

**REPORT OF THE  
SPECIAL ADVISORY COMMISSION ON MANDATED  
HEALTH INSURANCE BENEFITS**

**HOUSE BILL 182 (1994) MANDATED  
COVERAGE FOR RECONSTRUCTIVE  
MAMMOPLASTY**

**TO THE GOVERNOR AND  
THE GENERAL ASSEMBLY OF VIRGINIA**



**SENATE DOCUMENT NO. 11**

**COMMONWEALTH OF VIRGINIA  
RICHMOND  
1995**

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SENATE

November 4, 1994

To: The Honorable George Allen  
Governor of Virginia  
and  
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 9-298 and 9-299 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of House Bill 182 (1994 Session) regarding a proposed mandated coverage for reconstructive reduction mammoplasty.

Respectfully submitted,

A handwritten signature in black ink, appearing to read "Clarence A. Holland".

Clarence A. Holland  
Chairman  
Special Advisory Commission on  
Mandated Health Insurance Benefits

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## **INTRODUCTION**

During the 1994 Session of the General Assembly, the House Committee on Corporations, Insurance, and Banking referred House Bill 182 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). House Bill 182 is patroned by Delegate Shirley Cooper.

The Advisory Commission held a hearing on April 18, 1994 in Richmond to receive public comment on House Bill 182. Eight speakers addressed the proposal. One certified plastic surgeon and five former reconstructive reduction mammoplasty patients spoke in favor of the bill. Representatives from Blue Cross and Blue Shield of Virginia (BCBSVA) and the Virginia Association of Health Maintenance Organizations spoke in opposition to the measure. In addition, the Virginia Farm Bureau Federation filed written comments opposing House Bill 182. The Advisory Commission concluded its review of House Bill 182 on May 16, 1994.

## **SUMMARY OF PROPOSED LEGISLATION**

House Bill 182 requires insurers, health services plans, and health maintenance organizations to provide coverage to Virginia policyholders for reconstructive reduction mammoplasty performed to relieve signs and symptoms of macromastia. The provisions of this bill do not apply to short-term travel, accident only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.

Respondents to staff's insurer survey have expressed concern that House Bill 182, as currently drafted, does not include a clinical definition of macromastia and does not expressly limit coverage to "medically necessary" services and procedures.

## **CURRENT INDUSTRY PRACTICES**

The State Corporation Commission Bureau of Insurance recently surveyed 50 of the top writers of accident and sickness insurance in Virginia regarding House Bill 182. Thirty-two companies responded by April 14, 1994. Three of those indicated that they do little or no applicable health insurance business in Virginia and, therefore, could not provide the information requested. Of the 29 respondents that completed the survey, 23 (79%) reported that they currently provide the coverage required by House Bill 182 to their Virginia policyholders if the procedure is medically necessary. Insurers typically exclude expenses associated with cosmetic surgery from coverage.

Proponents of House Bill 182 contend that the measure is needed because some insurers deny coverage for reconstructive reduction mammoplasty if the woman is overweight. They argued that "medically

necessary" was ambiguous. They further argued that determining coverage based on a female's weight was discriminatory against women above their ideal body weight. Proponents argued that reduction of the body weight does not alleviate the signs and symptoms of macromastia. As an example, proponents described a situation where a patient reduced her weight; yet, the signs and symptoms of macromastia, which includes back, shoulder, neck, and breast pain and headaches, remained.

Opponents contend that any new mandated benefit will unnecessarily increase the cost of health insurance coverage and unfairly burden small employers and individuals that are often the least able to absorb premium increases. They stated that coverage for this procedure already exists. Opponents further argued that the very limited need for reduction mammoplasty services does not justify a mandate.

#### **FINANCIAL IMPACT**

Respondents to the insurer survey provided cost figures between \$0.11 and \$1.56 per month per policyholder or group certificate holder. In its written comments on this subject, BCBSVA estimates the impact on premiums for such coverage to be less than one tenth of one percent. BCBSVA also estimated that expenses for hospital, surgical and medical services associated with reduction mammoplasty average from \$3,500 to \$5,500 per case, depending on length of hospitalization. BCBSVA also reports that in 1993 fewer than 300 requests were made for coverage of reduction mammoplasty. Of those, BCBSVA reportedly approved 85% as medically necessary.

