

12-9-2013

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Recommended Citation

Frankel, Adam S. "California Health Insurance Law Opens the Floodgates for a Potentially Unsustainable Amount of Plastic Surgeries: What Went Wrong and How to Fix It." *Health Law & Policy Brief* 3, no. 1 (2009): 37-47.

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CALIFORNIA HEALTH INSURANCE LAW OPENS THE FLOODGATES FOR A POTENTIALLY UNSUSTAINABLE AMOUNT OF PLASTIC SURGERIES: WHAT WENT WRONG AND HOW TO FIX IT

*Adam S. Frankel**

I. Introduction

In 1998, after a contentious debate, California became the only state to enact a health care statute broadly mandating insurers to reimburse all surgical procedures that fall within its definition of “reconstructive surgery.”¹ There are two pending class action lawsuits alleging that two large insurers are in violation of the California statute by failing to cover certain surgical procedures within its definition of “reconstructive surgery.”²

Under the current California statute, health care service plans are mandated to reimburse a much greater spectrum of surgeries, including non-medically necessary surgical procedures with the sole purpose of creating an aesthetically “normal appearance.”³ The plaintiffs in the two suits claim the insurers are in violation of the statute by applying a blanket policy of denying reimbursement for all reconstructive surgery claims to remove excess skin following weight loss due to bariatric surgery (a broad term including gastric bypass surgery), a treatment for morbid obesity.⁴ This surgical procedure highlights the statute’s impermissibly ambiguous construction and illustrates how a common and costly surgery, not falling precisely into the statute’s broad definition of reconstructive surgery, is causing conflicts between patients and insurers over what procedures are eligible for insurance coverage.⁵

This article argues that the California legislature delegated an improper amount of discretionary authority to the Department of Managed Health Care (DMHC), the administrative agency tasked to enforce this statute, by allowing unelected agency officials to unconstitutionally exercise legislative power. By failing to draft more instructive standards for the agency to follow, the California statute violates the nondelegation doctrine by assigning legislative lawmaking power to an administrative agency.

Part II details the difference between reconstructive and cosmetic surgery, outlines the contentious debate over passing the California law, notes the claims made in the first significant pending class action suits brought under the statute’s provision defining reconstructive surgery, and introduces the nondelegation doctrine as a method of challenging the constitutionality of overly broad delegations of legislative power. Part III argues that the California statute is unconstitutional for violating the nondelegation doctrine. Part IV suggests several policy recommendations for future health care statutes, and more specifically, recommends that future healthcare statutes not broadly and ambiguously mandate insurance coverage for an expansive class of surgeries and instead, narrowly target the eligible individuals like the Federal Women’s Health and Cancer Rights Act of 1998 (WHCRA). The article concludes that the California statute should either be constitutionally challenged because of its impermissibly ambiguous delegation of lawmaking power or amended to allow greater predictability and guidance for the DMHC to follow.

II. Background

A. The Difference Between Reconstructive and Cosmetic Surgery

As surgical procedures become increasingly common avenues of patient treatment regimes and the cost of health care concurrently rises, an inevitable conflict arises between the insurers and patients as to what procedures should elicit insurance coverage.⁶ The American Medical Association (AMA) defines cosmetic surgery, not covered under most insurance policies, as surgery “performed to reshape normal structures of the body in order to improve the patient’s appearance and self-esteem.”⁷ The AMA defines reconstructive surgery as surgery “performed on abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease” and is “generally performed to improve function, but may also be done to approximate a normal appearance.”⁸ The California statute’s definition of reconstructive surgery and cosmetic surgery closely parallels the

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AMA's respective definitions.⁹ However, the statute, like the AMA's definition, does not define the meaning of several provisions. Prior to the enactment of the California statute, insurance companies only covered medically necessary procedures. By adopting a standard that allows non-medically necessary procedures for the purpose of creating a "normal appearance," the current law mandates insurers to cover an increasingly large amount of surgeries.¹⁰

When certain surgical treatments create other conditions that might not functionally impair the patient, problems arise as to the necessary conditions that must be present to receive additional coverage.¹¹ Given the increasing number of obese Americans, a significant issue for insurers nationwide is whether the surgical removal of excess skin following bariatric surgery for obesity is a covered procedure.¹²

Bariatric surgery, which includes gastric bypass surgery, is now a common treatment option for the disease of obesity.¹³ As a result of this increase in the surgery's popularity as well as its improved safety and efficacy, more patients are seeking insurance reimbursement for excess skin removal, claiming the excision of the skin that fails to contract following bariatric surgery is a reconstructive and not a cosmetic procedure.¹⁴

A problem arises with classifying this surgery as reconstructive under the statute's definition because the excess skin is not caused by a "disease" itself, but rather indirectly by the surgical procedure treating the disease of obesity.¹⁵ Thus, the lawmaker's legislative intent as to whether a disease causes the excess skin is unclear given the statute's nebulous language.¹⁶ Under the current California statute, in order to warrant insurance coverage for the reconstructive skin excision surgery following bariatric surgery, the excess skin must be both an abnormal structure of the body caused by a disease and must either improve function or create a normal appearance, to the extent possible.¹⁷

B. The Contentious Debate Over the California Law

California is the only state with a law both defining cosmetic and reconstructive surgery and mandating every health care service plan to cover what it defines as "reconstructive surgery."¹⁸ Prior to the current law's enactment, health care service plans that included hospital or surgical benefits covered reconstructive surgery for the purpose of restoring function, but not purely to restore normal appearance as the current law does.¹⁹

The California Society of Plastic Surgeons (CSPS) lobbied for legislation, citing instances when insurance companies would deny coverage for surgery that would correct physical deformities in patients, often children.²⁰ The insurers claimed these surgeries were not medically necessary because a person could continue to normally function without undergoing the procedure.²¹

During the legislative debate over this law, an eclectic body of interest groups expressed opinions.²² Advocates for the bill favored broad coverage of surgeries, stating that insurers should not have the ability to deny coverage of reconstructive surgery to repair physical abnormalities.²³ Advocates were concerned with the trend among insurers to employ cost-cutting measures that they believed negatively affected patient care.²⁴ Other supporters believed that denying coverage for physical abnormalities may also have a negative psychological impact on the patient.²⁵

Opponents of the legislation argued that the bill created an ambiguous order that is extremely difficult to implement.²⁶ Further, opponents believed that this legislation would make reconstructive surgery susceptible to fraud and would cost an inordinate amount of resources to implement and maintain.²⁷

C. An Overview of the Pending California Cases Regarding Health & Safety Code § 1367.63

The two pending class action lawsuits brought under Section 1367.63 of the California statute are before the Superior Court for the County of Los Angeles.²⁸ The plaintiffs are making identical claims against two large insurance companies.²⁹ Of the two suits, *Cox v. Health Net of California, Inc.* is further along in litigation so it is the focus of this article's examination.³⁰

The first cause of action against the insurers is for breaching their health plan contracts in violation of Section 1367.63 by applying a policy of denying all claims for the reconstructive surgery of excess skin following weight loss from bariatric surgery.³¹ The second cause of action is for violating the Unfair Competition Law (UCL).³²

Although it is uncertain whether these suits will make it to trial, they serve as the first precedents for litigating under this sweeping provision of the statute.³³ In the event that these cases make it to trial and the court interprets the meaning of Section 1367.63, the court will likely have difficulty interpreting and applying the statute's language to specific procedures in determining whether they are reconstructive.³⁴

D. Overview of the Nondelegation Doctrine

The nondelegation doctrine is a constitutionally rooted separation of powers principle that prevents the legislature from delegating legislative power to another branch of government.³⁵ However, beginning in the twentieth century, legislatures at the state and federal level began delegating broad discretionary authority to unelected administrative agencies to regulate complex areas that exceeded the capacity of lawmakers' expertise and was limited by time restraints.³⁶ As a result of lawmakers' lack of specialized expertise in highly technical areas, legislators write laws deciding the fundamental policy choices, while leaving the agency discretion to craft and implement effective and efficient regulatory laws.³⁷

