removal surgery was Sandra Gonering. Dr. Lane ("Lane") and then Dr. Dasika were her PCPs at SCPMG, and she underwent bariatric surgery at Kaiser in May of 2009. Prior to the surgery she attended classes where she received materials with a FAQs section (Exh. 509) and executed a form acknowledging "Risks Associated With Gastric By-Pass Surgery" ("Risk Form")(Exh. 229). The FAQs section and the Risk Form contain language on the restricted availability of excess skin removal surgery that is consistent with that set forth in the description of SCPMG's written materials described above. Based on her bariatric surgery orientation, Gonering understood at the time that excess skin might result from the surgery but surgical procedures to remove such excess skin were not a covered Kaiser benefit.

46. Gonering was approximately 350 pounds before the surgery and lost around 150 pounds as a result of the procedure. Post-surgery she had excess skin hanging from her arms, two rolls of excess skin on her pannus and excess skin hanging from the legs. In the summer of 2010 she asked Lane about excess skin removal and was told the procedure was not covered. In 2012 she emailed Dasika noting that she had maintained her weight loss and requested a referral to have the excess skin removed. Dasika responded through a nurse that "you need to meet medical criteria to have the skin removed, as it is not routinely covered by Kaiser Permanente." (Exh. 230.) Gonering did not file a grievance but subsequently did explore the possibility of

excess skin removal surgery outside of Kaiser. She did not pursue the latter option because she found it too expensive for her on a non-covered basis.

47. At trial Dasika explained that by "medical criteria" in his email he was referring to the fact that, when he saw Gonering alone or while she was accompanying her husband who was also his patient, he does not recall that she presented with any rash and he understood the RG to require some kind of functional impairment. He identified Exhibit 29 as the then-applicable RG, page 6 of which lists the various criteria, including the recurrent recalcitrant rash requirement and the other restrictions on panniculectomies and other excess skin removal procedures. These are the materials he relied upon in his dealing with Gonering. Dasika recalled that he had about a half dozen post-bariatric surgery patients, and Gonering was the only one he remembers asking about the availability of excess skin removal surgery.

G. KAISER'S MOTION FOR JUDGMENT

48. Kaiser has moved for judgment on the several independent grounds – namely, (a) because her BMI disqualified her from any surgical procedure, Plaintiff failed to prove that she would have received excess skin removal surgery had the SR and RG included some non-functional appearance test; (b) Plaintiff failed to prove that she had an "abnormal structure" so as to qualify for surgery even if there had been some non-functional appearance test; (c) Plaintiff failed to prove that Solis denied her an examination to consider whether she qualified for any surgery procedure; (d) Plaintiff failed to prove a loss of money or property sufficient to support a UCL claim; and (e) there is no present and concrete controversy to support a declaratory relief claim. Each of these is addressed in turn.

49. **Causation and Loss of Money/Property:** Kaiser points to Plaintiff's BMI and increasing weight to argue an alleged failure to prove that "but for" the challenged practice Plaintiff would have received a panniculectomy or any other surgery. Put another way, given her BMI and increasing weight, Kaiser argues that Plaintiff "would [have] suffer[ed] the same harm whether or not defendant [had] complied with [her interpretation of] the law" (*Daro v. Superior Court* (2007) 151 Cal.App.4th 1079, 1098) because other, unchallenged medical criteria disqualified her as a surgical candidate. In this regard, it is important to note that Plaintiff has consistently maintained that she is not challenging these other criteria as, for example, a pretext nor is she contending that the BMI reflected in her medical records is incorrect. Given these concessions, Kaiser believes the "causal connection is broken" between the alleged violation and alleged injury. (*Ibid.*)

50. Plaintiff responds by arguing that Kaiser errs by focusing on the requested surgery as opposed to her request to be evaluated under the proper criteria – an evaluation that might have led to a weight reduction program and ultimately surgery or at least not forced her to pay for the more expensive independent consultation she sought, obtained and paid for after she filed suit. The significance of the latter is not whether that cost was incurred before or after suit was filed but whether under her EOC she had a right to be evaluated under the correct statutory criteria. In making these arguments Plaintiff notes that the post-Proposition 64 case law Kaiser relies on does not impose a high bar but recognizes that the actual injury requirement now embodied in the ULA was enacted to "curtail the prior practice of filing suits on behalf of clients who have not used a defendant's product or service, viewed the defendant's advertising or had any other business dealings with the defendant ..." (*Kwikset Corp. v. Superior Court* (2011) 51 Cal.4th 310, 321.) To satisfy this purpose, the only injury that need be shown is an "identifiable

trifle" (*Sarun v. Dignity Health* (2015) 232 Cal.App.4th 1159, 1169) and certainly in this context that may be met without Plaintiff proving that she ultimately would have been offered a panniculectomy. Kaiser's rejoinder is that she was not denied a consultation, there is no statutory right to evaluation by a plastic surgeon, and in any event Solis may well have referred Plaintiff for a consultation if she had followed up on Solis' invitation to come in and see her.

51. The court agrees that Plaintiff need not prove that Kaiser would have ultimately offered her a panniculectomy but rather that standing, causation and injury may be proven by showing that but for the challenged conduct Plaintiff would have received some economic benefit or avoided some economic cost or burden. Here Solis invited Plaintiff to "self-refer" to the fee-for-service cosmetic surgery department rather than provide a reconstructive plastic surgery referral. In doing so, it is clear that Solis was relying on the RG challenged in this case and specifically the then-existing requirement that there be a rash or other functional problem. Plaintiff accepted that response as consistent with what she had been advised during her bariatric surgery orientation – namely, that if her surgery resulted in excess skin Kaiser would not provide corrective surgery on a covered basis but could offer a cosmetic surgery referral. Thus Plaintiff relied on the challenged orientation materials and her PCP relied on the challenged RG, and but for the challenged provisions in those documents it is fair to infer Plaintiff would have at least been referred to a plastic surgeon and not had to incur the cost of seeing either a Kaiser cosmetic surgeon or an independent plastic surgeon. While the cost of these latter alternatives may not have been significantly higher than the fee for the consultation she was denied, it is an economic loss caused by the challenged practice and sufficient for purposes of showing but-for causation and loss of money or property so as to satisfy the UCL requirement.

