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(FORM UPDATED: 08/11/2010)

WISCONSIN STATE LEGISLATURE ...
PUBLIC HEARING - COMMITTEE RECORDS

1995-96
(session year)

Assembly
(Assembly, Senate or Joint)

Committee on Insurance, Securities and Corporate Policy...

COMMITTEE NOTICES ...

- Committee Reports ... **CR**
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- Public Hearings ... **PH**

INFORMATION COLLECTED BY COMMITTEE FOR AND AGAINST PROPOSAL

- Appointments ... **Appt** (w/Record of Comm. Proceedings)
- Clearinghouse Rules ... **CRule** (w/Record of Comm. Proceedings)
- Hearing Records ... bills and resolutions (w/Record of Comm. Proceedings)
  (**ab** = Assembly Bill) (**ar** = Assembly Resolution) (**ajr** = Assembly Joint Resolution)
  (**sb** = Senate Bill) (**sr** = Senate Resolution) (**sjr** = Senate Joint Resolution)
- Miscellaneous ... **Misc**

* Contents organized for archiving by: Stefanie Rose (LRB) (October 2012)

MPSA

COSMETIC SURGERY
SURGERY OF THE HAND
PLASTIC AND RECONSTRUCTIVE SURGERY

MADISON PLASTIC SURGERY ASSOCIATES, LTD.
JOHN E. HAMACHER, M.D.
WILLIAM A. WOOD, M.D.

February 8, 1996

Representative Ladwig
Post Office Box 8952
Madison, WI 53708

Dear Representative Ladwig:

Enclosed are additional sheets regarding the effort to obtain insurance coverage for breast reconstruction. The first page is merely a facts sheet, the second page identifies the American Medical Association effort to assure breast reconstruction in all states, and finally, I think the most important, is Maine's Legislation which was enacted in 1995. It is very brief but all inclusive and should be a model for any legislation that is enacted in this state. I hope this will give you more information and help you in your efforts.

If I can provide you with any futher information, please feel free to contact me.

Sincerely,

William A. Wood, M.D.
Plastic and Reconstructive Surgeon
Madison Plastic Surgery Associates

WAW:mbh
Enclosure

MADISON MEDICAL CENTER • 20 SOUTH PARK STREET
MADISON, WISCONSIN 53715
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FACTS ON WHY WE NEED BREAST RECONSTRUCTION AVAILABILITY

Breast cancer is the most common cancer in American women, afflicting 182,000 women per year, striking 1 out of 9 and kills 46,000 a year. Coping with this disease is a medical and emotional struggle since it carries with it the fear of disfigurement in a society that places great value on physical appearance. Many of these women will require mastectomy or amputation of their breast to treat their disease.

Some women adjust well to their amputated breast while others feel desperately mutilated, losing their sexuality, self esteem and self worth. Breast reconstruction for these women is extremely important to restore their sense of wholeness and well being in society, family, and interpersonal relationships.

Some insurance carriers are denying coverage of breast reconstruction, considering the procedure not medically necessary. These carriers will cover reconstruction of other body parts clearly demonstrating discrimination against the female breast. Most insurance companies will not cover procedures on the opposite breast to provide symmetry for the reconstruction. If these women are not financially able to pay for the surgery they will have no option to have their bodies restored to wholeness.

There is no known cause or cure for this silent breast cancer epidemic for the 2.8 million victims in America. Early detection and treatment is the best means we have available to enhance survival. **If women know that they cannot be reconstructed because of lack of insurance coverage, then they may have greater fear in participating in early detection programs.** Therefore, we may see women with more advanced stages of disease and decrease survival.

Women should have access to breast reconstruction if they desire it. That access should be available regardless of timing in relationship to the onset of the deformity or absence of their breast.

Insurance carriers coverage should not discriminate against the female breast for reconstructive coverage.

To support _____ women, Legislative efforts and enactment of laws that include insurance coverage for breast reconstruction is necessary. The legislation should be specific and insure coverage of all costs associated with all stages of the reconstruction that may be necessary as well as symmetry operations on the opposite breast in order to restore a woman's body into wholeness.

AMA: Expand access to postcancer breast reconstruction in all states

By Christina Kent
AMNEWS STAFF

WASHINGTON — In 1992, an estimated 73,200 U.S. women underwent a radical mastectomy for breast cancer. But only 29,613 of them had breast reconstructive surgery, partly because many health plans do not cover that procedure.

In an effort to increase the availability of reconstructive surgery, the AMA agreed at December's Interim Meeting to develop model state legislation requiring all insurance plans that cover mastectomy to offer an optional plan that also covers reconstruction.

The proposal from the Medical Student Section builds on current AMA policy, which states that rebuilding of the breast after a mastectomy for cancer should be considered not aesthetic but reconstructive surgery.

Currently, state laws and practices vary widely.

In Missouri, for example, the breast alone, of all parts of the body, is consistently denied coverage for reconstruction, delegates said.

In contrast, California law requires that every insurance plan covering mastectomy "shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient."

Other practice, coding actions

In other practice-related actions, the AMA:

- Resolved to work with third-party payers to establish a uniform definition of "observation care," to provide that the physician intends the patient to stay in the hospital fewer than 24 hours.
- Adopted guidelines for physician responsibilities in subacute care, to include an on-site visit within 72 hours of admission, followed by at least weekly visits.

In actions related to coding, the AMA:

- Rejected a proposal for a new coding system to replace the ICD-9 system.

Speakers testified that the current system was burdensome and either too detailed or not detailed enough. But the estimated price tag for AMA development of a replacement was put at $2.7 million.

"It would be very difficult to implement the intent of the [proposal] at this time," said AMA Trustee Yank D. Coble Jr., MD.

- Agreed to work to require that insurance carriers and managed care organizations nationwide use the AMA's CPT coding system exclusively, and that they adopt its annual update on a common date, preferably Jan. 1.

MAINE'S LEGISLATION - ENACTED IN 1995

All individual and group non-profit and medical services plan contracts and all non-profit health care plan contracts providing coverage for mastectomy surgery must provide coverage for reconstruction of the breast on which surgery has been performed and surgery and reconstruction of the other breast to produce a symmetrical appearance if the patient elects reconstruction and in the manner chosen by the patient and the physician.


FORWARD
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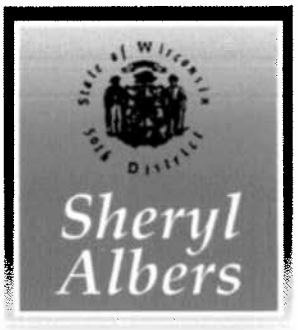

TO: Assembly Insurance, Security and Corporate Policy Committee Members

FROM: Representative Sheryl Albers

RE: Additional testimony on AB 965

DATE: March 20, 1996

Attached please find a copy of additional testimony I received from Dr. William Wood regarding AB 965.

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COSMETIC SURGERY
SURGERY OF THE HAND
PLASTIC AND RECONSTRUCTIVE SURGERY

MADISON PLASTIC SURGERY ASSOCIATES, LTD.
JOHN E. HAMACHER, M.D.
WILLIAM A. WOOD, M.D.