Notably, the legislature cannot constitutionally vest limitless and ill-defined authority to the administrative agencies and must provide a framework of guiding principles for the agency to follow.³⁸ This doctrine forces a politically accountable legislature to make policy choices as opposed to appointed administrative officials.³⁹ The Supreme Court in the modern era has rejected this doctrine and in over sixty years has upheld all delegations, no matter how broad, as proper delegations of authority.⁴⁰

The Supreme Court's nondelegation jurisprudence states that Congress must provide "intelligible principles" in order to guide agencies' exercise of their discretionary authority.⁴¹ By not striking down extremely broad regulatory statutes, the Court has signaled its approval of delegating great discretionary regulatory authority in areas of complex expertise, and also that the Court, like Congress, is ill-equipped to draw the appropriate lines.⁴² In *Mistretta v. United States*, Justice Scalia, the only modern advocate of the doctrine sitting on the Court, argued in sole dissent that Congress' delegation

was improper because the U.S. Sentencing Commission possessed broad discretion to make “value judgments and policy assessments.”⁴³ Further, the Court has held it unconstitutional for Congress to transfer legislative functions without imposing procedural safeguards curbing illegitimate exercises of discretionary authority.⁴⁴

The WHCRA is both an example of a constitutional delegation of regulatory power and an instructive paradigm for statutorily mandating insurance coverage for a specific surgical procedure meant to produce aesthetic normality by applying well-defined objective standards not susceptible to impermissibly flexible administrative interpretations.

E. The Federal Women’s Health and Cancer Rights Act of 1998

The WHCRA mandates insurance coverage for all stages of breast reconstruction for individuals receiving benefits for medically necessary mastectomies.⁴⁵ This coverage extends to surgical procedures solely meant to produce symmetrical appearance, an aesthetic criterion.⁴⁶ Additionally, this law does not equate to unrestricted coverage based on a subjective, autonomous decision by the patient.⁴⁷ This law, narrowly tailored in its purpose, carefully defines the individuals it seeks to cover and does not broadly mandate coverage for a general area of surgery.⁴⁸

III. Analysis

Despite the reluctance of the judiciary to accept the application of the nondelegation doctrine, California courts should hear a challenge applying the doctrine to the California statute. Although the pending lawsuits are not facial challenges to the law’s constitutionality, they may interpret the meaning of “reconstructive surgery” and serve as the first examples of litigation to guide future challenges made under the poorly crafted § 1367.63.⁴⁹

A. The Pending Class Action Suits Serve as Guideposts for Litigating Under the California Statute

The main issue the court must resolve is whether judicial review is currently proper for this case.⁵⁰ Health Net, the Defendant insurer, correctly argues that the DMHC has exclusive jurisdiction over this action because the plaintiff’s claims call for the determination of Health Net’s regulatory compliance with a provision in the Knox-Keene Act.⁵¹ The court in *Schmidt v. Foundation Health* expressed concern noting that when a legislature intends an agency to occupy “completely the field of health service plans,” one must be cautious of any intrusion into the agency’s function by seeking remedies in other venues.⁵² Although the statute is silent on this issue, California case law suggests an individual should have a private right of action in this circumstance.⁵³

Although Health Net acknowledges that individuals can sue for acts made unlawful by the Knox-Keene Act, it narrowly reads the act and emphasizes that the law does not specifically outlaw having a policy of refusing to cover the surgical removal of excess skin following weight loss due to bariatric surgery for morbid obesity.⁵⁴ Although this plain meaning reading is persuasive, a court will likely follow *Samura v. Kaiser Foundation Health Plan* and read the statute to allow a private right of action because Health Net is accused of the unlawful act of violating § 1367.63 by refusing to cover a surgery falling under its mandate.⁵⁵

Even though a private right of action likely exists, the court will probably not issue a ruling on the legal meaning of “reconstructive surgery” until the DMHC completes its non-routine survey examining Health Net’s statutory compliance as the judicial trend gives deference to the expertise of the agency.⁵⁶

Health Net properly invokes the doctrines of judicial abstention and California’s primary jurisdiction doctrine in their defense.⁵⁷ Employing these legal theories frames the legal debate as a regulatory issue not currently ripe for judicial review.

i. Judicial Abstention is Proper Because the Unique Circumstances of Each Plaintiff’s Request is Best Handled by the Statutorily Empowered DMHC

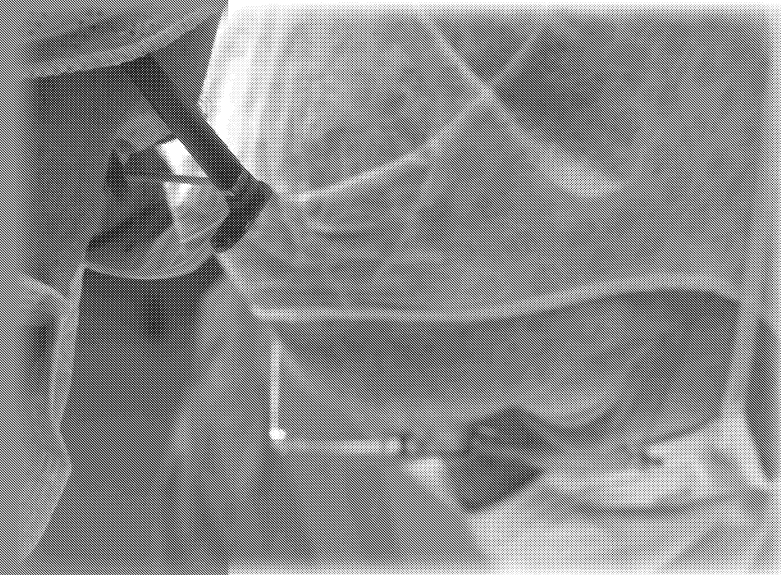
Judicial abstention is proper for this suit because the coverage requests made by each plaintiff within the class action are unique to the facts and circumstances of each request and are most appropriate for the DMHC, experts in health care and tasked to enforce compliance with the statute, to initially determine the insurer’s regulatory compliance.⁵⁸ Similar to *Alvarado v. Selma Convalescent Hospital*, where the court affirmed the trial court’s demurrer to a class action lawsuit that alleged a skilled nursing facility did not adequately provide care for residents, the claims made against Health Net involve complex health care matters where judicial involvement would assume the regulatory function of the agency.⁵⁹

Due to the variety of individual patient pathologies represented in this class action suit and the complex economic and health care implications of issuing broad declaratory and injunctive relief requiring Health Net to cease its alleged ‘blanket policy’ and to ‘review’ or ‘re-review’ each claim for coverage as ‘reconstructive surgery’ under Section 1367.63, the court will likely defer to the DMHC initially to make a conclusion on Health Net’s regulatory compliance.⁶⁰ Although the DMHC has already ordered Health Net to cover the representative plaintiff’s surgery, this order was only for the plaintiff’s specific surgery and not for the entire class of plaintiffs as the pending non-routine survey examines.⁶¹

ii. The Primary Jurisdiction Doctrine is Properly Applied Because the California Statute Delegated Enforcement Power to the DMHC

The California Supreme Court declared that the primary jurisdiction doctrine applies when a plaintiff brings a claim in court but a statute has delegated enforcement to an administrative body.⁶² If applied, this doctrine suspends the judicial process until the administrative body reaches a conclusion on the disputed issue.⁶³ Since the legislature vested exclusive authority in the DMHC and the DMHC is currently conducting a non-routine survey evaluating Health Net’s compliance with Section 1367.63, it is the DMHC’s statutory duty to complete its evaluation before a court orders injunctive relief.⁶⁴

Thus, as expressed in *Samura*, an individual has a judicial remedy for violations of actions made unlawful under the Knox-Keene Act if the agency tasked to enforce regulatory compliance fails to do so.⁶⁵ Since the statute expressly tasks the DMHC to enforce Section 1367.63, individuals should only have a private right of action if administrative redress is incapable of making the plaintiff whole and the DMHC completes its non-routine survey by issuing its final order regarding Health Net’s compliance.⁶⁶



Further, if the court holds that all excess skin is an “abnormal structure of the body,” and broadly orders insurers to cover its removal regardless of the individual patient’s circumstances, it would be deciding a medical policy question that it is ill-equipped to answer.⁶⁷ This would set a poor precedent by allowing the statute to become susceptible to manipulation in covering other surgeries not traditionally thought of as reconstructive.