52. **The "Abnormal Structure" Issue:** Kaiser argues that the foregoing fails to account for the fact that there is insufficient evidence to find that Plaintiff had an "abnormal structure" – much less one for which surgery could more than minimally improve her appearance. Kaiser is right that Plaintiff did not prove this fact, but again Plaintiff was not required to prove that she ultimately would have received a panniculectomy; there is no way to know that. She might have been rejected because of her BMI; she might have been referred to a weight management program that would have addressed that issue; her surgeon may have set other conditions or described the cost/benefit in a way that would have discouraged her; there are any number of things that might have happened. One of those things would have been an assessment of whether she had the kind of excess skin condition that qualified as an "abnormal structure" – a concept as to which there is some controversy. What is important on this motion, however, is not how that dispute is resolved. Rather what is important is that, because of the challenged rash requirement in the RG, neither a plastic surgeon nor a PCP informed of the correct statutory criteria ever evaluated Plaintiff's excess skin to determine whether or not she qualified for a panniculectomy or other excess skin removal procedure. That is sufficient to meet her burden on a motion for judgment.

53. **Whether Solis Denied a Referral:** As for the argument that Solis did not deny Plaintiff a referral but actually offered her a further consultation, this is also an invitation to speculate on what might have happened. Plaintiff could have engaged in a further email dialogue with Solis, could have come in for a further consultation, could have raised the issue at her next annual physical, or could have continued to press the issue until Solis gave her a referral. Indeed, there is some evidence in this record that Kaiser deals with these kind of referral disputes by having a broad policy limiting referrals but giving PCPs discretion to refer disgruntled members.

That may be a pragmatic business solution; however, if the referral guidelines violate the law – an issue reached later in this Decision – Kaiser cannot defend a challenge to such guidelines by encouraging physicians to refer only those who complain. Here the court finds that (a) Solis, in good faith, in fact relied on the rash requirement in the RG to evaluate Plaintiff's request, (b) in responding to Plaintiff, Solis intended to decline to make a referral on a covered basis because Plaintiff had no complaints of a rash in her records, and (c) Plaintiff reasonably understood Solis' response to be a denial of the requested referral. That Plaintiff might have been able to go in and talk Solis into a different referral decision does not change the decision Solis in fact communicated to Plaintiff.

54. **Present Controversy:** The only remaining issue on the MFJ is Kaiser's argument that there is no present and concrete controversy that would warrant declaratory relief under C.C.P. section 1061. (See, e.g., *Connerly v. Schwarzenegger* (2007) 146 Cal.App.4th 739, 746.) As Kaiser frames its argument, it is basically a reformulation of the preceding ones clothed in terms of declaratory relief rather than the UCL. Thus Kaiser argues there is no present and concrete dispute between the parties because Plaintiff's BMI precludes her from ever qualifying for plastic surgery under the uncontested portions of Kaiser's SG, Plaintiff has no "abnormal structure" within the meaning of the Statute, and Solis never refused a referral and would probably have given her one if she had insisted on it. All of these arguments are addressed above and require no further discussion in this context. While there may be problems with Plaintiff's declaratory relief cause of action, that may be addressed in the remedy context and does not need to be resolved on this motion. The MFJ is DENIED, but as discussed later in this Decision, the cause of action for declaratory relief is problematic and ultimately fails for reasons not raised in the MFJ.

H. THE MOTION TO DECERTIFY THE CLASS

55. Kaiser moves to decertify the class on five grounds: (a) Plaintiff lacks UCL standing because she has not shown injury in fact or any loss of money or property; (b) there was no evidence of a single improper denial much less of a pattern and practice of such denials but instead only an examination of written guidelines; (c) the alleged class is not sufficiently cohesive; (d) there was a failure to show any conduct justifying "final" injunctive relief; and (e) that the class should be decertified as to declaratory relief to the extent Plaintiff seeks a declaration that it breached its contract of coverage with every class member. The first of these arguments is simply a reassertion of those in the MFJ and are adequately addressed in the previous section. The four remaining arguments are addressed below in turn.[6]

56. **Lack of Evidence of Any Denial:** Kaiser's central argument is that there is no evidence of any identifiable post-bariatric patient who medically qualified for excess skin removal surgery but was denied such a procedure by application of a SG that violated the Statute. By way of example, Kaiser points to Plaintiff and Gonering as the two specific patients who testified at trial and the evidence that each of them had a BMI that medically disqualified them from any such procedure. Absent evidence of even a single denial in violation of the Statute, Kaiser argues that a fortiori there cannot be evidence of an actionable class-wide pattern or practice of such denials. Plaintiff's rejoinder is that she has presented evidence of bariatric

[6] Plaintiff objects that this motion is an untimely motion for reconsideration of the original order certifying the class and that it should be denied for lack of any newly discovered evidence or change in law. While there may not be any relevant change in law, there is now an entire trial record, which theoretically could change the certification analysis. It is important, however, to distinguish the dispute on the merits from the issue of class certification. Thus, for example, at trial there might be a failure to prove the alleged unlawful pattern and practice but the question of whether there is such a pattern and practice could still be answered in the negative on a class-wide basis. Revisiting the certification question would only be relevant if the proof of the allegedly unlawful pattern and practice was narrower than the class that was certified – e.g., perhaps the proof was sufficient only for a narrower geographic area than that used initially to certify the class. That may addressed in the remedy context, though, and does not require decertification.

surgery orientations that advise all such patients that all post-surgery excess skin removal procedures are not covered, of RG guidelines that advise PCPs that such procedures are not covered unless there is a functional problem, of SG that also reflect a functional requirement and of PCPs and surgeons who rely on such guidelines in evaluating patients. Plaintiff argues that this is evidence of a pattern and practice susceptible to class-wide adjudication.

