REPORT OF THE SPECIAL ADVISORY COMMISSION ON MANDATED HEALTH INSURANCE BENEFITS

MANDATED COVERAGE OF RECONSTRUCTIVE BREAST SURGERY

(SENATE BILL 948, 1997)

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 14

COMMONWEALTH OF VIRGINIA
RICHMOND
1998

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

JEAN W. CUNNINGHAM
POST OFFICE BOX 542
RICHMOND, VIRGINIA 23204

SEVENTY-FIRST DISTRICT

COMMITTEE ASSIGNMENTS:
PRIVILEGES AND ELECTIONS
APPROPRIATIONS
HEALTH, WELFARE AND INSTITUTIONS
MILITIA AND POLICE

December 12, 1997

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 (Advisory Commission) to assess the social and financial impact and the medical efficacy of Senate Bill 948, regarding mandatory coverage for reconstructive breast surgery.

This report is respectfully submitted on behalf of the remaining members of the Advisory Commission.

Member, Virginia House of Delegates
Special Advisory Commission on
Mandated Health Insurance Benefits

SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS

Jean W. Cunningham
Stephen H. Martin
William C. Wampler, Jr.
John T. Ashley, M.D.
Johanna B. Chase
Duval Dickinson
Rowena J. Fullinwider
Charles B. Garber
Matthew D. Jenkins
Myrna McLaughlin
Kelley Osborn
Randolph L. Gordon, M.D., M.P.H.
Alfred W. Gross

As of September 5, 1997

George W. Dawson
William McCall

Through September 1997

George H. Heilig, Jr., Acting Chairman

TABLE OF CONTENTS

INTRODUCTION

The 1997 Senate Committee on Commerce and Labor referred Senate Bill 948 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) to be reviewed prior to the 1998 Session of the General Assembly. Senate Bill 948 is patroned by Senator William Roscoe Reynolds.

The Advisory Commission held a public hearing on July 29, 1997 in Richmond to receive comments on Senate Bill 948. In addition to the bill's chief patron, representatives from the American Cancer Society (ACS), the American Society of Plastic and Reconstructive Surgery (ASPRS), the Virginia Society of Plastic Surgery, the Virginia Breast Cancer Foundation (VBCF), and seven interested parties spoke in favor of the bill. Written comments supporting the proposal were received from the ACS, VBCF, ASPRS, six plastic and reconstructive surgeons, two surgical oncologists, seven physicians, two psychologists, one obstetrician, and forty-six interested parties. One physician submitted the case history of a breast cancer patient who was denied coverage for reconstructive surgery. A plastic surgeon specializing in breast reconstruction submitted a list of the states that currently legislate reconstructive breast surgery. Another plastic surgeon submitted a petition with eighteen names and addresses of individuals who support Senate Bill 948.

Written comments in opposition to the bill were received from the Virginia Manufacturers Association (VMA), the Virginia Chamber of Commerce (VCC), and Trigon Blue Cross Blue Shield (Trigon). The Virginia Association of Health Maintenance Organizations (VAHMO) stated in written and oral comments that it had no position on Senate Bill 948.

The Advisory Commission concluded its review of Senate Bill 948 on August 27, 1997.

SUMMARY OF PROPOSED LEGISLATION

Senate Bill 948, as introduced, would amend the accident and sickness chapter of Title 38.2 of the Code of Virginia by adding § 38.2-3418.3 to require any 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 (HMO) providing a health care plan for health care services to provide coverage for reconstructive breast surgery under such policy, contract or plan delivered, issued for delivery or renewed after July 1,1997. The bill defines "reconstructive breast surgery" as surgery performed as a result of a mastectomy to re-establish symmetry between the two breasts. This bill does

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.

BREAST RECONSTRUCTION SURGERY

The ACS defines breast reconstruction as a surgical procedure or series of procedures that attempts to create a natural breast shape after a breast has been removed. There are two methods of breast reconstruction: man-made implants and autologous reconstruction. Implants are a simpler, less expensive procedure and are generally performed on an outpatient basis. Implantation is usually performed in two stages. The first stage prepares the breast area for the implants by gradually stretching the skin and muscles in the implantation site. A tissue expander (a collapsed balloon), is implanted in the breast area and gradually expanded by injecting a saline solution into the expander weekly. Once the breast area has reached the desired size, the second stage involves the removal of the extender and implantation of the artificial breast.