As a result, the DMHC is best qualified to make an initial judgment in this specialized and complex area that will likely lead the court to issue a stay and defer to the agency prior to interpreting the meaning of Section 1367.63 and judicially resolving Health Net’s statutory compliance. Although the suits are not facial challenges to the law’s constitutionality and will likely only exhibit the difficult application of its language, a challenge under the nondelegation doctrine is one method to invalidate the statute itself.

B. The California Statute Impermissibly Vests the DMHC With the Discretionary Authority To Enforce the Knox-Keene Act Without Providing Sufficiently “Intelligible Principles” to Guide Their Decision Making

Similar to the federal New Deal legislation struck down in *Schechter Poultry Corp. v. United States*, the California legislature cannot delegate its lawmaking authority to another body of government. The California Supreme Court stated that in interpreting a statute, courts should determine the legislature’s intent to effectuate the purpose of the law and that laws must not give an administrative agency the ability to exercise greater discretion than is necessary to achieve the law’s purpose.⁶⁸

In *Schechter*, the Court recognized the need for regulations focusing on a “host of issues with which the national legislature cannot deal directly,” while also acknowledging that Congress cannot individually police every area of regulation.⁶⁹ Although it is improper for the California legislature to undermine the necessary regulatory function of the DMHC by enforcing and crafting complex health care regulatory laws itself, it cannot constitutionally delegate total lawmaking power to the DMHC.

The California legislators failed to craft a sufficiently specific enabling act in accordance with the Supreme Court’s requisite standard of providing intelligible principles for the DMHC to follow. In order to be reconstructive, the California statute merely requires that the surgery must correct or repair an “abnormal structure of the body.”⁷⁰ The statute does not define the meaning of abnormal structure and, as a result, consistent application and interpretation by the DMHC, insurers, and physicians as to what conditions constitute an abnormal structure of the body is doubtful.⁷¹

Further, the statute broadly defines an eligible justification for having reconstructive surgery as to create a “normal appearance, to the extent possible.”⁷² This language creates an impermissibly flexible and subjective statute susceptible to interpretive problems. By using subjective language like “normal,” the legislators removed objective predictability and gave the DMHC virtually unfettered discretionary authority in coverage decisions.⁷³ This wording creates the possibility for patients to shop around for a doctor who will certify that his/her excess skin is an “abnormal structure of the body” caused by a “disease,” and that the surgery should be covered because the removal of excess skin would create more than a minimal aesthetic improvement in achieving a “normal appearance” according to the doctor’s personal opinion.⁷⁴

The DMHC, insurers, and physicians need detailed guidance on how to consistently and objectively determine if a patient’s requested surgery is reconstructive.⁷⁵ Under the statute’s current construction, one may argue that a particular procedure is reconstructive surgery even though it only corrects a slight aesthetic abnormality within medically normal ranges.⁷⁶

The statute also fails to define what conditions should be characterized as a “disease” and since there is no uniformly accepted definition as to what constitutes a disease, the DMHC again does not have the necessary “intelligible principles” to determine what conditions the legislature intended to be considered a disease under the statute.⁷⁷ The example regarding the surgical removal of excess skin that fails to retract following the

treatment of obesity with bariatric surgery exemplifies the difficulty of classifying whether a disease, under the statute's language, causes certain conditions warranting classification as reconstructive surgery.⁷⁸ Arguably, the disease of obesity does not directly cause the excess skin but merely is an unavoidable side effect patients voluntarily accept by undergoing the treatment of obesity with bariatric surgery.⁷⁹ In contrast, it is also arguable that the treatment of excess skin is merely a continuation of the treatment of the patient's obesity and as a result, the disease of obesity causes the excess skin.⁸⁰

Like the other provisions in the California statute, the legislators failed to define what constitutes "improve[d] function."⁸¹ Since varying degrees of functional improvements exist, this term is also susceptible to subjective interpretation.⁸² For example, although hanging skin can pose problems when it reaches a certain level, not all excess skin poses problems.⁸³ The sweeping statute is not helpful to allow for individual considerations regarding coverage determinations to a diverse patient population.⁸⁴ Arguably, having this excess skin has a negative psychological effect on the patient and, as a result, the surgery is reconstructive because it would improve mental health.⁸⁵ In a New York civil court case, the court held that a seventeen-year-old male's surgical excision of enlarged breast tissue was covered under his policy because of the psychological problems caused by the excess breast tissue.⁸⁶ By failing to sufficiently clarify whether psychological justifications are alone sufficient for coverage, the legislature again failed to provide the necessary "intelligible principles" for the DMHC to follow.⁸⁷

Although the legislature's intent was to provide eligible individuals with the necessary compensation for surgeries falling under the statute's definition of "reconstructive surgery," by failing to adequately define the necessary conditions that must be present to consistently effectuate this intent, the California legislators violated the nondelegation doctrine by allowing the DMHC to improperly exercise a greater amount of discretion than necessary to fulfill the legislature's intent.

C. The California Statute Impermissibly Vests the DMHC With Discretionary Decision Making Authority Over Complex Policy Questions

By mandating insurance companies to reimburse all procedures under its broad definition of reconstructive surgery, the legislature improperly vested the DMHC with complex policy assessments.⁸⁸ Although mod-

ern jurisprudence shows an extreme reluctance to strike down regulatory delegations of power, recent case law upholding broad legislative delegations is distinguishable from the subject matter of the California statute. California's jurisprudence states that to prevent unelected agencies from improperly rendering policy decisions, the legislature must utilize a "yardstick" for the administrative agency to follow.⁸⁹

In *Loving v. United States*, the Supreme Court rejected a nondelegation doctrine challenge to the President's prescription of aggravating factors in an Executive Order for the imposition of the death penalty in the military.⁹⁰ The Code failed to define the "aggravating" and "mitigating" factors to be considered and as a result, the President exercised discretionary authority by issuing an executive order specifying these factors.⁹¹ Although *Loving* argued that the President lacked authority to define the aggravating factors enabling the military court to issue a death sentence, the Court rejected the nondelegation doctrine theory emphasizing the long history of the chief executive making rules for the military and noted that it gives Congress great deference in organizing military affairs.⁹²

In contrast to the subject matter in *Loving* dealing with the long tradition of giving deference to the executive branch in making military rules, the California legislature's delegation vests unchecked health care regulatory and policy making authority in the hands of an unelected agency.⁹³ Unlike the President's constitutional action in *Loving*, the California legislature delegated its exclusive constitutionally rooted lawmaking power to an unelected and unaccountable body of administrative officials without adequately clear regulations.⁹⁴ The far-reaching language of the statute forces the DMHC to improperly make economic policy judgments by mandating insurers to cover a fiscally unsustainable amount of claims that may have the unintended consequence of causing insurers to provide unaffordable health care plans. As a result of the vast effect this may have on California residents, elected lawmakers, not appointed agency officials, are the proper individuals to make these significant decisions.⁹⁵

In *Kugler v. Yocum*, the California Supreme Court held that the legislature properly made the fundamental policy determination that wages for firemen in one area should be in parity with another and that the delegated power to effectuate this decision was proper.⁹⁶ In contrast to *Kugler*, the California legislature failed to make fundamental policy choices and allowed the DMHC to potentially mandate vast insurance coverage for surgeries which may threaten the long term financial vitality of California's health

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care system. Based on the vague language chosen by the California legislature in the statute, there is no sufficient “yardstick” in California preventing the DMHC from improperly rendering policy assessments.⁹⁷

D. The California Statute Provides Insufficient Procedural Safeguards to Adequately Curb the DMHC’s Discretionary Authority

California jurisprudence suggests that procedural safeguards checking the delegated body’s potential abuse of power are more important than substantive regulations in examining the constitutionality of a statutory delegation of power.⁹⁸ Further, the California Supreme Court has noted that it is unconstitutional for a legislature to delegate authority without establishing a mechanism to assure the proper implementation of its policy decisions.⁹⁹ Although there are minor safeguards within the California statute, the protective checks that limit the exercise of agency discretion are inadequate.¹⁰⁰