Distributed to Committee members

March 14, 1996

Sheryl Albers
127-W
P.O. Box 8952
State Capitol
Madison, WI 53708

Dear Representative Albers:

This letter is a follow-up to my testimony in front of your insurance committee on the 12th of March, 1996. My testimony was brief but I hope my point was made that certainly breast reconstruction is not covered in entirety by all insurance companies. The numbers, I am sure, can be generated by the insurance industry. I think that the issue is basically womens health rights versus increased cost for insurance. The increased costs are very small by my calculations. The added benefits from any woman that has been denied healthcare are huge. I think that in this era where womens health rights are important, as they should be, I think giving patients the opportunity to participate in their healthcare is very important.

As I stated in my testimony, I deal weekly with patients who are denied some aspect of breast reconstruction by their insurance plan. It seems a tragedy that in this State this still occurs. California and Maine have the most comprehensive legislation regarding breast reconstruction, it is all encompassing and I would hope that the Sate of Wisconsin could pass similar legislation.

If I can provide you with any further information, please feel free to contact me.

Sincerely,

WA Wood MD

William A. Wood, M.D.
Plastic and Reconstructive Surgeon
Madison Plastic Surgery Associates

WAW:mbh

P.S. Enclosed is an article which compares costs for breast reconstr

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Comparison of Resource Costs Between Implant-Based and TRAM Flap Breast Reconstruction

Stephen S. Kroll, M.D., Gregory R. D. Evans, M.D., Gregory P. Reece, M.D., Michael J. Miller, M.D., Geoffrey Robb, M.D., Bonnie J. Baldwin, M.D., and Mark A. Schusterman, M.D.

Houston, Texas

Resource costs, as measured by hours of time in the operating room, days of stay in the hospital, and other costs of care, were evaluated for 240 patients who underwent mastectomy with immediate breast reconstruction using either TRAM flaps or breast implants at The University of Texas M. D. Anderson Cancer Center. To make costs comparable, only patients who completed reconstruction of the nipple were included. As expected, the initial resource costs of implant-based reconstruction were much lower than those of TRAM flap reconstruction. After correcting for patients whose reconstructions were unsuccessful and including the costs of surgery subsequent to the initial reconstruction, however, the cost advantage of implant-based reconstruction disappeared. If current trends continue, it is likely that with increased follow-up, the long-term resource costs of implant-based reconstructions will continue to increase, while those of autogenous tissue reconstructions will not. Autogenous breast reconstruction with the TRAM flap therefore appears to be more cost-effective, in terms of time as well as dollars, in the long run than reconstruction based on prosthetic implants. (*Plast. Reconstr. Surg.* 97: 364, 1996.)

The high cost of medical care is coming under increasing scrutiny not only by insurance companies and other payers but also by thoughtful physicians as well. To plastic surgeons, the cost of our more complex reconstructive procedures is of particular concern. This concern is especially applicable to the field of breast reconstruction, where reconstruction with transverse rectus abdominis myocutaneous (TRAM) flaps[1] is becoming increasingly popular.[2–5] Compared with reconstructions based on prosthetic implants, reconstructions accomplished with TRAM flaps are softer, have had higher success rates, produce better aesthetic outcomes, and have fewer long-term complications.[6] Most plastic surgeons and patients who are familiar with TRAM flaps would agree that a successful TRAM flap offers the highest-quality breast reconstruction currently available. TRAM flaps are generally believed to be more expensive than implants, however, making them unattractive to some insurers and health maintenance organizations (HMOs). Many plastic surgeons have worried that HMOs in particular would not allow their patients to undergo TRAM flap breast reconstruction because of the higher costs believed to be associated with that technique.

At The University of Texas M. D. Anderson Cancer Center, the TRAM flap has been the most commonly used method of breast reconstruction for several years. This has come about partly because of the high degree of success enjoyed by our TRAM flap patients but also partly because of some degree of dissatisfaction with the results of breast reconstructions based on prosthetic implants. Many of our patients who have had reconstructions with implants have seen initially good results deteriorate with time, sometimes to the point of requesting that the implants be removed. Repeat operations for relief of capsular contracture and even for replacement of the implants with autogenous tissue have not been uncommon. We therefore questioned whether implant-based breast reconstruction was really less expensive than reconstruction with a TRAM flap in the long run.

From the Department of Reconstructive and Plastic Surgery at The University of Texas M. D. Anderson Cancer Center. Received for publication October 7, 1994; revised December 28, 1994.

We wished to compare the long-term costs of autogenous reconstruction—more complex but less likely to need subsequent surgery—with those of the initially cheaper but also less effective method of replacing the breast volume with an implant. We also wondered if, when failure rates were taken into account and cost-effectiveness was calculated, reconstruction with the TRAM flap would not appear less financially unattractive. To answer these questions, we reviewed our experience and compared the resource costs required for immediate breast reconstruction with implants and with TRAM flaps.

PATIENTS AND METHODS

All patients who had undergone immediate breast reconstruction at The University of Texas M. D. Anderson Cancer Center either with TRAM flaps or with silicone gel–filled or saline-filled implants (with or without tissue expansion) between March 1, 1986, and January 31, 1994, and who had completed the entire reconstructive procedure (including the nipple) were eligible for inclusion in the study. All eligible patients whose charts could be located were included. *Resource costs* were defined as the costs expended by the institution to provide the service being studied. Resource costs were selected for analysis instead of dollars billed to patients because the former were not affected by inflation and because in our institution billings to patients have been increased to subsidize research, physician training, and care for indigent patients. Moreover, hospital charges and billing strategies varied significantly during the period of our study, and focusing on resource costs eliminated those variations.

The major resource costs for mastectomy and immediate reconstruction were the hours of operative time and the number of days of hospital stay associated with the studied procedure. The operative times (including the time required for the mastectomy) and number of hospital days for the initial reconstructive procedure and for all subsequent procedures associated with the reconstruction, including reconstruction of the nipple, were determined from review of the charts. A patient was assigned to the implant or TRAM flap group on the basis of her initial reconstructive procedure. Any resource costs of additional surgery, including subsequent reconstruction using a different method, were then charged to the group to which the patient had been assigned initially.

The surgical fees charged for the breast reconstruction were ignored for the purposes of this study. Instead, personnel costs were calculated by using the operative times and the hourly cost of the surgeon's (and anesthesiologist's) salaries and benefits. This was done because proposed changes in our health care system may soon make our present surgical fee structure irrelevant. Resource costs were approached the way we believe they would be viewed by an HMO or other health care institution attempting to provide breast reconstruction using salaried employees. Anesthesia personnel costs were calculated and added to resource costs for those procedures performed under general or monitored anesthesia.