The second method, autologous reconstruction, is more commonly known as a transverse rectus abdominus myocutaneous (TRAM) flap. TRAM flap is a procedure during which the woman's own tissue is used to rebuild the breast. Fat from a woman's abdomen or back is used to shape a new breast, providing a more natural-looking breast. The procedure takes six to eight hours to complete and requires a woman to remain overnight in the intensive care unit, and to spend several additional days in the hospital. The Medical College of Virginia reported that average length of stay for reconstructive surgery is 6.5 days. The ASPRS notes that the average hospital stay for reconstructive surgery is 5.3 days. Follow-up treatment can range from eight to forty-eight months.

Senate Bill 948 defines reconstructive surgery to include surgery to restore symmetry between the two breasts. Surgery to restore symmetry involves lifting, reducing or enlarging the remaining natural breast to match the reconstructed one. According to a February 3, 1997 *Virginian-Pilot* article entitled "Insurers Reject Coverage for Some Breast Surgeries," about 25% of women that underwent reconstructive surgery on the diseased breast also required surgery to restore symmetry between the natural breast and the newly created breast.

Post-mastectomy patients have the option of immediate breast reconstructive surgery, which is performed at the time of the mastectomy surgery, or delayed reconstructive surgery, which can be performed months or years following the mastectomy surgery. Surgical oncologists and plastic surgeons recommend that in some cases, it is best to postpone reconstuctive surgery on the removed breast because some patients experience a reoccurrence of the cancer at the site of the mastectomy.

Plastic surgeons may also recommend that surgery to re-establish symmetry be delayed to allow the patient's body to heal completely following mastectomy or surgery to reconstruct the removed breast. Physicians explained that is difficult to realign a woman's breasts immediately following these surgeries because patients experience swelling and soreness in the entire upper torso area. Proponents expressed concern that insurers often impose time limits during which reconstructive or symmetry surgery must be performed following mastectomy. Patients who do not undergo these procedures within this time frame may be denied coverage.

The ACS notes that women seek breast reconstruction for several reasons, including: a restored sense of freedom, a feeling of being physically renewed, a reduced preoccupation with breast cancer, and an enhanced sense of sexual attractiveness. According to data provided by the Virginia Department of Health (VDH), women do not undergo reconstructive surgery to please their mate or other people. Many patients indicated that they undergo reconstructive surgery because mastectomy surgery leaves them disfigured. Studies conducted by the ASPRS indicated that fear of losing a breast is a leading reason many women do not participate in early breast cancer detection programs. The missing breast serves as a constant reminder that they harbored a potentially life-threatening disease. Patients explained that the loss of a breast leaves women feeling less feminine and less desirable.

MEDICAL EFFICACY

The medical efficacy of reconstructive breast surgery, as defined in Senate Bill 948, is questioned by opponents. Opponents do not argue against the medical efficacy of reconstruction of the breast that is removed due to mastectomy. Insurers indicated that reconstructive surgery of the removed breast is routinely, if not always, covered. Opponents of the bill questioned the medical efficacy of surgery to restore symmetry between the two breasts. Some insurers contend that surgery to lift, reduce or enlarge the remaining natural breast is voluntary and cosmetic surgery. The VCC noted in written comments that this kind of surgery can involve reshaping, reduction, or augmentation to achieve symmetry, which is more an issue of art than medicine, and often to the eye of the beholder. Some insurers noted that inclusion of this kind of coverage is best left to the competitive market.

Proponents of Senate Bill 948 contend that coverage for both the reconstruction of the removed breast and augmentation of the natural breast is integral to the recovery of the patient. The VBCF reported that some women will not undergo the initial reconstruction surgery on the breast that underwent the mastectomy if symmetry is not covered. Plastic surgeons and breast cancer patients contend that some Virginia insurers will cover the initial surgery, but will not cover additional surgeries to restore symmetry or to correct scarring because

these surgeries are considered cosmetic. Proponents report that molding the nipple and darkening the skin around it to create an areola are other procedures that often are not covered.

The ASPRS reports that there are limitations on the currently available techniques, so reconstruction of a new breast mound often results in a shape and contour that is significantly different from the remaining natural breast. The ASPRS contends that since breasts are paired organs, like eyes and hands, reconstructive surgery to achieve the best possible match of size and configuration is necessary and should be eligible for insurance coverage and reimbursement.