57. Without addressing at this juncture whether Plaintiff's evidence is sufficient to prove its case, or whether for Kaiser's conduct to be actionable there must be medically qualified patients who were denied the opportunity for a covered procedure for reasons that violate the Statute, the court agrees with Plaintiff that there is evidence of common patterns and practices sufficient to support class-wide adjudication. Put another way, Kaiser conflates the issue of whether, for example, its various guidelines and bariatric orientation materials violate HS 1367.63 with the issue of whether there are one or more questions that can be answered on a class-wide basis. The former is a merits question, while the latter is the class certification issue. The trial record here does present a set of common practices that can be adjudicated on a class-wide basis.

58. Kaiser argues alternatively that, assuming *arguendo* that there are common practices, there are material differences between TPMG and SCPMG that make it inappropriate to lump the patients of the two medical groups together in one class. While Kaiser is correct that there are differences between the two medical groups, if those differences lead to different merits determinations, then in the context of the merits rulings two subclasses may be recognized and those differences accommodated in the liability or remedy determinations as needed, but the court does not see this as a basis for decertifying the class.

59. **Whether Class Sufficiently Cohesive:** Kaiser's cohesiveness argument is based on the fact that post-bariatric patients present in a variety of circumstances – e.g., some may have a BMI or other medical condition that disqualifies them as surgical candidates, others regain their weight or "relapse" so that the excess skin is only a transitory condition, others choose not to expose themselves to the risk of additional surgery, and of those who remain their excess skin conditions vary substantially. Plaintiff's response is that, if she were seeking as a remedy some form of order that would require Kaiser to provide excess skin removal surgery to everyone in the class or were seeking damages, these differences might present an issue; however, the only relief sought is declaratory relief that the challenged practices are unlawful and an injunction to stop them. Given the scope of relief, Plaintiff cites cases such as *Arce* and *Rodriguez v. Hayes* (9th Cir. 2010) 591 F.3d 1105 to argue that cohesiveness is not an issue.

60. Plaintiff is correct. While not all members of the class may qualify for excess skin removal surgery and many who do may choose not to undergo such a procedure, they all have a common interest in being correctly advised as to the availability of coverage for such procedures and to have their physicians evaluating any request they might make do so under legally correct criteria. Kaiser, of course, maintains that it does advise its bariatric patients in a manner consistent with the Statute, that its RG and SG are compliant and that its physicians have the discretion to use their clinical judgment to do what is best for the patients. These are merit-based defenses, and if Kaiser is correct, it may prevail. However, there are not differences that bear on whether there are questions that can be answered on a class-wide basis. Nor are the interests of class members such that one subset would benefit from a construction of the law or remedy that would be against the interests of another subset. All class members' interests are aligned in benefiting from Kaiser having guidelines and practices that are consistent with the Statute.

61. **"Final Injunction" Argument:** Citing cases such as *Herskowitz v. Apple, Inc.* (N.D. Cal. 2014) 301 F.R.D. 460, 481 - 482, Kaiser argues that Plaintiff is not seeking "final" injunctive relief like a true Rule 23(b)(2) plaintiff but is really seeking damages and that, recast as a damages class action, common issues do not predominate. In *Herskowitz* the plaintiff appeared to seek injunctive relief in a Rule 23(b)(2) class action but the sought-for injunction was to declare an alleged Apple "no refund" policy unlawful so all class members could seek refunds. The trial court denied class certification because the so-called injunctive relief claim was no more than a claim for money damages and, viewed in that light, common issues did not predominate because different putative class members had different grounds for claiming a refund. Thus each class member's claim for damages turned on individualized liability issues rather than a single common theory that Apple had acted or refused to act on grounds that apply generally to the class. Kaiser argues the same logic applies here because Plaintiff seeks a determination that its policies are unlawful so that each class member can pursue a damages action for the cost of the surgical consultation or actual procedure he or she did not receive.

62. Plaintiff counters that this suit is not a merely a predicate for individualized damages but an effort to challenge an allegedly unlawful practice as was successfully done in *Arce*. That one or more class members might subsequently file a damage action does not bring this case within *Herskowitz* where such monetary recoveries were the only practical relief sought. Here the primary relief sought is a change in Kaiser's practices in terms of what it tells its members about coverage in its patient information materials and what physicians are advised regarding coverage in the RG and SG they use. While Plaintiff concedes that she also requests that a notice be sent out to class members advising them of any relief obtained in the case, that

request (discussed further in Part K below) does not make this action a mere predicate for individual damages claims.

63. Again without ruling in this context on the merits of Plaintiff's claims, she is correct that she is challenging the lawfulness of certain practices and in doing so presents a Rule 23(b)(2) form of class action. As in *Arce*, the court can reach the merits of the allegations and, if Plaintiff prevails, various kinds of relief other than monetary damages would be available.

64. **Declaratory Relief re Contract:** Citing cases such as *Newell v. State Farm General Ins. Co.* (2004) 118 Cal.App.4th 1094, 1103, Kaiser claims that Plaintiff is seeking a declaration that it breached the EOC with every class member and that such class-wide declaratory relief on the breach of contract theory is plainly inappropriate. To determine whether an insurance contract has been breached, Kaiser argues that the individual circumstances of each policyholder/ claimant must be examined and class-wide determinations are not possible. Plaintiff's rejoinder is that she is only seeking a declaration that Kaiser has failed to comply with the Statute, which happens to be incorporated by operation of law into each member's EOC. From this one might infer that Plaintiff is not seeking a declaration that Kaiser's practices constitute a breach of each member's EOC. Such an inference would be wrong. In fact in Plaintiff's Opening Post-Trial Brief states that the court should issue a declaration that Kaiser's requirement of a functional impairment, its use of the "covering the mons test," its categorical denial of coverage for certain procedures, and its practice of allowing PCPs to make an initial determination of whether there is an abnormal structure all violate the statute *and constitute a breach of each member's EOC*. (Pl. Op. Br., at 32-33.)