The mean costs for each day of hospital stay for the initial reconstruction and subsequent revisions were calculated by the Department of Management Systems and Finance at The University of Texas M. D. Anderson Cancer Center by averaging the actual costs of providing services to patients during calendar year 1993. The average cost of 1 hour in the operating room was determined in a similar manner. *Surgicenter day costs* were laboratory work and recovery room costs associated with outpatient surgery but not included in the hourly operating room cost. There were no additional costs (or anesthesia personnel costs) associated with procedures performed in the minor surgery room in the outpatient clinic. Additional cost components such as the tissue-expansion device, the mean number of clinic visits for tissue expansions, the breast implant, and the staff surgeon and surgical assistant also were converted to 1993 dollars and added to the cost of each reconstruction to calculate the *total resource cost* of each reconstruction. Because additional personnel usually were required for TRAM flap reconstruction, the cost of the salary and benefits for 1 full day of one extra surgical assistant was added to the total resource cost of each TRAM flap reconstruction (Table I).

Cost-effectiveness was determined by calculating the mean total resource cost of one complete breast reconstruction corrected by the ultimate success rate of the technique being considered. The ultimate success rate was the percentage of patients (for each technique) who ultimately achieved a successful reconstruction, even if that success required conversion to another technique. Failures salvaged by another technique were ignored for this purpose because the extra operative time and hos-

TABLE I
Cost Components, in 1993 Dollars

Cost Component	Dollar Value
Operating room (1 hour)	548.00
Hospital day, initial reconstruction, implant patient	1248.00
Hospital day, initial reconstruction, TRAM flap patient	1184.00
Hospital day, revision, implant patient	666.00
Hospital day, revision, TRAM flap patient	670.00
Surgicenter day*	530.00
Staff surgeon (1 hour)	156.00
Surgical assistant (1 hour)	43.00
Anesthesia personnel cost (1 hour)	119.00
Tissue-expansion device (each)	445.00
Saline breast implant (each)	950.00
Tissue-expansion session in clinic (each)†	36.00

* Surgicenter day costs were laboratory and recovery room costs associated with each day of outpatient surgery but not included in the hourly operating room costs.

† The mean number of clinic visits for tissue expansion by patients undergoing reconstruction with that method was 10.14 visits per patient.

pital stay incurred had already been added to the cost of the original reconstruction. The *total corrected resource cost* was calculated by using the formula

$$\text{Total corrected resource cost} = \text{mean total cost} \times \frac{1}{\text{ultimate success rate}}$$

Failure rates were computed from data on all patients who underwent immediate breast reconstruction during the study period, including those who did not complete nipple reconstruction. This was necessary because some patients who suffered failures chose not to complete their reconstruction with an alternative method so that those patients who completed nipple reconstruction had an unrepresentatively low incidence of failures. The *ultimate failure rate* for each technique was the percentage of patients who never successfully completed breast mound reconstruction, even using an alternate method. The *ultimate success rate* was calculated by subtracting the ultimate failure rate from 1.

Results

During the study period, 240 patients completed immediate breast reconstructions with nipple reconstruction and were included in the resource cost analysis. Of these, 172 had unilateral reconstructions, and 68 had bilateral reconstructions. Eighty-six patients underwent reconstruction with implants, and 154 underwent reconstruction with TRAM flaps. The initial and cumulative mean operative times and hospital stays are shown, by reconstruction method, in Table II.

Patients were then grouped into three categories: those with less than 2 years of follow-up (47 patients), those with 2 to 4 years of follow-up (91 patients), and those with more than 4 years of follow-up (102 patients). Data for the group with more than 4 years of follow-up are shown in Table III. Graphs were then constructed to show the relationship between total cumulative corrected time required for reconstruction and the duration of follow-up (Figs. 1 to 4).

For calculation of the failure rate of each method, 522 patients who underwent immediate breast reconstruction were reviewed. The failure rates for breast implants reconstruction and for reconstruction with TRAM flaps are shown in Table IV.

The *total corrected resource costs* are shown in Table V and in Figures 5 and 6. To obtain these corrected (for reconstruction failures) costs, the mean resource costs for each implant reconstruction were multiplied by 1.0958, while the costs for each TRAM flap reconstruction were multiplied by 1.0032.

TABLE II
Mean Operative Times and Hospital Stays for 240 Immediate Breast Reconstruction Patients with Follow-Ups of 1 to 5 years (Not Corrected for Failures)

		Initial Reconstruction		Total Cumulative		
Group	*n*	Hours of O.R. Time	Days in Hospital	Hours of O.R. Time	Days in Hospital	SC* Days
All patients	240	7.11	5.87	9.98	7.01	0.58
All implants	86	3.97	4.23	8.55	6.69	0.77
All TRAMs	154	8.85	6.78	10.77	7.19	0.47
Bilateral implant	22	4.69	4.50	9.75	6.68	0.95
Bilateral TRAM	46	9.93	6.83	11.63	7.15	0.22
Unilateral implant	64	3.73	4.14	8.14	6.70	0.70
Unilateral TRAM	108	8.40	6.76	10.41	7.20	0.58

* An SC day was the use of the outpatient surgicenter for any part of one day.

TABLE III

Mean Operative Times and Hospital Stays for 102 Immediate Breast Reconstruction Patients with 4 Years of Minimum Follow-Up

Group	*n*	Initial Reconstruction (Not Corrected)		Total Cumulative (Corrected for Failures)		
		Hours of O.R. Time	Days in Hospital	Hours of O.R. Time	Days in Hospital	SC* Days
All patients	102	5.57	5.51	10.03	8.04	0.71
All implants	58	3.74	4.29	9.75	7.95	0.72
All TRAMs	44	7.97	7.11	10.37	8.16	0.70
Bilateral implant	14	4.19	4.36	10.74	7.75	0.93
Bilateral TRAM	8	8.31	6.50	10.54	7.10	0.75
Unilateral implant	44	3.60	4.27	9.43	8.02	0.66
Unilateral TRAM	36	7.90	7.25	10.34	8.33	0.69

* An SC day was the use of the outpatient surgicenter for any part of one day.