A former breast cancer patient explained in written testimony that the surgery should be called "chest reconstruction" instead of breast reconstruction. She further stated that both breasts need to be symmetrical in size and shape for a woman to feel comfortable and confident in her appearance, as well as for health concerns such as back pain from an imbalance in breast size.

CURRENT INDUSTRY PRACTICES

Staff surveyed fifty of the top writers of accident and sickness insurance in Virginia regarding Senate Bill 948. Thirty-five companies responded by the May 2, 1997 deadline. Five companies indicated that they write little or no applicable health insurance policies in Virginia and could not provide the information requested. Of the 30 respondents that completed the survey, 29 indicated that they currently provide coverage for reconstructive breast surgery as part of their standard benefit package to both individual policyholders and group certificate holders. One company indicated that, while coverage for reconstructive breast surgery is included in their standard policies, they market only individual policies. Two companies indicated that they market only group policies, and coverage for reconstructive surgery is included in their standard policies. Of the 29 companies that do provide coverage, three indicated that reconstructive breast surgery is covered as long as it is medically necessary.

Trigon and its HMO subsidiaries (HealthKeepers, Physicians Health Plan, Peninsula Health Care, and Health First) indicated that reconstructive breast surgery is always covered for the side on which the mastectomy occurred, and that contralateral surgery is covered if the unaffected breast is too large or uneven in shape to be matched by the implant. Two insurers, Nationwide and Golden Rule, indicated that they provide coverage for reconstructive breast surgery on the side that received the mastectomy; however, surgery on the nondiseased breast is not covered because the procedure is considered cosmetic in nature. Only one insurer responding to the survey, Life Insurance of North America, indicated that they do not provide the coverage as specified in Senate Bill 948 to their Virginia policyholders.

Three insurers indicated that optional coverage for reconstructive breast surgery is available to its group certificate holders. None of the insurers responding to the survey indicated that they offer optional coverage for reconstructive breast surgery to their individual policyholders.

A survey conducted by the ASPRS found that in 1995, 84% of its members had at least 10 patients denied insurance coverage for breast reconstruction following a mastectomy. ASPRS' survey also found that 43% of the patients cared for by ASPRS members had been denied coverage for a symmetry procedure, and nearly 20% had been denied coverage for changes made after the initial surgery. The ASPRS found that in general, insurance companies are reluctant to pay for the initial breast reconstruction, as well as follow-up procedures because they consider both procedures to be cosmetic. A second ASPRS survey found that Virginia ranks 10th in the nation in patients who responded that they had been denied coverage for breast reconstruction as part of their treatment of breast cancer.

FINANCIAL IMPACT

Respondents to the Bureau of Insurance (Bureau) survey provided cost figures of between $0.01 and $2.00 per month per standard individual policy and cost figures that ranged from less than $0.01 to $2.00 per month per standard group certificate to provide the coverage specified in Senate Bill 948. Insurers providing coverage on an optional basis provided cost figures from $0.04 to $10.00 per month for both individual policies and group certificates. One insurer reported that the cost of providing coverage for reconstructive breast surgery on an optional basis would be $509.01 per month for its individual policyholders and $407.21 per month for its group certificate holders.

The *Virginian-Pilot* article states that the average cost for implants is $2,400 for the surgeon's fees, while the average cost for a TRAM flap procedure, including follow-up care, is about $6,400 for surgeon's fees. A study published in the February, 1996 issue of *Plastic and Reconstructive Surgery* (Vol. 97, No. 2) found that for all implant patients followed for more than four years, the estimated total cost of care in 1993 dollars was $19,762 per patient during the four-year observation. The estimated cost of care for all TRAM flap patients was $18,793 per patient during the same observation period.

Representatives from the Medical College of Virginia (MCV) reported by telephone that the average cost of inpatient care following TRAM flap surgery is $24,428 for 6.5 days. This figure is an average of all patients whose surgeries were performed at MCV during the 1996 - 97 fiscal year. The figure includes the cost of one to two days of hospitalization in the intensive care unit. MCV did not

provide cost figures for inpatient care for those patients who chose implants because implant surgery is performed on an outpatient basis at MCV.

SIMILAR LEGISLATION IN OTHER STATES

As of March 1997, four bills had been introduced on the federal level that include language requiring coverage for breast reconstruction following a mastectomy. According to information provided by the National Association of Insurance Commissioners and the National Insurance Law Service, there were 14 states that mandated coverage for reconstructive breast surgery during the Advisory Commission's review. Of those fourteen states, two states require mandatory offering of coverage for reconstructive breast surgery. Six states require policies providing coverage for mastectomy surgery to also provide coverage for reconstructive breast surgery. Three states include language in their statutes that limits the amount of time during which the reconstructive surgery must be performed following the mastectomy surgery. Seven states include language requiring coverage to restore symmetry between the diseased and non-diseased breasts.