65. The latter form of relief is clearly overbroad and inappropriate on a class-wide basis for all the reasons articulated by Kaiser. By way of example, assume Plaintiff is correct that

Kaiser's "covering the mons test" is a functional requirement rather than an attempt to implement the appearance prong of the Statute. Such a finding would not be tantamount to finding a breach of each class member's EOC. One class member may have had a pannus only partially covering the mons and been offered a surgery but declined it due to the risks involved; another with an "abnormal structure" unrelated to the mons might have had a BMI of 40, told he had to lose more weight by enrolling in a weight management program but chose not to do so; a third may have had a pannus covering the mons but been a smoker and declined to give it up so as to qualify as a surgical candidate. In none of these instances could it be said that their particular EOC was "breached." Simply put, Kaiser's use of surgical criteria that may be found to be too restrictive to satisfy the statutory mandate does not prove that each class member's EOC was breached regardless of other facts bearing on coverage. To determine a contact of coverage was breached, each class member's circumstance would have to be examined at a level of detail that would be impossible on a class basis and was never even attempted in this trial.

66. Having identified a claim or form of relief Plaintiff seeks that is not available on a class-wide basis does not, however, provide a basis to decertify the class. It simply demonstrates that Plaintiff has a theory that is not susceptible to class-wide adjudication and indeed on this record *was never proven*. Rather than provide a basis to decertify the class, this issue would be better framed by a motion for judgment on this theory of Plaintiff's case. Kaiser filed such a motion but did not use it to press this issue. The failure to move on that ground, however, does not mean the objection has somehow been waived. This defect in Plaintiff's declaratory relief claim along with others deficiencies will be addressed in Part K below, but none of these deficiencies provides a basis to decertify the class.

67. For all of the above reasons, the MDC is DENIED; however, that ruling does not preclude the court from narrowing, as appropriate, any liability determination it might eventually make if it determines that Plaintiff has proved her case as to only one region or time period or as to only a subset of her theories.

I. DMHC AND EXHAUSTION/ABSTENTION ISSUES

68. Kaiser raises two distinct issues related to the DMHC. The first is the availability of a DMHC grievance process for health plan members who believe that a plan has improperly denied them coverage, and Kaiser argues that Plaintiff should have exhausted those administrative remedies before filing suit. The second argument relates to the broader oversight exercised by the DMHC and, in this case, the agency's investigation of "Deficiency #4," Kaiser's response thereto and the resulting DMHC report. (Exh. 543.) This latter process leads Kaiser to argue that this court should abstain from ruling on the issues presented and defer to what it characterizes as DMHC's past and continuing oversight of Kaiser's compliance with the Statute.

69. **Exhaustion of Remedies**: The exhaustion argument was raised by Kaiser in *Arce*, and the court rejected it with the following explanation:

> Kaiser asserts that the [DMHC] has established well-defined parallel procedures to address issues of coverage and medical necessity for the members of health care service plans. It is true that, pursuant to the Knox–Keene Act, the DMHC provides an administrative process by which a health care plan member may challenge a denial of coverage. In the DMHC's grievance system, the DMHC determines whether a disputed service is a covered benefit under the health plan contract, and if so, it orders the plan to promptly offer and provide the service to the member. ... If the DMHC determines that a health care plan has denied coverage for a service on the ground that the service is not medically necessary, then the grievance is eligible for review under the agency's Independent Medical Review system. ... In the Independent Medical Review system, medical professional reviewers determine whether a disputed service is medically necessary based on such factors as the specific medical needs of the plan member and the

> medical evidence on the effectiveness of the service.... However, the Knox–Keene Act makes clear that the DMHC grievance system and the Independent Medical Review system are neither required nor exclusive remedies. ... *Thus, notwithstanding the availability of administrative remedies, a private party may still file suit under the UCL for violation of the Mental Health Parity Act.*
> [181 Cal.App.4th at 501-502 (citations omitted; emphasis added).]

The foregoing disposes of any argument in this case that Plaintiff's UCL claim is barred because she did not avail herself of the DMHC grievance system.

70. **Abstention:** The abstention argument was also raised in *Arce*, and there the court explained there were at least three circumstances where abstention might be appropriate. One is where "the lawsuit involves determining complex economic policy, which is best handled by the Legislature or an administrative agency." (*Id.*, at 496.) A second is where a suit seeks equitable remedies and "granting the requested relief would require a trial court to assume the functions of an administrative agency, or to interfere with the functions of an administrative agency." (*Ibid.*) The third is "where 'granting injunctive relief would be unnecessarily burdensome for the trial court to monitor and enforce given the availability of more effective means of redress.'" (*Ibid.*) The second and third instances are, in a sense, opposite sides of the same coin, as the second focuses on the impact of court involvement on the agency, while the third looks to whether the task is one the court can manage given its resources and limited competence. In *Arce* the court found that the Legislature had already made the complex economic policy decisions as to the extent certain treatments should be made available to patients with autism, and, as the case sought only a judicial construction of statutory and contractual terms, there was no danger of the court interfering with the functions of the DMHC or undertaking an unmanageable burden. (*Id.*, at 501.)

71. Here Kaiser argues that, in contrast to *Arce*, all three of the concerns that underlie the abstention doctrine are present. It points to a DMHC survey and report issued on October 3,

2011, which cited as "Deficiency #4" Kaiser's failure "to demonstrate the oversight necessary to ensure that the medical groups provide reconstructive surgery in accordance with the mandatory mandate for coverage" (Exh. 525, at 14), and a follow-up survey dated May 12, 2014, which concluded that that deficiency had been "corrected." (Exh. 543, at 4 & 14.[7]) Kaiser argues that Plaintiff is now trying to probe into exactly what the DMHC investigated and resolved through its surveys that culminated in the 2014 exculpatory report, that that kind of monitoring exercise and cost/benefit assessment is exactly what the agency is better positioned to do, and that it would be unduly burdensome for the court to now venture into the same sort of exercise. Plaintiff's rejoinder is that the trial examination of the DMHC's principal contacts at TPMG and SCPMG – Drs. Glauber and Brookey, respectively – demonstrate how relatively shallow the DMHC inquiry was, and indeed the SG and similar materials admitted into evidence in this case were not even provided to the DMHC. Further, Plaintiff cites *Arce* to argue that abstention does not apply when a UCL action simply seeks a declaration of what the law is, which is a traditional judicial function.