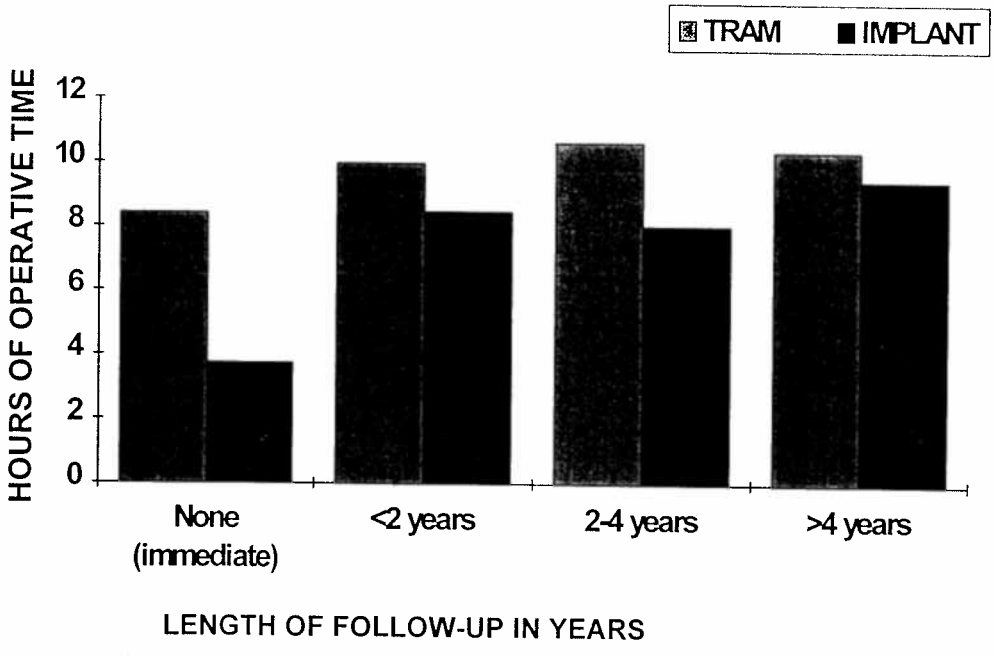

FIG. 1. Cumulative hours of operative time for unilateral immediate reconstructions (corrected for failures).

DISCUSSION

When compared with autogenous reconstruction, implant-based breast reconstruction methods have considerable superficial appeal to third-party payers, HMOs, and others who are attempting to provide health care for the lowest possible cost. The insertion of an internal breast prosthesis or tissue expander takes far less operative time than transfer of a TRAM flap and requires less time in the hospital for recovery. Moreover, the procedure is much less complex, requires less specialized training by the surgeon, and has less potential for serious complications. Reconstruction of a breast with a silicone implant (gel or otherwise) can be performed by almost any plastic surgeon and requires no specialized equipment. On first analysis, implant-based methods would therefore seem to be an ideal means of achieving inexpensive, cost-efficient breast reconstruction.

Unfortunately, the costs associated with the use of breast implants, in our experience, did not stop with the initial reconstruction. During the study period, 16.5 percent of our implant-based reconstructions failed (sometimes after several years of initial success) and had to be either replaced with another type of breast reconstruction or abandoned. For tissue expanders, additional surgery was usually required to replace the expander with a permanent implant. Even when a "permanent expander"[7,8] was used, additional surgery often was necessary to release bands of capsular scar tissue. If the patient developed a capsular contracture, re-

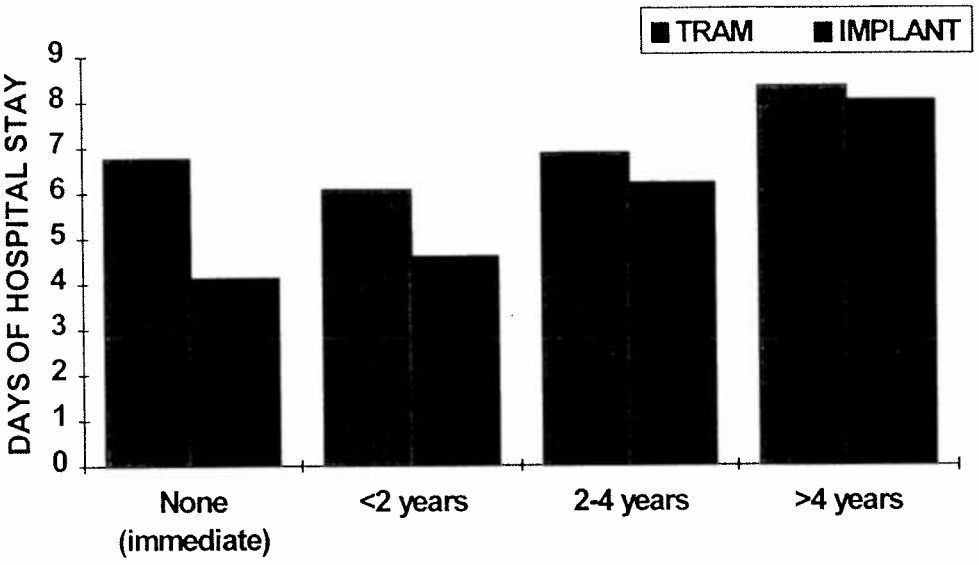

FIG. 2. Cumulative days of hospital stay for unilateral immediate reconstructions (corrected for failures).

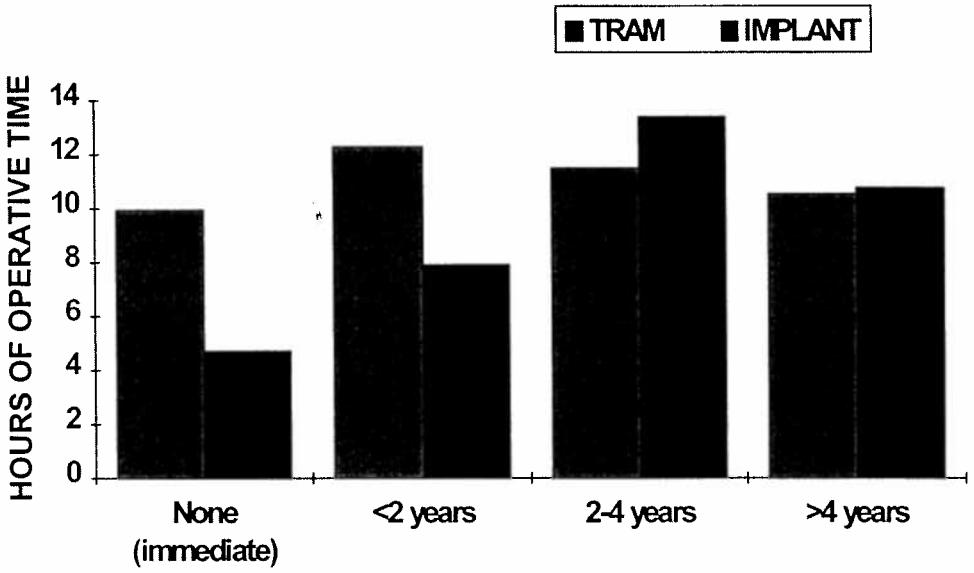

FIG. 3. Cumulative hours of operative time for bilateral immediate reconstructions (corrected for failures).

lease of the capsule and replacement of the implant often were required, sometimes years after the initial reconstruction. If capsular contracture recurred or became painful, patients often needed additional surgery, up to and including replacement with autogenous tissue. Even when the result was aesthetically good and the breast soft, if the implant was found to be leaking, it generally had to be replaced. There was no statute of limitations for such problems. Every year patients with some of our best implant-based reconstructions returned with problems that required additional surgery or removal of the implants.

In contrast, TRAM flap patients who achieved a good result rarely developed unfavorable late sequelae. Although many such patients required surgical revision for shaping and symmetry, most of these revisions were performed in the outpatient clinic under local anesthesia.