REVIEW CRITERIA

SOCIAL IMPACT

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

The ACS estimates that 4,400 women will be diagnosed with breast cancer in Virginia in 1997. The Virginia Cancer Registry (VCR) reports that over 56% of the cancer patients in Virginia treated their breast cancer with mastectomy surgery in 1992. The majority of those patients underwent a modified radical mastectomy, which is the removal of the entire breast, the overlying skin, and the lymph nodes.

Information provided by the VDH indicates that in 1983, only 3% of women sought breast reconstruction after mastectomy surgery. By 1992, that number grew to 25%. According to the *Virginian-Pilot* article, about 25% of reconstructive breast surgeries involve not only rebuilding the breast that was removed, but also lifting, reducing or enlarging the remaining, natural breast to match the reconstructed one.

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

Of the 30 respondents that completed the Bureau survey, 29 indicated that they currently provide coverage for reconstructive breast surgery as part of their standard benefit package to both individual policyholders and group certificate holders. Three insurers indicated that surgery on the unaffected breast to achieve symmetry is covered only when considered medically necessary.

VAHMO cited a recent survey of its members which found that all 19 licensed HMOs that responded to their survey provide coverage for reconstructive surgery on the diseased breast, and 17 HMOs routinely cover reconstructive surgery on the unaffected normal breast to achieve symmetry. Trigon and its HMO subsidiaries (HealthKeepers, Physicians Health Plan, Peninsula Health Care, and Health First) indicated that reconstructive breast surgery is always covered for the side on which the mastectomy occurred, and that contralateral surgery is covered if the unaffected breast is too large or uneven in shape to be matched by the implant.

A survey by the ASPRS found that 84% of its members had at least 10 patients that had been denied coverage for breast reconstruction following a mastectomy. ASPRS contends that insurers are reluctant to pay for the initial breast reconstruction, as well as follow-up procedures, because insurers consider these procedures to be cosmetic. The survey also found that 43% of the ASPRS members had patients who had been denied coverage for symmetry procedures, and nearly 20% had patients who had been denied coverage for changes made after the initial surgery.

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.*

Opponents contended that coverage is generally available for reconstruction of the removed breast. However, opponents argued that coverage for reducing, enlarging, repositioning, or shaping the unaffected breast may not be medically necessary in all cases. The VMA stated in written comments that Senate Bill 948 implies that coverage for mastectomy stops with the removal of the breast, which is not the case. Several insurers indicated that reconstruction of the removed breast is routinely reimbursed today.

Proponents agreed that coverage for reconstructive surgery on the diseased breast is generally available. However, coverage for surgery on the non-diseased breast to restore symmetry between the two breasts is not

generally available. Plastic surgeons and patients argued that mastectomy patients are often left with breasts that are uneven in size and shape. The VBCF stated in written comments that reconstruction of the non-diseased breast should be viewed as medically necessary because very large-sized asymmetrical breasts may cause back and/or neck problems leading to a need for physical therapy services or additional medical treatment.

Plastic surgeons and patients also expressed concern about the psychological impact of having part or all of a breast removed. Information provided by the ASPRS contends that the breast plays an important role in the self-image of women of all ages. The loss of a breast as a result of cancer can mean the loss of part of a woman's identity. For these women, breast reconstruction is extremely important in restoring their sense of wholeness and well-being.

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.

Opponents contended that breast reconstruction on the removed breast is routinely covered. The VCC stated that surgery to achieve symmetry is not medically necessary in all instances. The VCC further stated that this kind of surgery is more an issue of art than medicine and often in the eye of the beholder. The VMA noted that inclusion of this kind of coverage is best left to the competitive market and should not be a mandated benefit.

One patient wrote that being diagnosed with breast cancer is a financial strain on women and their families. When her insurer denied coverage for reconstructive breast surgery on the unaffected breast, her family was faced with a bill of $3,000. She further noted that she was forced to decide between putting a financial strain on her family or going through life disfigured. Another patient noted in written comments that often women recovering from breast cancer are unable to work; therefore, they are unable to pay out of pocket for the breast reconstruction surgery.