72. In resolving this argument the court returns to the three circumstances where the doctrine has been held to apply. The first concern is not present because, as in *Arce*, the Legislature made the complex economic policy decisions when it enacted HS 1376.63. As for the other two concerns, as long as the court is simply determining whether the SG, RG and various patient materials correctly state the statutory criteria, there is little risk of either interfering with the DMHC or undertaking an unmanageable burden. The latter concerns would arise only if the court went further in fashioning relief so as try to impose detailed measures to implement the appearance prong of HS 1367.63 or to monitor individual doctor/patient interactions to ensure

[7] These DMHC materials were admitted for the non-hearsay purpose of showing the nature and extent of the DMHC oversight in this case and not for the purpose of proving the truth of any assertion made in any DMHC report regarding what Kaiser does or does not do or the extent to which Kaiser does or does not comply with the Statute.

the patient was assessed under the correct statutory criteria. Thus the court concludes that the liability issues presented do not raise abstention concerns; however, if liability is found, the policies underlying the abstention doctrine need to be kept in mind when considering possible remedies.

J. WHETHER KAISER COMPLIED WITH THE STATUTE

73. **Obesity as a Disease:** Kaiser raises as a threshold issue the question of whether obesity is even a "disease." This is significant because the statutory coverage requirements reach only "abnormal structures of the body *caused by* congenital defects, developmental abnormalities, trauma, infection, tumors, or *disease*." (Emphasis added.) If the obesity addressed by bariatric surgery is not a "disease," and no one contends it is caused by congenital defects, developmental abnormalities, trauma,[8] infection or tumors, then the excess skin afflicting post-bariatric patients would not fall within the statutory definition of reconstructive surgery. This is true even if one were to view such excess skin as an "abnormal structure of the body." To trigger the statute coverage requirement Kaiser argues that Plaintiff must first prove that obesity is a "disease" within the meaning of the Statute.

74. Kaiser's position is puzzling in one respect – namely, it is uncontested that, in assessing whether post-bariatric patients qualify for excess skin removal surgery, Kaiser has *never* considered whether such patient's previous obesity was caused by a disease or itself was a disease. Put another way, when post-bariatric patients presented to a medical group physician with a hanging pannus, the decision to perform a panniculectomy or not turned on (a) medical criteria such as BMI and (b) functional issues such as the presence of a rash; no one otherwise

[8] Query whether the bariatric surgery itself constitutes a "trauma" so as to provide the statutory nexus. This line of analysis was not addressed by either party.

qualifying for a panniculectomy was ever denied one because their pre-bariatric obesity was neither a disease nor caused by a disease. Nevertheless, Kaiser maintains that a prerequisite to any coverage analysis is the question of whether obesity is or is not a "disease." If Plaintiff has failed to prove that fact, then as a matter of law Kaiser argues there can be no pattern or practice of denying reconstructive surgery to post-bariatric patients *in violation of the Statute.*

75. Kaiser called as a witness Dr. Jack Der-Sarkissian ("Der-Sarkissian"), a PCP practicing with SCPMG in Los Angeles, who is SCPMG's regional lead for adult weight management and has considerable expertise on obesity issues. He described the "classes" of obesity, which are tied to BMI (e.g., class 1 obesity equates to a BMI between 30 and 34.9), and explained the concept of "comorbitities" – that is, conditions or diseases that are often co-existent with obesity such as type 2 diabetes. If obesity is defined in terms of BMI, he explained why obesity using that definition would not in his opinion be a disease. (TR 969:1 – 970:6.) He admitted, however, that others disagreed and characterized himself as a "contrarian" on the issue compared to the positions of the American Medical Association, the American Board of Obesity Medicine, the American Heart Association and several other professional groups. (TR 1026:3 – 1028:16.)

76. The other evidence on this issue comes from Dr. Brookey. He testified that the issue of whether obesity is a disease came up in the context of his interactions with the DMHC in his capacity as Kaiser's PPA for SCPMG, that DMHC and Kaiser disagreed on whether obesity is a disease for purposes of the Statute, and that as part of the resolution of Deficiency #4 Kaiser agreed to accept obesity as a disease for purpose of the applying the Statute. (TR 1320:17 – 1321:18, 1325:1-25.) Given the general weight of professional opinion on the subject as acknowledged by Der-Sarkissian and Kaiser's agreement with the DMHC that it would treat

obesity as a disease for purposes of applying HS 1367.63, the court finds that to the extent this is an element of Plaintiff's case, it has been established.

77. **Coverage Compliance:** For the period prior to mid-2014, it is clear (a) that Kaiser's two affiliated medical groups in California maintained and followed policies and practices regarding the availability of excess skin removal procedures on a covered basis that were more restrictive than the statutory mandate and (b) that an even more restrictive policy regarding coverage was communicated to bariatric surgery candidates in orientation classes and materials. It is also clear (c) that the patients relied on the information communicated to them in forming their expectations of what procedures would be available to them after surgery, (d) that PCPs relied on the RG in deciding when to refer a patient for a reconstructive surgery consultation, and (e) that plastics surgeons relied upon the SG when deciding if a patients was a candidate for reconstructive as opposed to a cosmetic procedure. (f) The results were that fewer patients inquired about the availability of reconstructive surgery for excess skin resulting from massive weight loss, fewer patients were referred to a plastic surgeon for an evaluation of their excess skin condition and perhaps fewer excess skin removal procedures were performed on a covered basis than would otherwise have been the case. The foregoing are all findings of the court on this evidentiary record.

78. That said, there are a number of things that are less clear. It is unclear, indeed most likely unknowable, how many Kaiser members qualified under all the relevant criteria for an excess skin removal procedure but did not receive one because of the non-compliant policies and practices recounted above. It is also unclear whether the changes undertaken in the two medical groups during the past two years have had any appreciable impact on the relevant patient population(s) because, while improvements in materials and guidelines have been made in both

geographic areas, neither region's materials and guidelines are fully compliant. The SCPMG has dropped the rash requirement for panniculectomies but substituted an objective standard that may simply be a marker for a likely physical impairment, and it has not done anything to address the appearance prong of the Statute with regard to procedures other than panniculectomies. TPMG has guidelines that admit the possibility that procedures other than panniculectomies may be reconstructive but until recently they, too, were tied to functional impairments. A Smart Phrase tool has been introduced to call the attention of surgeons to the statutory standards, but until trial the underlying SG and RG were not fully compliant. As explained earlier, near the end of the trial Kaiser offered previously undisclosed exhibits and elicited testimony of recent changes showing an effort to achieve compliance; however, on this record the court finds that, while significant progress has been made, full compliance is still a work in progress.