In *California Air Constituency v. California State Air Resources Board*, the California Supreme Court determined that the legislature provided sufficient procedural safeguards that checked the California State Resources Board’s discretionary authority to delay a program meant to control automobile emissions.¹⁰¹ Unlike the enabling act in *State Air Resources* that provided safeguards mitigating the potential abuse of discretionary power, the DMHC has the power to make sweeping coverage conclusions without adequate safeguards checking its discretion.¹⁰²

Under the California statute, if the insurer denies a claim, a patient may challenge the insurer’s decision by requesting an Independent Medical Review (IMR) of the health plan’s decision to deny coverage under which medical records and other relevant information to the coverage determination are examined by an independent third party.¹⁰³ Even if the DMHC approves an IMR and it concludes that the coverage decision deserves compensation, the Director of the DMHC is still the final arbiter and possesses much discretionary latitude in penalizing non-compliance.¹⁰⁴

Although the statute does not explicitly provide or deny a private right of action or mandate that claimants exhaust their channels of administrative redress under the administrative procedures in place, the barriers to challenge the DMHC’s coverage decisions create an almost insurmountable barrier for individual claimants to pursue. In order to receive reimbursement, a claimant can either go through a long administrative grievance system with the ultimate final decision making ability residing in the DMHC’s Director, or the claimant can begin a costly litigation battle in civil court against

well capitalized insurance companies. Thus, with the onerous and lengthy grievance process currently available to individual claimants, and the fact that insurer’s resources dwarf those of individual claimants, the procedures currently in place fail to assure that the DMHC’s discretionary power is exercised in a proper and fair manner.

Unlike the Charter Schools Act upheld in *Wilson v. State Board of Education* on the grounds that the legislature properly made fundamental policy decisions and provided adequate safeguards to protect against the State Board of Education’s abuse of discretionary power, the California health care statute fails to sufficiently curb the DMHC’s discretionary power.¹⁰⁵ Even though the legislative intent is to ensure coverage for eligible individuals that meet the definition of reconstructive surgery set forth in the act, the procedural safeguards set forth by the legislature are insufficient to both successfully implement the statute’s intent and to prevent abuse of the DMHC’s enforcement power because the safeguards do not provide sufficiently detailed definitions for the DMHC to follow.

In considering whether the statute’s procedural safeguards are reasonable, a court will consider the magnitude of the interests affected by the legislative grant of authority.¹⁰⁶ In contrast to the act upheld in *Wilson* that properly delegated discretionary authority to those with the particularized educational knowledge and with a great vested interest in the quality of the educational system, the DMHC is an unaccountable agency tasked to enforce statewide medical insurance decisions that may greatly affect a claimant’s greatest asset, life.¹⁰⁷ The DMHC makes health care coverage decisions that determine the available surgical treatment options available to patients and thus individuals affected by the DMHC’s regulatory decisions have a much greater personal interest at stake than the state residents and taxpayers challenging the constitutionality of the Charter Schools Act in *Wilson*.¹⁰⁸

As a result of the statute’s insufficiently guiding “intelligible principles,” the great policy assessments improperly bestowed upon the DMHC, and the lack of adequate procedural safeguards effectively curbing the DMHC’s discretionary authority, the California statute is a fitting example for a constitutional challenge under the nondelegation doctrine. Until a facial challenge to the California law occurs, the pending lawsuits will likely show the law’s interpretive difficulties and could put insurers in financially unstable positions creating concern over their future ability to afford covering individuals who are at heightened risk of needing medically indicated surgical procedures in the future.¹⁰⁹

IV. Recommendations for Future Health Care Statutes

Given the increasingly vast amount of costly procedures that do not fit clearly into either the definition in Section 1367.63 of reconstructive or cosmetic surgery, legislators may learn several lessons from the construction of the statute.¹¹⁰ If a facial challenge to the law is unsuccessful, legislators should amend the California statute and Congress should not adopt the identical federal bill now before it.¹¹¹ This article recommends following the strategies and methods employed by the drafters of the WHCRA and some insurance policies when drafting eligibility criteria for statutes mandating coverage for specific procedures.¹¹²

With health care costs taking up a greater percentage of this nation's resources, statutes require more detailed criteria and careful drafting in order to ensure insurers continue to offer affordable coverage that employers will extend to employees.¹¹³ Statutes should not contain broad definitions mandating coverage for all reconstructive surgeries but rather only once a certain amount of insurance denials are made for a specific procedure should a statute procedurally require the DMHC or other equivalent administrative agencies to investigate the insurers compliance with the statute. If the agency finds that insurers are not in compliance and believe a specific statute covering a defined surgery (similar to the WHCRA) is appropriate, a process should be created where legislators debate and decide whether to write a law mandating insurance coverage for patients that meet detailed medical eligibility requirements for the specific procedure recommended by the agency.¹¹⁴

Under the statute's current construction, virtually any surgical procedure is arguably deserving of coverage.¹¹⁵ Adopting this proposition would: (1) ensure that legislators are not wasting their time crafting legislation for every rare procedure denied coverage by insurers; (2) save scarce judicial resources by utilizing the expertise of the DMHC or equivalent administrative agencies to make initial but limited coverage determinations; and (3) sufficiently place lawmaking and policy authority in the elected legislature by allowing them to balance the fiscal ability of insurance companies (and indirectly on individual consumers of health care) to cover certain procedures and the desire to follow the agency's recommendation to have specific surgeries universally covered.¹¹⁶ Once legislators begin drafting the legislation, they should narrowly tailor the language, much like the WHCRA, in order to ensure that only those intended to receive coverage actually do.¹¹⁷

Implementation of laws that mandate coverage for reconstructive surgery for the sole purpose of eliciting 'normal appearance' without further guidelines is not advisable. If California lawmakers wish to keep the statute's basic definitions, the legislators should amend the statute to mandate the utilization of an objective method like the Pittsburgh Rating Scale to mitigate the statute's susceptibility to inconsistent and subjective interpretation.¹¹⁸ Although a physician's treatment decision always holds a degree of subjectivity in deciding the appropriate treatment strategy for patients, the standard currently utilized in California and in the proposed Reconstruction Act of 2007 is greatly susceptible to subjectivity and will necessarily lead to unpredictable results in insurance coverage.¹¹⁹ The WHCRA is a guiding example requiring an objective basis for determining whether a surgery is coverable.¹²⁰

In contrast to the California statute that employs inherently subjective language like 'normal' and 'abnormal,' the WHCRA uses the word 'symmetrical' to describe the eligibility for reimbursement.¹²¹ Although the WHCRA does not define 'symmetrical' and is not as numerically quantitative as the Pittsburgh Rating Scale, courts can more objectively interpret the popular meaning of 'symmetrical' than the language in the California statute.¹²² By selecting a word that has a quantifiable definition, the language chosen in the WCHRA serves as a useful precedent to guide legislators in amending the statute's language.

Another method of solving the statute's deficiencies would be to return to the old law's standard covering only those surgeries that will cause functional improvements. However, if amended, legislators should specifically include psychological functioning in the statute as a sufficient justification for coverage.¹²³ Adding psychological impairments into the statute's language appeases the law's advocates who noted in the congressional debate that the old law failed to take into account the psychological trauma that accompanies physical disfigurement.¹²⁴ Providing authoritative documentation of the physiological or psychological impairment should be required to receive coverage.¹²⁵ Since plastic surgeons are not qualified to diagnose psychological afflictions, patients claiming a psychological justification should either obtain a certified psychologist or psychiatrist to diagnose or present a documented psychological difficulty directly caused by their condition.