Several plastic surgeons explained that in some cases where the patient has been denied coverage for reconstructive surgery, many of the surgeons will perform symmetry surgery on the natural breast without charging the patient. However, the hospital charges related to this surgery are usually the responsibility of the patient. One plastic surgeon explained by telephone that many women are faced with the decision between financial ruin or a normal appearance that is acceptable in society.

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

The ACS estimates that 4,400 women will be diagnosed with breast cancer in Virginia in 1997. The VCR reports that over 56% of the cancer patients in Virginia treated their breast cancer with mastectomy surgery in 1992. The majority of those patients underwent a modified radical mastectomy, which is the removal of the entire breast, the overlying skin, and the lymph nodes.

Proponents noted that not all mastectomy patients are interested in breast reconstruction or symmetry surgery. Some patients choose a prostetic to achieve a normal appearance.

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

Plastic surgeons, surgical oncologists, psychiatrists, an obstetrician, and several physicians submitted comments supporting enactment of Senate Bill 948. One psychologist stated in written comments that she has seen the stress on the women and their families attempting to raise money to "purchase" a life-saving medical treatment. The stress of wondering how to pay for necessary reconstructive surgery slows the physical and emotional healing process.

An ASPRS survey found that 43% of its members had patients that had been denied coverage for symmetry procedures. The survey also found that 20% had patients that had been denied coverage for changes made after the initial surgery. One plastic surgeon noted that obtaining approval for the opposite breast surgery and the areola was not a problem five years ago. He contended that denial of coverage for these procedures is a routine problem today.

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.*

No information or relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of this mandated benefit was presented during this review.

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 Senate Bill 948 would either increase or decrease the cost of reconstructive breast surgery.

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

Proponents anticipate that the appropriate use of this treatment will increase with the enactment of the proposed mandate. Breast cancer patients who undergo mastectomy surgery would access benefits to reconstruct the breast that was removed, as well as the surgery to restore symmetry to the opposite breast.

Opponents expressed concern that enactment of Senate Bill 948 would increase the inappropriate use of a surgery that is not medically necessary. VAHMO expressed concern that the language of Senate Bill 948 was too broad. VAHMO questioned whether there would be a limit on the number of surgeries that a woman can undergo to achieve a symmetrical appearance.

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

A February, 1997 *Virginian-Pilot* article reported that the average cost for implants is $2,400 for the surgeon's fees. One plastic surgeon provided a case study of a recent patient who chose an implant for reconstruction of her right breast. The surgical cost to the patient included: $2,000 for the replacement of the tissue expander with a permanent implant; $1,600 for nipple reconstruction; and $500 for areola reconstruction by tattooing. A 1996 *New York Times* article reported that the average cost for TRAM flap procedure, including follow-up

care, is about $6,400 for surgeon's fees. A study published in the February, 1996 issue of *Plastic and Reconstructive Surgery* (Vol. 97, No. 2) found that for all implant patients followed for more than four years, the estimated total cost of care in 1993 dollars was $19,762 per patient during the four-year observation. The estimated cost of care for all TRAM flap patients was $18,793 per patient during the same observation period.

Representatives from the Medical College of Virginia (MCV) reported by telephone that the average cost of inpatient care following TRAM flap surgery is $24,428 for 6.5 days. This figure is an average of all patients whose surgery was performed at MCV during the 1996 - 97 fiscal year. The figure includes the cost of one to two days of hospitalization in the intensive care unit. MCV did not provide cost figures for inpatient care for those patients who chose implants because implant surgery is performed on an outpatient basis at MCV.

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.*

The number and type of providers of the mandated service are not expected to increase over the next five years as a result of this bill.

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.*

An increase in the administrative expenses of insurance companies and the premiums and administrative expenses for policyholders is anticipated because of the expenses associated with such things as policy redesign, form filing, claims processing systems and marketing, and other administrative requirements. Trigon stated in written comments that consumers and purchasers of health insurance should be given the option to design their health care benefits based on the services they desire and the price they are willing to pay. Trigon further stated that mandating benefits takes choice out of the hands of those who use and pay for health care services.

The premiums to policyholders are also expected to increase if Senate Bill 948 is enacted. All patients who undergo mastectomy surgery would be able to access benefits for symmetry surgery. VMA indicated in written comments that mandating benefits that are medically unnecessary serve only to raise premiums and make health insurance more unaffordable for those who need it most.