79. Kaiser argues that the foregoing conclusion regarding the materials and guidelines used by the two medical is not the same as finding that "Kaiser has violated the UCL by systematically refusing to comply with section 1367.63 for all bariatric patients who need or may need excess skin removal" as alleged in paragraph 20 of the Complaint. To make the latter finding, Kaiser argues there would need to be evidence that post-bariatric patients who were medically qualified for such procedures, presented with an "abnormal structure" that could be more than minimally improved through surgery, wanted such surgical procedure(s) and were nonetheless denied such procedure(s) on a covered basis. No such individuals are identified in this record. The court concludes that for purposes of a UCL and/or declaratory relief action it is sufficient that a Rule 23(b)(2) class plaintiff show that Kaiser has coverage policies and practices that are inconsistent with the statutory mandate, that those policies and practices dissuade persons who may qualify for such covered services from pursuing them and that there is a still

controversy as to whether Kaiser's policies and practices are facially compliant or not. Plaintiff has made this showing.[9]

80. **Responsibility of Kaiser vs. Medical Groups:** Kaiser argues that the foregoing conclusion overlooks the role of the medical groups and their physicians who, even prior to the changes of the past two years, had the discretion to use their clinical judgment to address any unusual or "abnormal" condition, and there is no evidence that, in the rare instances such a patient presented himself or herself, there was any failure to provide a surgical consultation or offer an appropriate procedure on a covered basis to an otherwise qualified candidate. Further, Kaiser argues that what Plaintiff is really dissatisfied with, and trying to challenge in this case, is the clinical judgments of Plan physicians regarding their assessments of the suitability of different patients for particular procedures. Indeed, it argues that the whole purpose of the Katzen testimony was to challenge the clinical judgments of the TPMG and SCPMG plastic surgeons as to what is or is not an "abnormal structure" for which reconstructive surgery is an appropriate remedy. In Kaiser's view, to allow Plaintiff to use this case for that purpose goes way beyond the competence of judiciary, is unworkable on a class-wide basis and would improperly charge Kaiser with responsibility for the clinical judgments of medical group physicians.

81. With respect to Kaiser's responsibility for the decisions and actions of the medical groups and their physicians, it is apparent from the Medical Service Agreements ("MSAs") Kaiser has with TPMG (Exh. 198) and with SCPMG (Exh. 197) that the medical groups are

[9] Further, with respect to Kaiser's argument that the Statute is only violated if Kaiser actually denies coverage to a specific patient who proves he or she qualified for and requested a specific reconstructive surgical procedure, that "merely misrepresenting" the statutory coverage mandate is not "illegal," and thus a claim pled only in terms of the "unlawful prong" of the UCL cannot be sustained based on such misrepresentations – if that is Kaiser's actual position – then it is beyond cavil that such conduct would violate the "unfair prong" of the UCL. If Plaintiff were to request leave to amend to conform to proof, *that motion would be granted.*

solely responsible for the provision of medical services in accordance with the membership agreements and the professionally recognized standard of care. (E.g., Exh. 198, at 9.) However, there is a clear division of responsibility when it comes to interpreting the membership agreements. Kaiser and each medical group are obligated to meet and confer on all interpretation issues with (a) the medical group retaining final authority on questions primarily relating to "questions of a medical nature or relating primarily to physician-patients relationships or to the professional and ethical obligations of physicians" and (b) Kaiser retaining final authority on all other issues. (*Id.*, at 44.) In the context of this case, these distinctions mean that the PCPs are solely responsible for their clinical judgments regarding whom to refer to a plastic surgeon and the latter are solely responsible for their clinical judgments as to which patients are suitable surgical candidates. Kaiser, on the other hand, has final responsibility for coverage decisions, e.g., whether an otherwise medically qualified patient is entitled to have his or her surgery treated as reconstructive or cosmetic under the Statute.

82. To the extent Plaintiff would challenge in this action a Plan physician's decision on whether or not to perform a particular excess skin removal procedure on her, she has the wrong defendant; however, to the extent she seeks to challenge the *coverage criteria* for such surgeries as reflected in surgical orientation classes and materials, RG and SG and the like, she has the right defendant. It is Kaiser's responsibility to oversee the communications to members as to what procedures are or are not covered and, specifically in this case, that the coverage criteria stated in the Statute is accurately communicated to both members and physicians. This responsibility is not only reflected in the MSA but also was clearly established through the testimony of Deborah Espinal, Kaiser's Executive Director of Health Plan Policy, who described the role of her group in overseeing such communications and ensuring that they correctly state

Kaiser's position on coverage. (TR 1793:24 – 1796:21.) And while the SG fall principally within the medical groups' sphere of responsibility, to the extent they, in effect, reflect coverage positions, Kaiser has a responsibility to make sure any statement therein is in compliance with the Statute. Indeed, DMHC's Deficiency #4 addressed this very issue, and Kaiser designated a PPA for each group whose job it was to make sure the physicians in the medical groups were aware of the statutory criteria.

83. In sum, while Plaintiff may disagree with the views of various Plan surgeons as to what is or is not an "abnormal structure" that may be appropriately corrected through surgery – with one possible exception noted below – Plaintiff has not invited the court into that controversy, and the case as pled is limited to certain discrete coverage issues. The court can address those coverage issues without delving into the clinical judgments of the medical group physicians, and Kaiser cannot avoid its responsibilities regarding coverage by pointing to the separate and distinct role of the Plan physicians in delivering medical care. The latter are simply not raised by the pleadings as interpreted during the course of this case and, even if they were, would not be susceptible to class-wide adjudication.