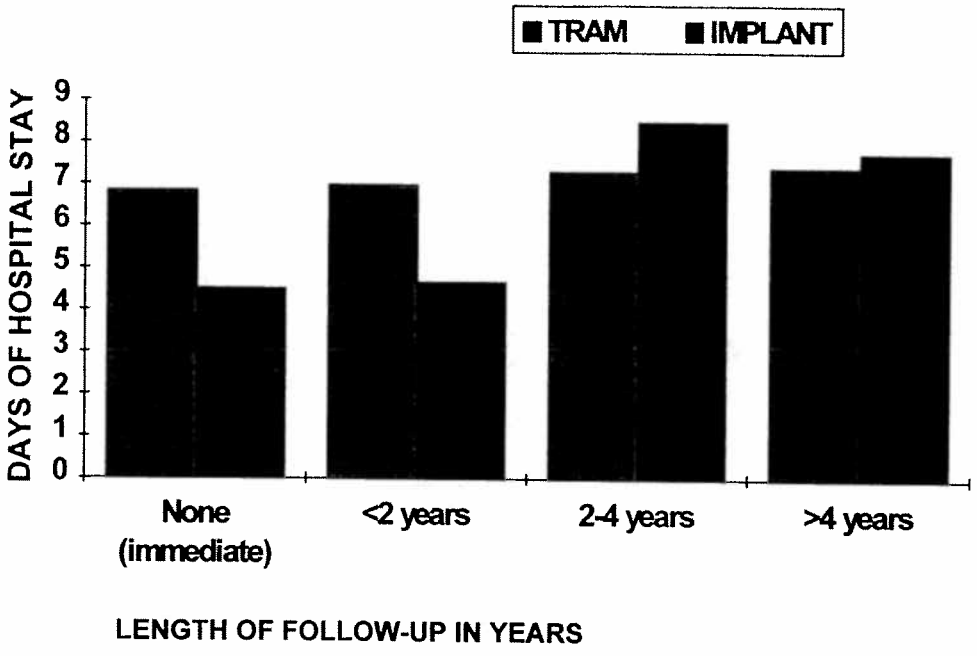

FIG. 4. Cumulative days of hospital stay for bilateral immediate reconstruction (corrected for failures).

TABLE IV
A Comparison of Failure Rates between Breast Reconstruction with TRAM Flaps and Implants

Group	*n*	Failures	Unsalvaged Failures	Percentage of Failures	Percentage of Unsalvaged Failures
All patients	522	37	19	7.1%	3.64%
Implant patients	206	34	18	16.5%	8.74%
TRAM patients	316	3	1	0.9%	0.3%

TABLE V
Total Corrected Estimated Resource Costs in 1993 Dollars

Follow-Up Period	Bilateral Implants	Bilateral TRAM Flaps	Unilateral Implants	Unilateral TRAM Flap	All Implants	All TRAM Flaps
None (immediate)	11,580	17,082	9,687	15,669	10,171	16,091
<2 years	16,326	19,048	15,148	16,253	15,672	17,724
2–4 years	24,524	18,807	15,894	17,844	17,711	18,085
>4 years	21,578	18,112	19,184	18,944	19,762	18,793

Hernia and bulges, rare anyway once we had learned how to prevent them,[9] were almost always apparent within the first 6 months after the initial surgery. Once nipple reconstruction was completed, further surgery rarely was necessary. Instead of deteriorating with time, the results of TRAM flap reconstruction tended to improve as the scars faded and the tissues softened. Although there was a slight increase in the costs associated with TRAM flaps with the longest follow-up, this was not due to recent additional surgery. In all likelihood, it was due to longer operative times required in earlier years prior to accumulating our current level of experience.

Because of the continuing need for surgery on patients who had reconstructions with implants, the initial cost advantage of that method was progressively lost. This was particularly true if the costs were corrected for failure rates. While only one TRAM flap patient did not ultimately achieve a successful reconstruction, many patients for whom reconstruction with implants was attempted never did achieve a successful breast reconstruction. To complete 100 successful reconstructions with implants, we had to (in theory) attempt reconstruction on 109.58 patients. In

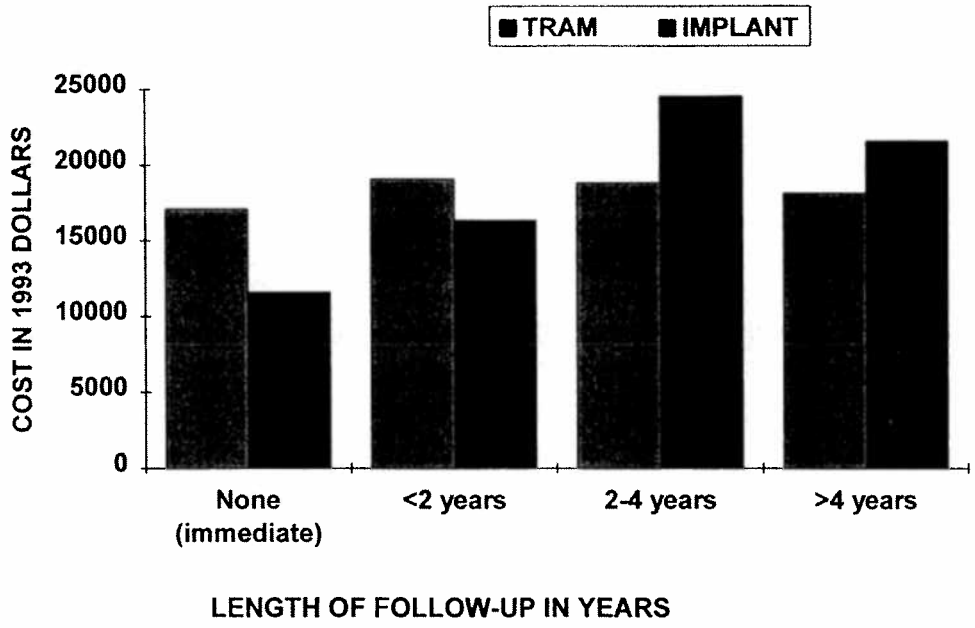

FIG. 5. Cumulative total corrected resource costs in dollars, bilateral reconstruction.