Lawmakers should also amend the statute to specifically require objective and up to date scientific criteria in making their decisions on: (1) which surgeries elicit functional improvements; (2) whether the condition

Implementation of laws that mandate coverage for reconstructive surgery for the sole purpose of eliciting 'normal appearance' without further guidelines is not advisable.

is an abnormal structure of the body; and (3) whether the surgery will elicit a normal appearance.¹²⁶ Objective criteria and rating systems like the Pittsburgh Rating Scale, should be required to more consistently and accurately determine whether the desired surgery is cosmetic or reconstructive.¹²⁷

V. Conclusion

Although a successful facial challenge to a statute using the nondelegation doctrine has not occurred on the federal level since the New Deal Era, the California statute is a fitting example for employing this doctrine at the state level. The statute unconstitutionally delegates legislative power to an administrative agency by failing to provide adequate guiding principles for the DMHC to follow, by allowing an unelected agency to make complex policy decisions, and by lacking the necessary procedural safeguards needed to curb the DMHC's discretionary authority.

As the line between cosmetic and reconstructive surgery blurs and health care costs make up an increasing amount of our GDP, statutes need more definitive standards for regulatory agencies, insurers, and physicians to follow. The ambiguous California statute, though well intentioned, requires a consistent and accurate method to determine whether the desired surgery is cosmetic or reconstructive as intended by its crafters. Lawmakers need to make a policy choice balancing the need to treat the necessary patients and conserving increasingly scarce economic resources.¹²⁸ Even though the California statute is in accordance with the AMA's definitions of reconstructive and cosmetic surgery, its construction is fundamentally flawed in mandating coverage of all procedures within its vague and subjective definition of reconstructive surgery. Health care insurance statutes require objective and precise statutory standards capable of long-term fiscal sustainability as opposed to poorly defined sweeping insurance mandates in order to most accurately and efficiently reimburse patients for the appropriate surgical procedures.

1 See CAL. HEALTH & SAFETY CODE § 1367.63(c) (West 1999).

2 See *Cox v. Health Net of Cal., Inc.*, No. BC386181 (Cal. Super. Ct. Feb. 26, 2008) (pending in the Superior Court of the State of California for the County of Los-Angeles-Central Civil West).

3 *But see* § 1367.63(e)(1) (noting that if there is a more appropriate surgical procedure, coverage can be denied).

4 See First Amended Class Action Compl. for Declaratory & Injunctive Relief at 5, *Cox v. Health Net of Cal., Inc.*, No. BC386181 (Cal. Super. Ct. Feb. 26, 2008) (seeking declaratory relief to enjoin Health Net to review or re-review all denials for certain skin excision surgeries).

5 See § 1367.63(c) (highlighting that using language like "caused by disease" without providing further guidance creates interpretive problems).

6 See Cal. Ass'n of Health Plans, *The Rising Cost of Healthcare: Causes and Affordability* (2008), available at http://www.calhealthplans.com/7press/documents/_Affordability%20Causes.pdf (noting that in 2007, health spending was \$2.2 trillion and consumed 16.3 percent of the gross domestic product and by 2017, spending is expected to reach \$4.3 trillion taking up an estimated 19.5 percent of the gross domestic product).

7 See Am. Soc'y of Plastic Surgeons, *Insurance Coverage: A Patient's Guide* (2008), available at http://www.plasticsurgery.org/patients_consumers/planning_surgery/insurance_coverage.cfm [hereinafter *A Patient's Guide*] (emphasizing that cosmetic surgery is elective and not considered a medical necessity); Am. Soc'y of Plastic Surgeons, *ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients* (2006), available at http://www.plasticsurgery.org/medicalprofessionals/health_policy/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=18091 (distinguishing various types of skin excision surgeries and stressing patients might need various surgeries depending on the symptoms they present).

8 See *A Patient's Guide*, *supra* note 7 (emphasizing that the surgery's sole purpose may be to improve appearance).

9 See § 1367.63(c)(2).

10 *Id.*

11 See, e.g., Pat Speer, *Obesity Surgery Spawns 'New Frontier' for Plastic Surgery*, PLASTIC SURGERY NEWS (2003) available at http://www.plasticsurgery.org/medical_professionals/publications/obesity-surgery-spawns-new-frontier.cfm (finding after bariatric surgery, an increasing number of patients seek coverage claiming that surgery to remove skin failing to contract is reconstructive).

12 See Am. Soc'y of Plastic Surgeons, *Practice Parameter for Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients*, (2007) available at http://www.plasticsurgery.org/medical_professionals/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=24212 (citing that obesity affects fifty eight million people in America causing an explosive demand for bariatric surgery and skin excision following weight loss).

13 See Alan Matarasso et al., *Bariatric Surgery: An Overview of Obesity Surgery*, 119 PLASTIC & RECONSTRUCTIVE SURGERY 1357, 1358 (2007) (explaining bariatric surgery reduces the capacity of the stomach and prevents the mixing of food with the digestive enzymes until food is further down the intestinal path); Kim Dixon, *Medicare May Broaden Obesity Payment*, REUTERS, May 20, 2008 available at <http://www.reuters.com/article/healthNews/idUSN1914912220080520> (noting the government may expand coverage for bariatric surgery for the 'obese' and not just the 'morbidly obese' after a study found the surgery can help reverse diabetes).

14 See generally Speer, *supra* note 11 (noting the current number of surgeons qualified to operate on weight loss patients is not sufficient to meet the growing demand).

15 See T. Oguz Acarturk et al., *Panniculectomy as an Adjuvant to Bariatric Surgery*, 53 ANNALS OF PLASTIC SURGERY 360 (2004) (asserting that excess skin is a common trait of patients who underwent bariatric surgery).

16 See CAL. HEALTH & SAFETY CODE § 1367.63(c) (West 1999) (containing a provision explicitly noting that reconstructive surgery must correct an abnormal structure of the body caused by a disease).

17 *But see id.* § 1367.63(e)(2) (stating that if only a minimal improvement in appearance will occur after the requested surgery, denial is appropriate).

18 *Id.* § 1367.63(a).

19 See ASSEMB. COMM. ON INS. ANALYSIS, A.B. 1621, 1997–1998 Reg. Sess., (Ca. 1998) (stating the previous law required plans to cover all medically necessary services).

20 See S. HEALTH & HUMAN SERVICES COMM. ANALYSIS, A.B. 1621, 1997–1998 Reg. Sess., (Ca. 1998) (noting the CSPS considers these surgeries a medical necessity).

21 See ASSEMB. COMM. ON INS. ANALYSIS, *supra* note 19 (applying the 'bodily functions' test where if the patient can continue to function without the surgery, coverage would be denied). See, e.g., S. HEALTH & HUMAN SERVICES COMM. ANALYSIS, *supra* note 20 (noting an instance where a girl born without an ear was refused coverage for surgery to construct an ear because the surgery would not restore her hearing and her policy did not cover surgery for restoring normal appearance unless the surgery is primarily to re-establish normal function).

22 *Id.*

23 *Id.*

24 *Id.*

25 See *id.* (denying coverage for individuals who are able to hear but have malformed ears ignores the psychological trauma of physical disfigurements).

26 See S. COMM. ON INS. ANALYSIS, *supra* note 20.

27 See *id.* (noting the bill's language could be interpreted to make all reconstructive surgery medically necessary, even elective surgeries like rhinoplasty).

28 See *Cox v. Health Net of Cal., Inc.*, No. BC386181 (Cal. Super. Ct. filed Feb. 26, 2008) (specifying that the plaintiff in *Woelk v. Blue Cross*, the other

suit, is alleging that Blue Cross is employing the same statutory violations as Health Net).

29 *See id.* (having the same law firm representing the plaintiffs in both suits).

30 *Woelk v. Blue Cross of Cal., Inc.*, No. BC 391522 (Cal. Super. Ct. filed May 27, 2008).

31 *See Class Action Compl. for Declaratory & Injunctive Relief at 5, Cox v. Health Net of Cal., Inc.*, No. BC386181 (Cal. Super. Ct. Jun. 12, 2008) (asserting Health Net violates the statute by improperly claiming that excess skin does not constitute an abnormal structure of the body and/or its removal is not medically necessary).

32 *See id.* at 6 (claiming the insurer's alleged blanket policy constitutes a prohibited act of unfair competition by the UCL which specifically includes any unlawful, unfair, or fraudulent business act or practice and unfair, deceptive, untrue or misleading advertising).