84. **The "Pannus Covering the Mons" Standard:** The possible exception to the court's characterization of Plaintiff's claims is her attack on the use of the "pannus covering the mons" standard as an indicator of when a panniculectomy may qualify as reconstructive surgery. In Plaintiff's view, while Kaiser characterizes this as an appearance standard, it is in fact functional because Dr. Tan and others view a pannus of that length as typically causing functional problems. While that is a fair inference, it does not mean that the use of that standard violates the statutory mandate. That mandate defines reconstructive surgery using alternative functional and nonfunctional criteria. Because Kaiser uses the covering-the-mons standard and

Plaintiff does not dispute that a pannus of that length would indicate reconstructive surgery, it is a valid test whether it is viewed as an appearance-based standard or merely a marker that there is a functional impairment.

85. What Plaintiff is really challenging in her criticism of the covering-the-mons standard is the notion that that is the *only* appearance condition that may justify a reconstructive procedure to address an excess skin condition. The court agrees with Plaintiff that, were Kaiser to promulgate a coverage rule stating that the second prong of the statutory mandate is *only* met when a patient presents with a pannus of a certain length, then that would be too narrow to satisfy the statutory mandate. There are other conditions that even the Kaiser surgeons agree would constitute an "abnormal structure" warranting reconstructive surgery (e.g., the W-shaped mons). It is not for the court, however, to wade into the debate of if-and-how all "abnormal" excess skin "structures" can be objectively defined. Indeed, it would appear that all plastic surgeons agree that given the wide range of possible structures, no such definition is even possible. But the need for a broader statement of the statutory mandate (already addressed above) does not mean that Kaiser cannot use the covering-the-mons test as an example or a part of whatever coverage criteria it ultimately adopts.

86. **The PCP vs. Surgeon Issue:** In addition to challenging the coverage positions in the patient materials and various guidelines used by medical group physicians, Plaintiff challenges the practice of allowing PCPs to decide whether or not to refer a patient to a plastic surgeon for evaluation of whether the patient has an abnormal structure that can be more than minimally improved by surgery. The challenge is based on HS 1367.63(e), which states in relevant part:

> In interpreting the definition of reconstructive surgery, a health care service plan may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following:
> ...
> (2) Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care *as practiced by physicians specializing in reconstructive surgery*, offer only a minimal improvement in the appearance of the enrollee.
> [Emphasis added.]

Plaintiff argues that this language requires plastic surgeons rather than PCPs to make the judgment regarding whether the patient has an abnormal structure that can be more than minimally improved by surgery. She also cites to Katzen's testimony that it takes the expertise of a plastic surgeon to make the kind of assessment required by the Statute.

87. Kaiser points out that the language Plaintiff relies on applies on its face only to how health plans implement "prior authorization and utilization review" processes and was never meant to regulate how a primary care physician interacts with his or her patients or surgical colleagues. Rather, Kaiser argues, subsection (b) is the relevant provision: "No individual, other than a *licensed physician competent to evaluate the specific clinical issues* involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section." (Emphasis added.) Kaiser argues that PCPs fall within this statutory language and are clearly competent to apply whatever SG the medical group may adopt. To the extent a PCP believes that he or she can render a judgment, needs to consult with a surgeon or simply elects to refer a patient to a plastic surgeon are all matters left to the physician's exercise of clinical judgment.

88. The court agrees with Kaiser that it would be a considerable reach to find a statutory requirement that all patients with excess skin complaints be referred to a plastic surgeon under all circumstances. There are a wide range of circumstances that may be presented by a

patient with excess skin, and one cannot say that all of them need a consultation with a plastic surgeon. Moreover, there are many ways PCPs can access the expertise of surgeons without referring every possible reconstructive surgical candidate to a plastic surgeon – e.g., email, a phone call or an e-Consult inquiry. While there certainly may be some cases where a plastic surgeon's expertise may be required to apply the statutory criteria, Plaintiff's argument does not distinguish between the easy and the hard cases. In addition, the PCPs who testified in this case all presented as very competent professionals concerned with their patient's well-being. When there was a decision not to refer a patient, it was because they consulted and relied upon a clear prohibition in the surgical criteria – typically, the requirement that the patient have a rash or other physical impairment. The court has no doubt that, if the PCPs are provided with compliant RG, they can apply them as written and will consult with a plastic surgeon where such expertise is needed.

89. For the foregoing reasons, the court rejects Plaintiff's UCL claim to the extent she seeks a finding that HS 1367.63 requires post-bariatric patients with excess skin who are interested in possible surgical solutions to be referred by their PCPs to a plastic surgeon. The Statute does not require that, there is no evidence to suggest such a requirement is needed to cure any abuse, and such remedies would draw the court into monitoring the interactions of physicians and patients in the clinical setting. The latter is a bridge too far.

90. **Conclusions:** Plaintiff has proven and the court finds that Kaiser's coverage positions as communicated to members and medical group physicians are not compliant with the statutory mandate that excess skin removal procedures be made available on a covered basis (that is, as reconstructive surgery) when such procedures would improve function *or* address an abnormal structure so as to create a more normal appearance to the extent possible. On the other

hand, Plaintiff has failed to prove that Kaiser has violated the Statute by allowing use of a covering-the-mons standard as an indicator of when a panniculectomy may qualify as a reconstructive (covered) procedure. Plaintiff has also failed to prove that Kaiser has violated the Statute by not requiring that the PCPs in its medical groups refer all patients with post-bariatric excess skin issues to a plastic surgeon for an evaluation of their condition in light of the appearance prong of the Statute. These conclusions support a finding of liability on one of Plaintiff's UCL theories, and in the next section the court will address the appropriate remedy. As for Plaintiff's declaratory relief cause of action, it presents difficulties that are best addressed in the remedy discussion that follows.