Respondents to the Bureau survey provided cost figures of between $0.01 and $2.00 per month per standard individual policy and cost figures that ranged from less than $0.01 to $2.00 per month per standard group certificate to provide the coverage as specified in Senate Bill 948.

Insurers providing coverage on an optional basis provided cost figures from $0.04 to $10.00 per month for both individual policies and group certificates. One insurer reported that the cost of providing coverage for reconstructive breast surgery on an optional basis would be $509.01 per month for its individual policyholders.

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

The total cost of health care is not expected to be significantly affected.

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.

The medical efficacy of breast reconstruction of the removed breast is not challenged by opponents. Insurers routinely cover reconstruction of the removed breast. Opponents question the medical efficacy of augmentation of the non-diseased breast. VMA and VCC stated in written comments that there are some instances where it is medically necessary to surgically realign the opposite breast. However, both organizations contended in some cases symmetry surgery is cosmetic and voluntary surgery.

Proponents argued that reconstruction of the diseased breast and symmetry surgery on the non-diseased breast is critical to the overall health of a breast cancer patient. A study conducted by the ASPRS concluded that women benefit psychologically and physically if they undergo breast reconstruction immediately following a mastectomy. Women participating in the study indicated that the offer of reconstructive surgery gave them the emotional strength to continue fighting the cancer.

A plastic surgeon explained in written comments that although prosthetic devices can be used to provide a more normal appearance following the removal of a breast, they are often problematic for the patient. One reason mentioned is that prosthetics shift out of place. Another reason is that prosthetics can be hot and heavy. She noted that other paired body parts, such as the eyes or ears,

are covered by insurers when they are traumatically or surgically lost. A representative from the VAHMO indicated in oral comments that their organization recognizes the trauma of breast cancer and the fact that nearly half of Virginia's population may be faced with the disease.

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.*

Opponents of Senate Bill 948 argued that the proposed coverage is not consistent with the role of health insurance because it is cosmetic surgery and not medically necessary. VMA contended that Senate Bill 948 seeks a legislative determination that the surgery is always medically necessary. VMA acknowledged that there are cases where it is medically necessary to perform surgery on the non-diseased breast. However, VMA also argued that there are instances where augmentation, shaping or reduction of the non-diseased breast could be properly described as voluntary or cosmetic surgery.

Proponents argued that Senate Bill 948 addresses a medical and broader social need. The VBCF noted in written comments that very large-sized asymmetrical breasts may cause back and/or neck problems leading to a need for physical therapy services or additional medical treatment. The ASPRS contended that since breasts are paired organs, like eyes and hands, reconstructive surgery to achieve the best possible match of size and configuration is necessary and should be eligible for insurance coverage and reimbursement.

One patient explained that when a woman loses a breast to cancer or is left with uneven breasts following surgery, the woman and society see a disfigurement. She further explained that each time a woman with a missing or uneven breasts looks in the mirror, it is a reminder of a loss of a breast, femininity, and womanhood. Another patient stated in written comments that reconstructive surgery and symmetry surgery restore dignity to women who undergo a traumatic illness such as breast cancer. Proponents further argued that women who receive a diagnosis of breast cancer and undergo surgery, radiation, and/or chemotherapy should not have to engage in a struggle with their insurers at a time when they are fighting for their lives.

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

Respondents to the Bureau survey provided cost figures of between $0.01 and $2.00 per month per standard individual policy and cost figures that ranged from less than $0.01 and $2.00 per month per standard group certificate to provide the coverage as specified in Senate Bill 948. Insurers providing coverage on an optional basis provided cost figures from $0.04 to $10.00 per month for both individual policies and group certificates. One insurer reported that the cost of providing coverage for reconstructive breast surgery on an optional basis would be $509.01 per month for its individual policyholders and $407.21 per month for its group certificate holders.

Several breast cancer survivors argued that breast reconstruction of the diseased breast, as well as the non-diseased breast, improves the patient's mental and emotional health and speeds up recovery. One patient stated in written comments that the cost for insurers to provide this coverage is nominal when compared to the emotional, psychological and physical health of the patient.

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

It is expected that the cost of a mandated offer of coverage would be higher than a mandate of coverage because of adverse selection by women who have strong family histories of breast cancer. In the case of group coverage, the decision of whether to select the optional coverage would lie with the master contract holder and not the individual insureds. Therefore, it is possible that many women would not benefit from such a mandate.