33 *See, e.g., Notice of Demurrer & Demurrer to Compl. of Plaintiff by Health Net of California at 3, Cox v. Health Net of Cal., Inc.*, No. BC386181 (Cal. Super. Ct. Feb. 26, 2008) [hereinafter *Demurrer*] (addressing uncertain issues like whether individuals have a private right of action under the statute); *see generally Schmidt v. Found. Health*, 42 Cal. Rptr. 2d 172, 181 (Cal. Ct. App. 1995) (advocating caution in seeking remedies in venues other than those provided by the legislature); *Samura v. Kaiser Found. Health Plan*, 22 Cal. Rptr. 2d 20, 29 (Cal. Ct. App. 1993) (acknowledging the ability to bring suit to enjoin acts unlawful under the Knox-Keene Act).

34 *See Plaintiff's Opposition to Defendant Health Net of California, Inc.'s Demurrer to Compl.; Memorandum of Points and Authorities at 4, Cox v. Health Net of Cal., Inc.*, No. BC386181 (Cal. Super. Ct. Feb. 26, 2008) [hereinafter *Opposition to Demurrer*] (stating that the legal issue for the court to resolve is the meaning of "reconstructive surgery" under § 1367.63).

35 *See U.S. CONST. art. I, § 1.* (vesting exclusive legislative power in the Congress of the United States).

36 *See, e.g., Kugler v. Yocum*, 445 P.2d 303, 311 (Cal. 1968) (delegating power to ensure that firemen's wages were in parity with other localities); *see generally ERWIN CHERMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES* 319 (Richard A. Epstein et. al. eds., Aspen Publishers 2d ed. 2002) (identifying that the rise of the modern administrative state spawned out of the New Deal's programs).

37 *See id.* at 320 (noting the last federal laws declared unconstitutional by the Supreme Court under a nondelegation theory were New Deal legislation exceeding the scope of Congress's commerce power).

38 *See, e.g., Mistretta v. United States*, 488 U.S. 361, 379 (1989) (upholding a delegation from the legislature to the judiciary for the intricate task of formulating sentencing guidelines because it did not infringe on another branch or improperly expand the judiciary's power); *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 541-42 (1935) (holding that there was an insufficient amount of standards to limit the delegated discretionary authority).

39 *See, e.g., Whitman v. Am. Trucking Ass'n*, 531 U.S. 457, 475-76 (2001) (upholding a delegation of power to the Environmental Protection Agency to enforce air quality standards because Congress made the fundamental policy decision to regulate air quality while narrowing EPA's discretionary authority by not allowing the agency to consider implementation costs in creating clean air act rules).

40 *See, e.g., Loving v. United States*, 517 U.S. 748, 773 (1996) (upholding a delegation to the President even without standards limiting discretion).

41 *See Whitman*, 531 U.S. at 472-74 (acknowledging that drafting air quality regulations requires great expertise and noting the commerce clause delegations struck down by the Court did not curb discretion at all).

42 *See Richard Stewart, The Reformation of American Administrative Law*, 88 HARV. L. REV. 1669, 1695-97 (1975) (outlining that if the judiciary strikes down agency decisions, the administrative agencies may lose legitimacy by exposing them to the ongoing threat of judicial invalidation).

43 488 U.S. at 413 (Scalia, J., dissenting); *see Wilson v. State Bd. of Educ.*, 89 Cal. Rptr. 2d 745, 759 (Cal. Ct. App. 1999) (finding that the Board of Education was not making policy decisions but merely effectuating the legislature's policy choices).

44 *See, e.g., A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 541-42 (1935) (striking down a regulation designed to both ensure poultry quality and regulative employment because it set insufficient standards and in fact delegated virtual law making authority to the President); *Air Constituency v. Cal. State Air Res. Bd.*, 523 P.2d 617, 628 (Cal. 1974) (providing a limited and proper amount of discretionary power to the state resource board).

45 *See The Federal Women's Health and Cancer Rights Act of 1998*, 29 U.S.C. § 1185(a) (1998) (having the attending physician determine if reasonable symmetry is attainable with reconstructive surgery).

46 *See generally* 143 CONG. REC. S820-01 (1997) (statement of Sen. Snowe) (stating the fear of losing a breast is the leading reason women do not utilize early breast cancer detection programs and covering reconstructive surgery to achieve symmetry is necessary to return to a normal life given the psychological damage of losing breasts to cancer).

47 *See J.L.F. v. Ariz. Health Care Cost Containment Sys.*, 91 P.3d 1002, 1005 (Ariz. Ct. App. 2004) (requiring some medically rooted objective support to garner insurance coverage).

48 *See id.* at 1006 (noting that the drafter's intent was to provide coverage for symmetrical appearance if the treating physician believed that undergoing the procedure is supported by sufficiently competent evidence).

49 *See Opposition to Demurrer at 4, Cox v. Health Net of Cal., Inc.*, No. BC386181 (Cal. Super. Ct. Feb. 26, 2008) (alleging the sole issue in need of judicial resolution is the legal meaning of "reconstructive surgery" under § 1367.63).

50 *See Demurrer, supra* note 33, at 3 (requesting judicial deference to the DMHC because this is a regulatory dispute).

51 *See* § 1341(a) (stating expressly that the DMHC executes the laws relating to health care service plans); *Van de Kamp v. Gumbiner*, 270 Cal. Rptr. 907, 921-22 (Cal. Ct. App. 1990) (holding that pursuant to the Knox-Keene Act's express grant of authority, the DMHC regulates all aspects of the regulation of health plans including financial stability, organization, advertising and capability to provide health services).

52 *See* 42 Cal. Rptr. 2d 172, 181 (Cal. Ct. App. 1995) (asserting that administrative agency's interpretation of its own regulation deserves great weight).

53 *See Kasky v. Nike, Inc.*, 27 Cal. 4th 939, 950 (Cal. 2002) (noting that a plaintiff may bring a UCL action even when conduct violates a statute for the direct enforcement of which there is no private right of action).

54 *See Demurrer, supra* note 33, at 5-6 (stating the plaintiff failed to provide the necessary facts involved in each coverage request, and thus has not alleged Health Net committed acts made unlawful by the Knox-Keene Act).

55 *See Samura v. Kaiser Found. Health Plan*, 22 Cal. Rptr. 2d 20, 29 (Cal. Ct. App. 1993) (holding that despite a statutory enforcement scheme, the plaintiff still may sue to enjoin acts made unlawful by the Knox-Keene Act).

56 *But see Reno v. Baird*, 18 Cal. 4th 640, 660 (Cal. 1998) (finding that although an agency's decision is significant, statutory interpretation is an issue of law fit for a court).

57 *See Alvarado v. Selma Convalescent Hosp.*, 153 Cal. App. 4th 1292, 1295 (Cal. Ct. App. 2007) (requiring a trial court to become involved in an agency's duty to regulate complex health care issues is a proper circumstance for judicial abstention).

58 *See, e.g., CAL. HEALTH & SAFETY CODE* § 1346 (West 1999) (detailing the broad powers that the Director of DMHC possesses to ensure compliance with the statute).

59 *See Alvarado*, 153 Cal. App. 4th at 1298 (indicating that abstention is also proper where injunctive relief would be unnecessarily burdensome to monitor and enforce or where enforcement elsewhere would be more effective).

60 *See Defendant Health Net of California, Inc.'s Notice of Motion and Motion for an Order to Stay the Action, or Alternatively, to Dismiss Action Without Prejudice at 6, Cox v. Health Net of Cal., Inc.*, No. BC386181 (Cal. Super. Ct. Feb. 26, 2008) [hereinafter *Motion to Stay*] (observing that the DMHC's Technical Assistance Guide for the Focused Survey on Reconstructive Surgery was created to ensure plan compliance with § 1367.63 and is currently being used by the DMHC in conducting a non-routine survey of Health Net's compliance).

61 *Demurrer, supra* note 40, at 3.