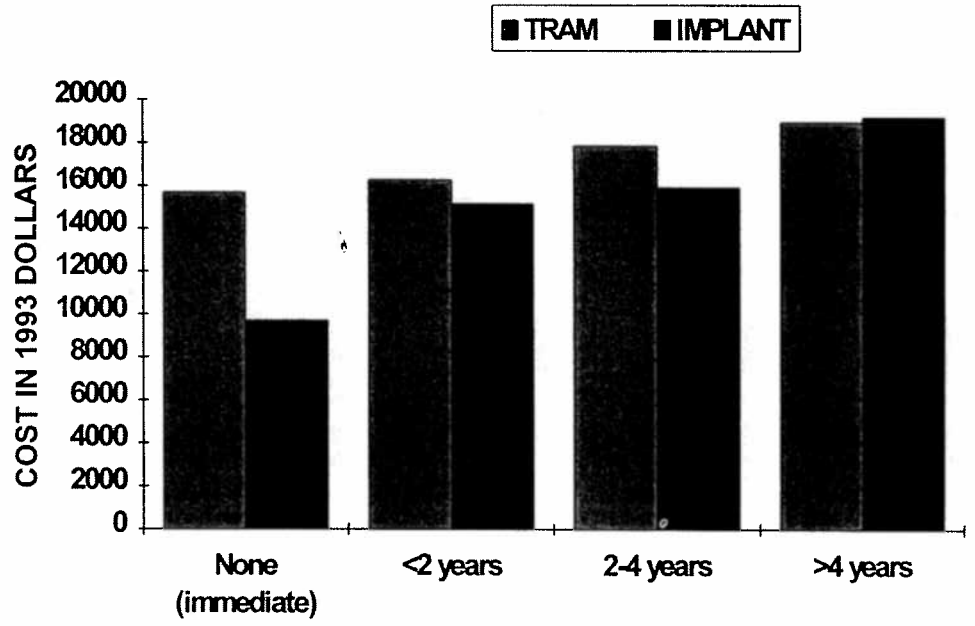

FIG. 6. Cumulative total corrected resource costs in dollars, unilateral reconstruction.

contrast, to complete 100 successful TRAM flap reconstructions, attempts on only 100.32 patients were required.

Obviously, the costs of implant-based reconstructions were adversely influenced by the currently high cost of breast implants, in large part because of the ongoing medicolegal costs of the silicone breast implant controversy.[10–17] Had these costs not been so high, it is possible that the corrected total resource costs of implant-based reconstruction might not have been higher than those of TRAM flap reconstruction, since the cumulative operative times and hospital stays were similar for the two groups. It is also likely that some breast implant removals (and failures of that method) were in part motivated by medicolegal concerns and unreasonable[18–21] fears about the dangers of silicone implants. Even so, the long-term cost advantages (or at least absence of disadvantages) of autog-

enous reconstruction, in terms of operative time and hospital stay, remain valid. If current trends continue, and if additional resource costs for current patients with implant-based breast reconstructions continue to accumulate as patients develop leaks and capsular contractures, the relative cost advantage of TRAM flap reconstruction is likely to increase. In addition to any advantage the TRAM flap already enjoys in terms of quality of result, it may well become the method of choice based on cost-effectiveness.

It is still open to question whether cost-conscious insurance companies and HMOs will encourage use of the TRAM flap. Successful TRAM flap reconstruction requires more training and experience than does reconstruction with implants, which could be an obstacle for some provider groups. Moreover, while the long-term costs are of concern to society as a whole, they may be of less concern to an individual HMO or insurance company that is concerned primarily with containing costs over the shorter term, especially if that company believes that it might not be responsible for all long-term costs as patients change their insurance coverage over time. It is clear from this study, however, that patients and others who desire the most effective, as well as the most cost-effective, method of breast reconstruction would benefit from increased use of TRAM flaps.

This study provides evidence to support the use of autogenous tissue and of the TRAM flap. It is not intended to denigrate the use of breast implants, which remain the method of choice for some patients, especially those who are not good candidates for autogenous tissue reconstruction. Our findings reinforce the general principle that the most economical way to do things is often to do them in the most effective way possible from the beginning, even if the methodology is more complex. "High-tech" medical care can be cost-effective if it is significantly more effective than the alternatives and is executed correctly. Going back to the past, when medical care was "low-tech" and cheaper but less effective, when care was provided by generalists who had limited capabilities, will not improve our health care system. We believe that there is still a place for specialists capable of delivering complex health care and that, in the long run, such care may be more cost-effective than the alternatives.

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ACKNOWLEDGMENTS

We would like to acknowledge the assistance of Molly Joyce and Jayne Nyman, of the Department of Management Systems and Finance at The University of Texas M. D. Anderson Cancer Center, in obtaining the cost data used in this research.

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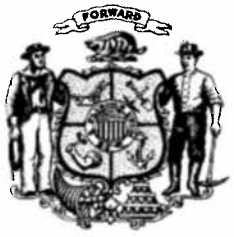
WISCONSIN STATE LEGISLATURE


FORWARD

In 1995 about 182,000 women will be diagnosed with breast cancer making it the most common form of breast cancer among women in the United States. Statistics show a woman's life time risk of breast cancer, if she lives to be eighty-five, is one out of nine, or eleven percent of our population. It is estimated that forty-six thousand women will die of breast cancer in 1995 making it the second major cause of death among women after lung cancer.

Recent advances in breast cancer management have allowed most women to be treated with the breast conserving technique of lumpectomy and radiation. However, a significant percentage of women with breast cancer must undergo mastectomy or amputation of their breast to treat their disease most appropriately. Some women adapt well to their breast amputation and some feel desperately mutilated. It is not a question of age or beauty as many older women are more devastated by the loss then a younger woman. Because of the breast role as a sexual organ, the breast plays an important role in the self image of the women. For many women the loss of a breast as a result of breast cancer can also mean the loss of part of their sexual identity. For these women breast reconstruction is extremely important to restore their sense of wholeness and well being.

Unfortunately, breast reconstruction is only partially covered by some third party payers. Worst yet, some state sponsored health programs (Medicare, Medicaid) do not cover breast reconstruction at all (Oregon).

The American Cancer Society, the Breast Cancer Coalition and American Society for Plastic and Reconstructive Surgeons have organized a national campaign to pass legislation in all states mandating insurance coverage for breast reconstruction. To date ten states have passed the legislation. These include California, Connecticut, Nevada, Arizona, Washington, Michigan, Illinois, Florida, New Jersey, and Maine. The remaining forty states will be introducing the legislation this fall and this winter as a national coordinated effort.

QUESTIONS AND ANSWERS

Q: By mandating breast reconstruction won't that add tremendous cost to our health care systems?

A: Most breast cancers fortunately can now by treated without mastectomy. The breast sparing procedure of lumpectomy, and radiation is generally recommended. Of the women who require mastectomy less than one half desire reconstruction. Studies have shown that woman in the lower socioeconomic group tend to present with later stages of diseases. One of the factors they report in not participating in early detection in treatment programs is fear of loosing a breast. If these women can't have reconstruction through their state systems their fear will logically be much greater. Therefore, we could see women showing up with even later stages of diseases and thus more health care cost.

Q: Why should insurance's pay for breast reconstruction, isn't it cosmetic?

A: Medical care involves both the function of the physical body as well as the quality of life issues. For some woman the loss of a breast is a desperate mutilation of their bodies. The breast plays a sexual role and the loss of this highly emotional structure may represent a loss of sexual identity and self esteem. It is not like scraping a knee. Cosmetic surgery is done on normal structures to enhance their beauty. Reconstructive surgery is done on abnormal structures to restore them to a more normal state. Insurance companies pay for prosthetic eyes, hips, and nasal reconstruction after tumor excisions. None of these structures are necessary for life but do represent important quality of life issues. The importance of the breast to some women is essential to their well-being and sense of wholeness and ability to live happy and productive lives.

Q: The last thing we need is government regulations. Shouldn't the market decide this issue?