Insurers noted that it is best to leave this type of coverage to the competitive market and not to make it a mandated benefit. Insurance policies which exclude sought-after coverage are likely to be at a competitive disadvantage, and companies that fail to respond will suffer in the market.

RECOMMENDATION

The Advisory Commission voted on August 27, 1997 to recommend that Senate Bill 948 be enacted (Yes - 8, No - 2).

CONCLUSION

The Advisory Commission found that reconstruction of the removed breast is generally covered by insurers. However, coverage for surgery on the opposite breast to restore symmetry between the breasts varied greatly from insurer to insurer. Women unable to pay out-of-pocket for symmetry surgery are often left with breasts that are uneven in size and shape. The Advisory Commission concluded that to restore a woman to physical, emotional and psychological health following the loss of a breast due to mastectomy, mandatory coverage of reconstructive surgery to replace the removed breast and surgery to re-establish symmetry is necessary.

978007428

SENATE BILL NO. 948

Offered January 16, 1997

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 38.2-3418.3, relating to accident and sickness insurance; coverage for reconstructive breast surgery.

Patrons—Reynolds, Couric, Houck, Howell, Lucas, Miller, Y.B. and Whipple; Delegate: Rhodes

Referred to the Committee on Commerce and Labor

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 38.2-3418.3 as follows:

§ 38.2-3418.3. Coverage for reconstructive breast surgery.

A. Notwithstanding the provisions of § 38.2-3419, 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 for reconstructive breast surgery under such policy, contract or plan delivered, issued for delivery or renewed in this Commonwealth on or after July 1, 1997.

B. For purposes of this section, "reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts.

C. 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 38.2-1309, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1, 38.2-3418.1:1, 38.2-3418.1:2, 38.2-3418.2, *38.2-3418.3*, 38.2-3419.1, 38.2-3431, 38.2-3432, 38.2-3433, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3525, 38.2-3542, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 54 (§ 38.2-5400 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 et seq.) 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.

MANDATED COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY

STATE	CITATION	SUMMARY
Arizona	20-1342 (individual) 20-1402 (group) (1983/1996)	Policies providing coverage for mastectomy surgery shall provide coverage for reconstructive breast surgery. Coverage includes at least two external postoperative prostheses incidental to the patient's recovery.
Arkansas	I-Act 1196 Effective 07-31-97	Every health care insurer that provides benefits for mastectomy surgery shall include coverage for prosthetic devices and reconstructive surgery.
California	§ 10123.8 (group) § 11512.10 (hospital service plans) § 1367.6 (health service plans) (1989/1991)	Policies providing coverage for mastectomy surgery shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to the mastectomy.
Connecticut	38a-504 (individual) 38a-542 (group) (1986/1997)	Coverage for the surgical removal of tumors and treatment of leukemia, including outpatient chemotherapy following surgical procedure in connection with the treatment of tumors, and reconstructive surgery. Requires health plans to cover reasonable cost of breast reconstruction surgery following a mastectomy. The coverage provides for the following: $500/yr for surgical removal of tumors; $500/yr for reconstructive surgery; $500/yr for outpatient chemotherapy; and $300/yr per breast for prosthesis.
Florida	627.6417 (individual) 627.6612 (group) (HMOs) (1988/1997)	Policies providing coverage for mastectomy surgery must provide coverage for the prosthetic device and reconstructive surgery incident to the mastectomy. Breast reconstruction is defined as re-establishing symmetry between two breasts, in a manner determined by the physician in consultation with the patient.

MANDATED COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY

STATE	CITATION	SUMMARY
Illinois	215 ILCS 5/356g (individual, group) (1981/1991) [OPTIONAL COVERAGE]	Policies providing coverage for mastectomy surgery must offer coverage for prosthetic devices or reconstructive surgery incident to the mastectomy. Coverage may be limited to the provision of prosthetic devices and reconstructive surgery to within two years after the date of the mastectomy.
Indiana	IC 27-8-5-26 (1997)	Policies providing coverage for a mastectomy may not be issued unless the policy provides coverage for: (1) prosthetic devices; and (2) reconstructive surgery incident to the mastectomy. Coverage includes (a) all stages of reconstruction of the diseased breast; and (b) surgery and reconstruction of the other breast to produce symmetry, in the manner determined by the attending physician in consultation with the patient. If a mastectomy is performed and there is no evidence of malignancy, coverage may be limited to the provision of prosthetic devices and reconstructive surgery for two years following the surgery.
Maine	24-A § 2745-C (individual) 24-A § 2837-C (group) 24-A § 4237 (HMOs) 24 § 2320-C (nonprofits) (1995/1997)	Policies providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed. Coverage also includes surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner chosen by the patient and the physician.
Maryland	48A § 490GG (individual, group, HMOs) 48A § 354Q (nonprofits) (1996)	Coverage for reconstructive breast surgery resulting from a mastectomy. Coverage includes all stages of reconstructive breast surgery performed on a nondiseased breast to establish symmetry when reconstructive breast surgery is performed.