#### **RECONSTRUCTIVE REDUCTION MAMMOPLASTY**

According to materials submitted by one proponent to the Advisory Commission, reduction mammoplasty is the surgical excision of a substantial portion of the breast, including the skin and the underlying glandular tissue, until a clinically normal size is obtained. Reduction mammoplasty, while sometimes considered cosmetic to correct sagging or to improve appearance, is often reconstructive and prompted by physical necessity. Information provided by a proponent of House Bill 182 indicates that reduction mammoplasty to relieve macromastia is provided over 40,000 times annually in the United States. Dr. Patricia Gomuwka, a board certified plastic surgeon, stated at the public hearing that "the signs and symptoms [of macromastia] consist of back pains, intertrigo, as well as difficulty maintaining posture, participating in physical activities and sleeping." At least one interested party noted that other symptoms of macromastia included limited range of motion in the upper body and neck.

Dr. Gomuwka noted that the normal breast is about 21 centimeters from sternum to nipple notch. She stated that individuals with macromastia measure from 30 to 40 centimeters from sternum to nipple notch. She also contended

that if 300 to 350 grams (about three quarter pounds) of breast tissue is removed from each breast, the procedure should be covered by insurers.

Proponents of House Bill 182 agreed that coverage currently exists for this procedure. However, they expressed concern that insurers deny coverage to those women above their ideal weight. They contended that this denial is discriminatory in nature. They emphasized that above-average body weight does not lessen the effectiveness of the treatment. They also emphasized that decreasing one's body weight does not alleviate the signs and symptoms of macromastia.

#### **SIMILAR LEGISLATION IN OTHER STATES**

According to information published by the National Association of Insurance Commissioners, no state currently mandates coverage or the availability of coverage for expenses associated with reduction mammoplasty.

#### **REVIEW CRITERIA**

##### SOCIAL IMPACT

- a. *The extent to which the treatment or service is generally utilized by a significant portion of the population.*

One proponent cited statistics that indicate that this service is provided over 40,000 times per year nationwide. BCBSVA reported that of the 300 cases it considered in 1993, it approved 85% as medically necessary.

- b. *The extent to which insurance coverage for the treatment or service is already available.*

Of the 29 respondents to complete the insurer survey, 23 (79%) reported that they currently provide the coverage required by House Bill 182 to their Virginia policyholders if the procedure is medically necessary.

- c. *If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.*

Based on information provided to the Advisory Commission by proponents, it is not uncommon for insurers to refuse coverage if the patient is determined to be overweight based on its standards. These proponents do not agree with this practice and contend that above-average patient weight does not

lessen the effectiveness of the procedure. One proponent explained that in order for the insurer to cover her procedure, she first had to lose 36 pounds.

- d. *If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.*

Coverage is available; however, there is concern among proponents that some insurers will not provide such benefits for patients that are above-average weight. The case cited under the criterion listed above is an example. In written testimony submitted to the Advisory Commission, BCBSVA stated that depending upon the length of hospitalization, the cost of the procedure ranges from \$3,500 to \$5,500 on average. One proponent contended that in 1992, the total estimated cost, including surgical and hospitalization, of uncomplicated breast reduction surgery was \$10,860. If there are complications, the estimated average cost was \$64,000.

- e. *The level of public demand for the treatment or service.*

One proponent stated that this service is provided over 40,000 times per year. BCBSVA reported that it considered less than 300 cases involving reduction mammoplasty in 1993. Eighty-five percent of those cases were approved as medically necessary.

- f. *The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.*

The level of public demand for this coverage is unknown. As with many health insurance benefits, it is accepted that many policyholders are not knowledgeable about the specific terms of their coverage until they are diagnosed with a disease or condition that requires a specific treatment.