- 62 See *Farmers Ins. Exch. v. Superior Court*, 826 P.2d 730, 739 (Cal. 1990) (enunciating that the doctrine advances two policies: enhancing judicial decision making and efficiency by taking advantage of agency expertise and helping ensure uniform and predictable application of regulatory laws).
- 63 See, e.g., *Jonathan Neil & Assoc., Inc. v. Jones*, 94 P.3d 1055, 1063-63 (Cal. 2004) (holding the doctrine of ‘primary jurisdiction’ was proper and issued a stay until the California Department of Insurance interpreted insurance rules).
- 64 See, e.g., *Alvarado*, 153 Cal. App. 4th at 1303 (adjudicating a class action case would assume regulatory power over the health care industry through the guise of enforcing the UCL).
- 65 See *Samura v. Kaiser Found. Health Plan*, 22 Cal. Rptr. 2d 20, 31 (Cal. Ct. App. 1993) (finding that although the plaintiff had certain remedies, the trial court erred in assuming regulatory power over health maintenance organizations).
- 66 See, e.g., CAL. HEALTH & SAFETY CODE § 1391 (West 2000) (detailing that if a cease and desist order is issued and a timely request for a hearing is made, the order is stayed until a hearing occurs, and also that every final order of the DMHC is subject to review in accordance with the APA and or judicial review); see also *Motion to Stay*, *Cox v. Health Net of Cal., Inc.* at 9, No. BC386181 (Cal. Super. Ct. Feb. 26, 2008) (noting any review of DMHC’s action would be subject to review in accordance with the APA and then judicial review).
- 67 See § 1342(a) (declaring the legislature’s intent was to assure the role of the health care professional as the decision maker of patient’s health needs); see also *Samura*, 22 Cal. Rptr. 2d at 29-30 (acknowledging that although an individual can sue to enjoin acts made unlawful by the Knox-Keene Act, a court should not interfere in regulatory matters when doing so impermissibly encroaches on the legislature).
- 68 See *Cal. Toll Bridge Auth. v. Kuchel*, 251 P.2d 4, 8-10 (Cal. 1952) (holding the California Bridge Authority improperly exercised legislative power not necessary to achieve the law’s purpose).
- 69 *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 530 (1935).
- 70 See S. COMM. ON INS. ANALYSIS, *supra* note 33 (stating the Department of Health Services believes that subjective language hampers regulator’s enforcement ability).
- 71 See *Irelan v. Standard Mut. Ass’n of Cassville*, 379 S.W.2d 815, 824 (Mo. Ct. App. 1964) (finding that unless otherwise noted in the policy, courts apply the popular meaning); *Webster’s II New Riverside University Dictionary* 67 (Anne H. Soukhanov ed., Houghton Mifflin Co. 1994) (1984) (defining abnormal as ‘deviant’).
- 72 See S. COMM. ON INS. ANALYSIS, *supra* note 20 (applying normal appearance standard mandates a much broader and costly scope of coverage).
- 73 See S. RULES COMM. ANALYSIS, A.B. 1621, 1997–1998 Reg. Sess., (Ca. 1998) (stating that taking the language out requiring reconstructive surgery to be ‘medically necessary and appropriate’ removes health plans power of discretion to deny a procedure given the enrollee’s particular condition or if it is too risky for the enrollee).
- 74 See Robert F. Ryan, *The Achilles Heel of Plastic Surgery: Insurance Forms, Fraud, and Loss of Credibility*, 76 PLASTIC & RECONSTRUCTIVE SURGERY 293 (1985) (discussing insurance fraud and noting that some doctors illegitimately cite respiratory obstruction to garner insurance coverage for rhinoplasty).
- 75 But see § 1367.63(b) (attempting to mitigate subjectivity by requiring the surgical judgment to be made in accordance with the standard of care of a trained reconstructive surgeon).
- 76 See S. COMM. ON INS. ANALYSIS, *supra* note 20 (noting that CAHP suggested that under the bill’s language, a scar caused by acne or an ear-piercing would be insured irregardless of the fact that the procedures are cosmetic).
- 77 See J.A. Bryant Jr., Annotation, *What Conditions Constitute “Disease” Within Terms of Life, Accident, Disability, or Hospitalization Insurance Policy*, 61 A.L.R.3d 822 (1975) (outlining what courts emphasize in determining whether a condition is a disease under the terms of insurance policies and emphasizing it is an individualized fact specific inquiry).
- 78 See § 1367.63(c) (failing to offer guidance on whether conditions that may result from the treatment of certain diseases are also considered as caused by a disease under the statute).
- 79 See, e.g., Am. Soc’y of Plastic Surgeons, *ASPS Recommended Insurance Coverage Criteria for Third-Party Payers: Surgical Treatment of Skin Redundancy for Obese and Massive Weight Loss Patients* (2006), available at http://www.plasticsurgery.org/medicalprofessionals/health_policy/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=18091 (citing that the largest body of plastic surgeons worldwide believe that when purely to enhance appearance, skin excision is a cosmetic procedure).
- 80 See, e.g., T. Oguz Acarturk et al., *supra* note 22, at 360 (emphasizing that hanging skin is almost uniformly present in patients who underwent bariatric surgery and that it causes other health problems until excised).
- 81 See § 1367.63(c) (failing to specify if psychological improvements caused by a surgery is a sufficient justification to be become eligible for reconstructive surgery).
- 82 See S. COMM. ON INS. ANALYSIS, *supra* note 20 (discussing the possibility of fraud where patients shop around for a doctor to fraudulently certify that a minimal functional improvement is possible with surgery).
- 83 See Acarturk et al., *supra* note 15, at 360 (noting a dense pocket of fatty tissue usually in the abdominal cavity, called a hanging panniculus, can cause difficulties in movement which in turn may exacerbate the patient’s weight and cause recurrent infections).
- 84 See also Reconstructive Surgery Act of 2007, H.R. 2820, 110th Cong. (2007) (introducing a federal bill employing language nearly identical to the California statute and that identical legislation has been introduced in every session of Congress since the 106th in 1999 with no significant movement to become a law).
- 85 See Acarturk et al., *supra* note 15, at 360 (explaining that excess skin can interfere with the psychological well-being and social life of the patient).
- 86 See *Steven S. v. GHI*, 787 N.Y.S.2d 828 (N.Y. Civ. Ct. 2004) (stating that his avoidance of situations that would expose his condition and subject him to ridicule constituted a functional defect because he was unable to function as a normal adolescent).
- 87 § 1367.63.
- 88 See *Kugler v. Yocum*, 445 P.2d 303, 306 (Cal. 1968) (highlighting that while the formulation of policy is a legislative decision, it is proper to delegate the power to fill in the implementation details to administrative officials).
- 89 See *Am. Distilling Co. v. St. Bd. of Equalization*, 131 P.2d 609, 612 (Cal. Dist. Ct. App. 1942) (clarifying the legislature may not delegate authority that abridges, expands, or modifies the enabling statute).
- 90 517 U.S. 748, 773 (1996).
- 91 See generally *id.* at 772-73 (summarizing the Supreme Court’s jurisprudence regarding military questions and giving examples of proper delegations of power).
- 92 *Id.* at 764.
- 93 See CAL. HEALTH & SAFETY CODE § 1341 (West 1999) (prescribing that the DMHC and the appointed Director have the power to execute laws relating to health service plans, the health care service plan business, providing enrollees with access to health care services, and laws protecting the interest of enrollees).
- 94 See *CHEMERINSKY*, *supra* note 36, at 323 (suggesting that the Court’s refusal to enforce the nondelegation doctrine may undermine government accountability as political decisions are made by unelected officials).
- 95 See S. APPROPRIATIONS COMM. FISCAL SUMMARY, A.B. 1621, 1997–1998 Reg. Sess., (Ca. 1998) (noting potential increases in both costs to individuals purchasing health care and on the state in the form of higher premiums paid on behalf of public employees and also that the bill will likely cost millions annually).
- 96 See 445 P.2d 303, 311 (Cal. 1968) (holding that an unlawful delegation occurs either when the legislature fails to render basic policy decisions or fails to assure that they are implemented when made).
- 97 See, e.g., *Am. Distilling Co. v. St. Bd. of Equalization*, 131 P.2d 609, 612 (Cal. Ct. App. 1942) (finding that certain exercises of discretion by the State Board of Equalization excepting certain chemicals from sales tax were unconstitutional because they resulted in an exception not in accordance with the statute’s purpose).