A: Not all insurance's are involved with the market. Medicare and Medicaid for example are government run and serve primarily the low income. These are also the people who present with later stages of breast cancer partially due to fear. The only way to allow these women the opportunity for reconstruction is through legislation. Also women are fraught with complicated and varying insurance policies. Usually they do not have any awareness of the problems with their insurance policies until they use it. The legislation would eliminate the prolong paper work, cost to the system, and emotional agony and frustration some women have to endure in getting their breast surgery approved by their insurance companies.

Q: This sounds like plastic surgeons trying to make more money and preserve their income.

A: This is a issue for all women. Breast cancer is the most common cancer in American woman striking one out of nine by age 85. The American Cancer Society, Breast Cancer Coalition, National Organization of Women, and a multitude of other organizations support this legislation.

Q: With all the health problems with silicone breast implants why should we encourage women to have breast reconstruction when it could cause more harm to their bodies?

A: Recent studies have determined that silicone breast implants have not been found to be associated with any major disease. Breast reconstruction can be done in a variety of different techniques and does not require silicone breast implants. If implants are required saline implants may be used. The other popular methods of breast reconstruction do not use prosthesis but rather are formed out of the woman's own tissues like the lower abdomen, buttock, or back. Breast reconstruction has been performed for over 30 years and does not interfere with any further cancer therapies or in the detection of recurrences. Survival statistics are the same whether reconstruction was performed or not.

Article 4. Pregnancy Benefits

3100. The director shall, in accordance with authorized procedures for establishing regulations, reimburse employers with private disability plans or paid sick leave plans, or both, for payments made by employers of pregnancy benefits to the extent that such benefits would have been payable under Section 2626.2 of this code and under the provisions of Section 1420.35 of the Labor Code, to the extent permitted by federal law.

SEC. 4. In the event Congress enacts legislation amending Title VII of the Civil Rights Act of 1964 to prohibit sex discrimination on the basis of pregnancy, the provisions of this act, except paragraph (2) of subdivision (b) of Section 1420.35 of the Labor Code, shall be inapplicable to any employer subject to such federal law, except that this section shall not pertain to complaints filed prior to the effective date of this act.

SEC. 5. Notwithstanding Section 2231 of the Revenue and Taxation Code, there shall be no reimbursement pursuant to that section nor shall there be an appropriation made by this act because the duties, obligations, or responsibilities imposed on local government by this act can be accomplished with no additional cost to local government.

CHAPTER 1322

An act to add Section 1367.6 to the Health and Safety Code, and to add Sections 10123.8 and 11512.15 to the Insurance Code, relating to mastectomy.

[Approved by Governor September 28, 1978. Filed with Secretary of State September 28, 1978.]

The people of the State of California do enact as follows:

SECTION 1. Section 1367.6 is added to the Health and Safety Code, to read:

1367.6. Every health care service plan contract which provides for the surgical procedure known as a mastectomy and which is issued, amended, delivered or renewed in this state on or after July 1, 1980, shall include coverage for prosthetic devices or reconstructive surgery incident to the mastectomy, providing that such mastectomy is performed after July 1, 1980. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits. As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Any provision in any contract issued, amended, delivered or renewed in this state on or after July 1, 1980, which is in conflict with this section shall be of no force or effect.

SEC. 2. Section 10123.8 is added to the Insurance Code, to read:

10123.8. Every group policy of disability insurance or self-insured employee welfare benefit plan which provides for the surgical procedure known as a mastectomy and which is issued, amended, delivered or renewed in this state on or after July 1, 1980, shall include coverage for prosthetic devices or reconstructive surgery incident to the mastectomy, providing that such mastectomy is performed after July 1, 1980. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to other benefits. As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Any provision in any contract issued, amended, delivered or renewed in this state on or after July 1, 1980, which is in conflict with this section shall be of no force or effect.

SEC. 3. Section 11512.15 is added to the Insurance Code, to read:

11512.15. Every nonprofit hospital service contract which provides for the surgical procedure known as a mastectomy and which is issued, amended, delivered or renewed in this state on or after July 1, 1980, shall include coverage for prosthetic devices or reconstructive surgery incident to the mastectomy, providing that such mastectomy is performed after July 1, 1980. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to other benefits. As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Any provision in any contract issued, amended, delivered or renewed in this state on or after July 1, 1980, which is in conflict with this section shall be of no force or effect.

CHAPTER 1323

An act to amend Sections 4550 and 4800 of the Civil Code, relating to family law.

[Approved by Governor September 28, 1978. Filed with Secretary of State September 28, 1978.]

CHAPTER 1398

An act to amend Section 1367.6 of the Health and Safety Code, to amend Sections 10123.8 and 11512.15 of the Insurance Code, and to amend Section 14132.6 of the Welfare and Institutions Code, relating to health, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor October 2, 1989. Filed with Secretary of State October 2, 1989.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1059, M. Waters. Mastectomy: prosthetic devices.

(1) Existing law imposes a requirement upon health care service plans, disability insurance, self-insured employee welfare benefit plans, and nonprofit hospital service contracts to provide coverage for prosthetic devices, as specified, if coverage is provided for mastectomy.

This bill would define "prosthetic devices" for purposes of these provisions to mean provision of initial and subsequent prosthetic devices pursuant to an order from the patient's physician.

(2) Existing law requires Medi-Cal coverage to include specified external and internal prostheses in connection with mastectomies.

This bill would require this coverage to include the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician.

(3) The bill would state that it clarifies rather than changes existing law.

(4) The bill would declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.6 of the Health and Safety Code is amended to read:

1367.6. Every health care service plan contract which provides for the surgical procedure known as a mastectomy and which is issued, amended, delivered or renewed in this state on or after July 1, 1980, shall include coverage for prosthetic devices or reconstructive surgery incident to the mastectomy, providing that the mastectomy is performed after July 1, 1980. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits. As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a

licensed physician and surgeon.

Any provision in any contract issued, amended, delivered or renewed in this state on or after July 1, 1980, which is in conflict with this section shall be of no force or effect.

As used in this section, "prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician.

SEC. 2. Section 10123.8 of the Insurance Code is amended to read:

10123.8. Every group policy of disability insurance or self-insured employee welfare benefit plan which provides for the surgical procedure known as a mastectomy and which is issued, amended, delivered or renewed in this state on or after July 1, 1980, shall include coverage for prosthetic devices or reconstructive surgery incident to the mastectomy, providing that the mastectomy is performed after July 1, 1980. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to other benefits. As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Any provision in any contract issued, amended, delivered or renewed in this state on or after July 1, 1980, which is in conflict with this section shall be of no force or effect.

As used in this section, "prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician.

SEC. 3. Section 11512.15 of the Insurance Code is amended to read:

11512.15. On or after January 1, 1989, every individual or group nonprofit hospital service plan contract which is issued, amended, or renewed, and which includes coverage for mastectomy and prosthetic devices and reconstructive surgery incident to the mastectomy described in Section 11512.10 shall also be deemed to provide coverage for mammography for screening or diagnostic purposes upon the referral of the patient's physician.