- g. *The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.*

The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts is unknown.



- h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

The Advisory Commission is not aware of any such findings of a state health planning agency or appropriate health system agency relating to the social impact of this proposal.

#### FINANCIAL IMPACT

- a. The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.*

No information was provided by either proponents or opponents that would suggest that enactment of this bill would either increase or decrease the cost of treatment for reconstructive reduction mammoplasty.

- b. The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.*

Proponents stated that some patients are not able to undergo the procedure because of the weight restrictions and/or the ambiguous definition of the term "medically necessary." No information was provided regarding a possible increase in the inappropriate use of such treatment.

- c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.*

The range of services covered by this bill were not identified as substitutes for more or less expensive treatments of the same conditions.

- d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.*

It is unlikely that the proposed coverage would significantly affect the number and types of providers of the mandated treatments because it is apparent that many insurers already provide such coverage and because the number of insured needing such treatment is relatively small.

- e. *The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.*

It is unlikely that this proposal will significantly increase or decrease the administrative expenses of insurance companies and the premium and administrative expense of policy holders because it would apply to all policyholders equally and is not likely to result in a significant increase in claim submissions because of its limited scope.

- f. *The impact of coverage on the total cost of health care.*

The impact on the total cost of health care is not expected to be significant.

#### MEDICAL EFFICACY

- a. *The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.*

Opponents did not challenge the medical efficacy of reconstructive reduction mammoplasty, when medically necessary.

- b. *If the legislation seeks to mandate coverage of an additional class of practitioners:*
  - 1) *The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.*

Not applicable.

- 2) *The methods of the appropriate professional organization that assure clinical proficiency.*

Not applicable.

EFFECTS OF BALANCING THE SOCIAL, FINANCIAL AND MEDICAL EFFICACY  
CONSIDERATIONS

- a. *The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.*

House Bill 182 addresses the medical need to surgically treat the signs and symptoms associated with macromastia. The coverage is consistent with the role of health insurance.

- b. *The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.*

The cost of the mandated coverage has been estimated to be very low. BCBSVA estimates that less than one tenth of one percent of premiums is attributable to claims involving reconstructive reduction mammoplasty. Insurers responding to the insurer survey projected monthly premium costs in the range of \$0.11 and \$1.56 per month per policyholder or group certificate holder to comply with House Bill 182.

- c. *The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.*

The cost of a mandated offer of coverage would be expected to be higher due to adverse selection by those who had reason to believe they might need such treatment in the future. In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual insureds. Therefore, it is possible that many insureds would not benefit from such a requirement.

**RECOMMENDATION**

The Advisory Commission voted unanimously (9-Yes, 0-No) on May 16, 1994 to recommend that House Bill 182 not be enacted.

**CONCLUSION**

Currently, many insurers provide coverage for reconstructive reduction mammoplasty to alleviate the signs and symptoms of macromastia if the procedure is deemed medically necessary and not cosmetic in nature. Based on the information obtained during the course of its review, the Advisory Commission concluded that coverage for reduction mammoplasty is already generally available.

## 1994 SESSION

LD3113160

## HOUSE BILL NO. 182

Offered January 14, 1994

*A BILL to amend and reenact § 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding a section numbered 38.2-3418.2, relating to insurance coverage for reduction mammoplasty.*

Patrons—Cooper, Christian, Crittenden, Darner, Keating, Puller and Van Landingham;  
Senator: Lucas

Referred to Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3418.2 as follows:

*§ 38.2-3418.2. Coverage for reduction mammoplasty.*

*A. Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth for reconstructive reduction mammoplasty performed to relieve signs and symptoms of macromastia.*

*B. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies, or to short-term nonrenewable policies of not more than six months' duration.*

*§ 38.2-4319. Statutory construction and relationship to other laws.*

*A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1310, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3500, 38.2-3525, 38.2-3542, and Chapter 53 (§ 38.2-5300 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200) of this title except with respect to the activities of its health maintenance organization.*

*B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.*

*C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.*

*D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.*