- 98 *Wilson v. State Bd. of Educ.*, 89 Cal. Rptr. 2d 745, 759-60 (Cal. Ct. App. 1999); see 73 C.J.S. *Public Administrative Law and Procedure* § 62 (2008) (emphasizing courts want to assure discretionary power is not unnecessarily or indiscriminately exercised).
- 99 *Kugler*, 445 P.2d at 306-07.
- 100 See CAL. HEALTH & SAFETY CODE § 1374.30 (West 1994) (outlining the independent medical review process available to those challenging an insurer's denial of coverage).
- 101 See 523 P.2d 617, 628 (Cal. 1974) (holding the provision in dispute which ambiguously empowered the Resource Board by allowing them to consider 'all relevant factors' in assessing the means of implementing the Air Resource Act included only narrow factors directly relating to the three stated goals of the Act).
- 102 See *id.* (stating any discretionary action by the Resource Board delaying a pollution control program must be justified by directly relating their action to the three specific purposes of the legislation).
- 103 *But see* § 1374.30(j) (requiring those seeking an IMR to meet specific criteria in order to even qualify for such a review).
- 104 See *generally id.* § 1374.34 (allowing broad discretion in choosing the method to penalize health plans for non-compliance with the statute).
- 105 See *Wilson*, 89 Cal. Rptr. 2d at 759-60 (finding the fundamental policy choices by the legislature included giving parents, teachers, and community members the opportunity to set up public schools with operational independence, promoting education innovation and accomplish related public education goals); CAL. EDUC. CODE § 47600 (West 1992) (establishing procedures for individuals to petition local school district governing boards to establish charter public schools).
- 106 *Matter of Powell*, 602 P.2d 711, 716-717 (Wash. 1990) (en banc).
- 107 See *Wilson*, 89 Cal. Rptr. 2d at 759-60 (acting constitutionally by creating a state system of common schools while delegating a proper amount of power to the officers of the public school system to control curriculum, textbooks and operations).
- 108 See T. Oguz Acarturk et al., *Panniculectomy as an Adjuvant to Bariatric Surgery*, 53 ANNALS OF PLASTIC SURGERY 360 (2004) (outlining the variety of serious physiologic and psychological effects hanging skin may have on patients who underwent bariatric surgery).
- 109 See S. COMM. ON INS. ANALYSIS, *supra* note 20 (finding the California Manufacturers Association and Californians for Affordable Health Reform believe that this statute may cause present and potential employers to drop or never consider adopting health plans).
- 110 See Alan Matarusso et al., *Bariatric Surgery: An Overview of Obesity Surgery*, 119 PLASTIC & RECONSTRUCTIVE SURGERY 1357, 1360 (citing that in 2005, 144,000 individuals had bariatric surgery and an estimated 170,000 in 2006).
- 111 See The Reconstructive Surgery Act of 2007, H.R. 2820 110th Cong. (2007) (clarifying that as of the date of this publication, legislators have not yet introduced a new version of this law).
- 112 See, e.g., Shawkat Sati & Sonal Pandya, *Should a Panniculectomy/Abdominoplasty After Massive Weight Loss Be Covered by Insurance?*, 60 ANNALS OF PLASTIC SURGERY 502, 504 (2008) (listing an example of some insurance guidelines for panniculectomy/abdominoplasty which generally include: 1) pannus that hangs below level of pubis; 2) patient has had significant weight loss of 100 pounds or more, as well as the following: a. individual has maintained stable weight for at least 6 months, and b. if the individual has had bariatric surgery, they are at least 18 months postoperative; and 3) one of the following: a. if there are recurrent or chronic rashes, infections, cellulites, or non-healing ulcers that do not respond to conventional treatment for a period of 3 months, information must be documented in the records or b. if there is difficulty with ambulation and interference with activities of daily living, information must be documented in office visit records).
- 113 See, e.g., Jesse T. Nguyen et al., *Reduction Mammoplasty: A Review of Managed Care Medical Policy Coverage Criteria*, 121 PLASTIC & RECONSTRUCTIVE SURGERY 1092, 1098-99 (2008) (outlining that insurance policies require the documentation of the severity and impact on specific quality of life issues to elicit coverage).
- 114 See, e.g., 28 U.S.C. § 1185(b) (1998) (mandating coverage for breast reconstruction only for those currently receiving coverage for a medically necessary mastectomy and for the aesthetic purpose of achieving a symmetrical appearance).
- 115 See S. COMM. ON INS. ANALYSIS, *supra* note 20 (finding the California Public Employees' Retirement System believed the bill improperly deemed all reconstructive surgery medically necessary).
- 116 See S. APPROPRIATIONS COMM. FISCAL SUMMARY, A.B. 1621, 1997-1998 Reg. Sess., (Ca. 1998) (noting potential increases in both costs to individuals purchasing health care and on the state in the form of higher premiums paid on behalf of public employees and that because of the statute's mandate, the bill will likely cost hundreds of thousands to millions annually).
- 117 See *J.L.F. v. Ariz. Health Care Cost Containment Sys.*, 91 P.3d 1002, 1006 (Ariz. Ct. App. 2004) (explaining the drafters of the WHCRA intent was to specifically reimburse breast reconstruction to produce symmetrical appearance for individuals receiving coverage for medically necessary mastectomy).
- 118 See, e.g., Angela Y. Song et al., *A Classification of Contour Deformities after Bariatric Weight Loss: The Pittsburgh Rating Scale*, 116 PLASTIC & RECONSTRUCTIVE SURGERY 1535 (2005) (creating a 10-region, four point grading system that was designed to quantitatively describe common deformities found in each region of the body).
- 119 See S. COMM. ON INS. ANALYSIS, *supra* note 20 (CAHP criticized the use of the words 'normal' and 'abnormal' because these terms, inherently subjective in nature, will necessarily lead to conflict over what is 'normal').
- 120 See § 1185(b) (requiring a physician to certify that the surgery will produce a **measurable** [emphasis added] increase in symmetry and thus resulting in the decreased possibility of unnecessary and costly operations occurring).
- 121 See, e.g., *J.L.F.*, 91 P.3d at 1003 (stressing the quantifiable nature of achieving symmetry by noting that there was about .5 centimeter difference between the two breasts).
- 122 See WEBSTER'S II NEW RIVERSIDE UNIVERSITY DICTIONARY 1172 (Anne H. Soukhanov ed., Houghton Mifflin Co. 1994) (1984) (defining symmetry as "correspondence of form and arrangement of parts on opposite sides of a boundary, as a plane or line or around a point or axis").
- 123 See, e.g., *Steven S. v. GHI*, 787 N.Y.S.2d 828 (N.Y. Civ. Ct. 2004) (taking into account the patient's psychological impairments that elicited the need for his surgery).
- 124 S. HEALTH & HUMAN SERVICES COMM. ANALYSIS, *supra* note 27.
- 125 See, e.g., *Steven S.*, 787 N.Y.S.2d at 831 (observing that the lack of documentation from a mental health specialist was the apparent reason for his initial insurance denial for surgery).
- 126 See, e.g., Jesse T. Nguyen et al., *Reduction Mammoplasty: A Review of Managed Care Medical Policy Coverage Criteria*, 121 PLASTIC & RECONSTRUCTIVE SURGERY 1092 (2008) (finding insurance company's policies with respect to a reduction mammoplasty are often arbitrary and not founded upon a scientific basis).
- 127 See Angela Y. Song et al., *A Classification of Contour Deformities after Bariatric Weight Loss: The Pittsburgh Rating Scale*, 116 PLASTIC & RECONSTRUCTIVE SURGERY 1535, 1536 (2005) (stating previous classification systems did not cater to the unique deformities caused by bariatric surgery including the fact that none of the abdominal classification systems have a category for multiple rolls in the pannus which often occurs after bariatric surgery).
- 128 See *generally* Robert Pearl & Hugh McAllister, *An Economic Analysis of Health Care Reform and Its Implications for Plastic Surgery*, 99 PLASTIC & RECONSTRUCTIVE SURGERY 1 (1997) (finding a decline in plastic surgery's profitability because of an unwillingness to increase health care expenditures by private insurers and the federal government).