MANDATED COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY

STATE	CITATION	SUMMARY
Michigan	500.3406a (individual) 500.3613 (group) 550.1415 (nonprofits) (1982)	Coverage for the cost of medical care for prosthetic devices to maintain or replace the body parts of an individual who has undergone a mastectomy.
Missouri	376.1209 (individual, group, HMOs, nonprofits) Effective 01-01-98	Policies that provide coverage for mastectomy surgery shall provide coverage for prosthetic devices or reconstructive surgery necessary to restore symmetry as recommended by the oncologist or primary care physician incident to the mastectomy.
Minnesota	62A.25 (individual, group, HMOs, nonprofits) (1985/1992)	Coverage for reconstructive surgery incidental to or following surgery resulting from injury, sickness or other disease of the involved part, as determined by the attending physician. Coverage for reconstructive breast surgery decided on a case-by-case basis.
Montana	Effective 01-01-98	Coverage for reconstructive surgery incidental to or following a mastectomy resulting from breast cancer, including all stages of one reconstructive surgery on the nondiseased breast to establish symmetry. Coverage includes costs of any prostheses.
Nevada	689A.041 (individual) 689B.0375 (group) 695B.191 (nonprofits) 695C.171 (HMOs) (1983/1989)	Policies providing coverage for mastectomy surgery must provide coverage for at least two prosthetic devices and for reconstructive surgery incident to the mastectomy. Benefits for reconstructive surgery are provided for up to three years after the original surgery. Coverage is required for all stages of breast reconstruction on the nondiseased breast to make it equal in size to the diseased breast after a mastectomy or reconstructive surgery on the diseased breast has been performed.

MANDATED COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY

STATE	CITATION	SUMMARY
New Hampshire	Effective 01-01-98	Coverage for breast reconstruction, including surgery and reconstruction of the other breast to produce a symmetrical appearance.
New Jersey	17B:26-2.1a (individual) 17B:27-46.1a (group) 17:48-6b (HMOs, nonprofits) (1983/1997)	Coverage for reconstructive breast surgery, including but not limited to: (1) the costs of prostheses, and (2) costs of outpatient chemotherapy in connection with treatment under any policy providing benefits for x-ray or radiation therapy.
New York	§ 3216 (individual) § 3221 (group) § 4303 (HMOs) Effective 01-01-98	Coverage for breast reconstruction surgery on the breast which the mastectomy has been performed. Coverage includes surgery and reconstruction of the other breast to produce a symmetrical appearance in the manner determined by the attending physician and the patient.
Oklahoma	Effective 01-01-98	Coverage for reconstructive breast surgery performed as a result of a partial or total mastectomy. Coverage includes all stages of reconstructive surgery performed on the nondiseased breast to establish symmetry.
Rhode Island	§ 27-18-39 (individual and group) § 27-19-34 (hospital service plans) § 27-20-29 (medical service plans) § 27-41-43 (HMOs) (1996)	Coverage for prosthetic devices and reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Any reconstructive surgery under this section must be performed within 18 months of the original mastectomy.

APPENDIX B

MANDATED COVERAGE FOR RECONSTRUCTIVE BREAST SURGERY

STATE	CITATION	SUMMARY
Texas	Act 296 (individual, group, HMO) Effective 09-01-97	Health plans that provide coverage for mastectomy must provide coverage for breast reconstruction. Breast reconstruction means reconstruction of a breast incident to mastectomy to restore or achieve breast symmetry. Coverage includes surgical reconstruction of both the diseased breast and the nondiseased breast.
Washington	48.20.395 (individual) 48.21.230 (group) 48.46.280 (HMOs) 48.44.330 (nonprofits) (1983/1985)	Coverage for reconstructive breast surgery resulting from a mastectomy. Coverage includes all stages of reconstructive breast reduction on the nondiseased breast to make it equal in size with the diseased breast after definitive reconstructive surgery on the diseased breast has been performed.