K. REMEDIES

91. Given the court's liability determinations, it is clear where the court need not go in terms of remedies. There is no need to address the circumstances that would appropriately lead a PCP to refer a patient to a plastic surgeon for a consultation. There is no evidentiary or legal basis for the court to chime in on the issue of what is or is not an "abnormal structure of the body" or one that may be more than minimally improved by surgical procedures. Whatever could be said on such matters cannot be framed on a class-wide basis. Accordingly, the court's only concern is with the statements regarding *coverage* in materials and classes for bariatric surgical candidates, in the RG and other resources available to the PCPs and in the SG and other materials used by plastic surgeons. Much has already been done in this regard. For example, the introduction of the Smart Phrase tool is a positive step for the plastic surgeons, but the deployment of that tool is not a substitute for removing incorrect coverage statements from SG and RG – e.g., any statements that make a particular excess skin removal procedure "cosmetic"

without exception. How all of these materials are brought into compliance is a matter the court would rather leave to the parties. The court will not micromanage the solution or assume the drafting role, but the court will insist that incorrect statements regarding coverage be corrected or removed. Thus the court will not approve unqualified statements to the effect that a particular excess skin removal procedure is always "cosmetic."

92. In reaching these conclusions, the court has considered Kaiser's argument that an injunction is not needed because the DMHC has already addressed these issues and any remaining instances of non-compliance have been resolved by Kaiser's efforts up to and including trial. While the court does have discretion to deny injunctive relief in various circumstances, this is not an appropriate case to exercise such discretion for the benefit of Defendant. The DMHC identified Deficiency #4 in *2011*, and it took Kaiser *three years* to satisfy the DMHC, and even then Plaintiff has shown Kaiser's efforts fell short of full compliance. Rather it took the actual commencement of trial to move Kaiser to address the additional issues raised by Plaintiff. Under such circumstances, it is unfortunate that an order is required to ensure full compliance with the statutory mandate, but one is indeed required.

93. As for Plaintiff's request that notice be sent to all class members or at least all current Kaiser members who have undergone bariatric surgery, the court is reluctant to require that. It is clear to the court that many of these individuals would not be candidates for the procedures in question because their BMI is too high, they have some other disqualifying condition, or the cost/benefit analysis would indicate the procedure is not appropriate. The court does not want to see the expectations of this population unduly raised, a flood of requests come in for a consultation and then the vast majority of the persons so contacted turned away for one bona fide reason or another. It would be appropriate, however, to send a notice to all PCPs about

the change in criteria, direct them to be alert for patients of theirs with excess skin conditions and request that they discuss the revised criteria with such patients. The court has no doubt that the PCPs would take such a directive seriously and discharge their clinical obligations in accordance with an accurate statement of the statutory mandate.

94. Thus with respect to the injunctive relief requested under the UCL cause of action, the court rules that Kaiser is required (a) to review for compliance all of its bariatric patient materials, all the medical group RG and SG and all internal and external webpages, (b) to use its best efforts to modify those that still have the shortcomings described above, (c) to file monthly compliance reports detailing its efforts until it can represent that all non-compliant materials have been corrected and attach copies of the corrected versions, (d) to have its medical groups disseminate to their PCPs and plastic surgeons the new RG and SG once they are finalized, and (e) to provide a cover letter to the PCPs that they should review these new materials with any post-bariatric patient who presents him or herself with excess skin problems. The first compliance report shall be filed and served 30 days after this Decision becomes final. The court would hope that full compliance could be achieved within three months.

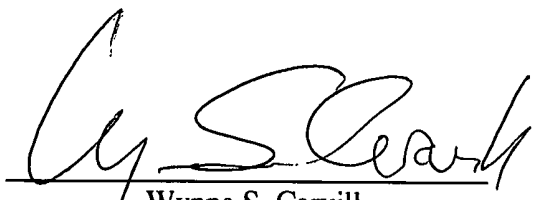
95. As for the cause of action for declaratory relief, it fails – but not for the reasons raised in the MFJ. To begin with, to the extent it seeks a class-wide declaration that each member's EOC has been breached, Plaintiff failed to prove that case, and indeed, for the reasons discussed above in Part H, it is hard to see how that case could be proven on a class-wide basis. More fundamentally, though, once the coverage issues are addressed in the context of the UCL request for injunctive relief, there is no remaining "controversy" that would justify a declaration of the respective rights and duties of the parties. (*General of America Ins. Co. v. Lilly* (1968) 258 Cal.App.2d 465, 470 ["The object of the statute is to afford a new form of relief where needed

and not to furnish a litigant with a second cause of action for the determination of identical issues"].) Put another way, the gravamen of the complaint attacks Kaiser's failure to communicate the statutory coverage mandate to members and physicians; once that problem has been addressed through an injunctive remedy, no further relief is required. The request for declaratory relief is thus DENIED, and that cause of action is DISMISSED.

96. The parties are ORDERED to meet and confer on Plaintiff's request for an award of reasonable attorneys' fees and costs of suit. If they cannot reach agreement, Plaintiff may apply for same as allowed by law. The parties are further ORDERED to meet and confer on a form of judgment containing the terms set forth above and submit same to this court within ten days of this Decision becoming final. A Case Management Conference is set for 8:45 a.m. on September 10, 2015, to determine the status of the case, including any outstanding motions or disputes. File a joint CMC statement 5 court days in advance outlining any such remaining issues and the parties' agreed or competing proposal(s) on how to proceed.

IT IS SO ORDERED.

Dated: July 15, 2015



Wynne S. Carvill
Judge of the Superior Court

Superior Court of California
Alameda County

Case # RG12 616206
Case Name: Gallimore vs. Kaiser
Document: Tentative Ruling and Proposed Statement of Decision

CLERK'S CERTIFICATE OF SERVICE

I certify that the following is true and correct:

I am a Deputy Clerk employed by the Superior Court of California, County of Alameda. I am over the age of 18 years. My business address is 1221 Oak St. Oakland, California. I served this **Tentative Ruling and Proposed Statement of Decision** by:

☐ **First Class Mail (CCP 1013a)** - Placing copies in envelope(s) addressed as shown below and then by sealing and placing them for collection, stamping or metering with prepaid postage, and mailing on the date stated below, in the United States mail in Oakland, California, following standard court practices.

☒ **Electronic Service (CCP1010.6(C)(3) CRC 2.251(j))** - Emailing copies to the email addresses as shown below, following standard court practices.

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Date: 07/15/15

Leah T. Wilson
Executive Officer/Clerk of the Superior Court

By _____
Kimberly McCoy, Deputy Clerk