Nothing in this section shall be construed to require an individual or group policy to cover the surgical procedure known as mastectomy or to prevent application of deductible or copayment provisions contained in the policy or plan, nor shall this section be construed to require that coverage under an individual or group policy be extended to any other procedures.

As used in this section, "prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician.

SEC. 4. Section 14132.6 of the Welfare and Institutions Code is amended to read:

14132.6. External prostheses constructed of silicone or other comparable materials, prosthetic implants, and reconstructive surgery incident to mastectomy shall be deemed medically necessary and shall be covered under this chapter. As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Coverage under this section shall include the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician.

SEC. 5. The changes made by this act do not constitute a change in, but clarify, the existing law.

SEC. 6. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

It is necessary that this act go into immediate effect in order that persons entitled to health coverage under this act may receive the protection of this act without delay.

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CHAPTER 486

An act to amend Sections 1367.6, 1704.5, 25817, and 25817.1 of, and to add Section 25660.1 to, the Health and Safety Code, and to amend Sections 10123.8 and 11512.10 of the Insurance Code, relating to breast cancer.

[Approved by Governor October 4, 1991. Filed with Secretary of State October 7, 1991.]

LEGISLATIVE COUNSEL'S DIGEST

AB 918, Tanner. Breast cancer.

(1) Existing law requires every health care service plan and nonprofit hospital service plan contract and every group policy of disability insurance or self-insured employee welfare benefit plan which provides for a mastectomy and which is issued, amended, delivered, or renewed in this state on or after July 1, 1980, to include coverage for prosthetic devices or reconstructive surgery incident to the mastectomy if the mastectomy is performed after July 1, 1980.

This bill would delete the qualification to the requirement that the mastectomy be performed after July 1, 1980. It would also provide that the devices or surgery be for purposes of restoring or achieving symmetry for the patient. Since a violation of the above requirement by health care service plans is a misdemeanor, this bill would impose a state-mandated local program by changing the definition of a crime.

(2) Existing law requires the State Department of Health Services to develop a standardized written summary of alternative efficacious methods of treatment which may be medically viable when the patient is being treated for any form of breast cancer, as prescribed.

This bill would require the department to review the summary at least once every 5 years and to revise the summary if the department determines that new or revised information should be included in the summary. The bill also would require information regarding certain methods of treatment for breast cancer that are in the investigational or clinical trial stage and are recognized for treatment by the Physician's Data Query of the National Cancer Institute to be included in the next revision of the summary. This bill also would require the department to provide specified reference telephone numbers for breast cancer patients to obtain current information.

(3) Existing law contains legislative findings that the public health interest requires that the people of this state be protected from excessive and improper exposure to ionizing radiation.

This bill would contain legislative findings that the public health interest requires that increased steps be taken to ensure the accuracy

of mammograms, as specified.

(4) Existing law requires the average inspection frequency for ionizing radiation machines to be once every 3 years for high priority sources of ionizing radiation and also specifies the average inspection frequency rate for other sources of radiation. Existing law also requires the State Department of Health Services to provide by regulation a ranking of priority for inspection, as determined by the degree of potentially damaging exposure of persons by ionizing radiation, and a schedule of fees, based upon that priority ranking, to be used for the purpose of carrying out the inspections.

This bill would require the average inspection frequency to be once each year for mammography X-ray units. This bill also would require the department to consider the average inspection frequencies required by certain provisions of law, including that applicable to mammography units, in providing a ranking of priority for inspection. This bill would also delete an obsolete provision limiting the amount of fees to be assessed during the 1986–87 fiscal year.

(5) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

The people of the State of California do enact as follows:

SECTION 1. Section 1367.6 of the Health and Safety Code is amended to read:

1367.6. Every health care service plan contract which provides for the surgical procedure known as a mastectomy and which is issued, amended, delivered or renewed in this state on or after July 1, 1980, shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits. As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Any provision in any contract issued, amended, delivered or renewed in this state on or after July 1, 1980, which is in conflict with this section shall be of no force or effect.

As used in this section, "prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician and surgeon.

SEC. 2. Section 1704.5 of the Health and Safety Code is amended

to read:

1704.5. The failure of a physician and surgeon to inform a patient by means of a standardized written summary, as developed by the department on the recommendation of the Cancer Advisory Council, in layman's language and in a language understood by the patient of alternative efficacious methods of treatment which may be medically viable, including surgical, radiological, or chemotherapeutic treatments or combinations thereof, when the patient is being treated for any form of breast cancer constitutes unprofessional conduct within the meaning of Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code.

A standardized written summary in layman's language and in a language understood by the patient, to be developed by the department on the recommendation of the Cancer Advisory Council and printed and made available by the Medical Board of California to physicians and surgeons, informing the patient of the advantages, disadvantages, risks and descriptions of the procedures with regard to medically viable and efficacious alternative methods of treatment, which is given to the patient shall constitute compliance with the requirements of this section.

The department shall review the written summary at least once every five years and shall revise the written summary if the department determines that new or revised information should be included in the written summary.

At the next revision of the standardized written summary required by this section, information regarding methods of treatment for breast cancer that are in the investigational or clinical trial stage and are recognized for treatment by the Physician's Data Query of the National Cancer Institute shall be included in the summary. The department shall also provide available reference numbers, including, but not limited to, the "800" telephone numbers for the National Cancer Institute and the American Cancer Society, in order for breast cancer patients to obtain the most recent information.

Prior to performance of a biopsy, the physician and surgeon shall note on the patient's chart that he or she has given the patient the written summary required by this section.

SEC. 3. Section 25660.1 is added to the Health and Safety Code, to read:

25660.1. The Legislature finds and declares that the public health interest requires that increased steps be taken to ensure the accuracy of mammograms, including increased inspections and calibration of equipment, competency requirements for radiologic technologists, accreditation of mammography facilities, and the use of computers to read mammograms.

SEC. 4. Section 25817 of the Health and Safety Code is amended to read:

25817. (a) The department shall provide by regulation a ranking

of priority for inspection, as determined by the degree of potentially damaging exposure of persons by ionizing radiation and the requirements of Section 25817.1, and a schedule of fees, based upon that priority ranking, which shall be paid by persons possessing sources of ionizing radiation which are subject to registration in accordance with subdivision (b) of Section 25815, and regulations adopted pursuant thereto. The revenues derived from the fees shall be used, together with other funds made available therefor, for the purpose of carrying out any inspections of the sources of ionizing radiation required by this chapter or regulations adopted pursuant thereto. The fees shall, together with any other funds made available to the department, be sufficient to cover the costs of administering this chapter, and shall be set in amounts intended to cover the costs of administering this chapter for each priority source of ionizing radiation. Revenues generated by the fees shall not offset any general funds appropriated for the support of the radiologic programs authorized pursuant to Chapter 7.4 (commencing with Section 25660) and Chapter 7.6 (commencing with Section 25800) of this division. Persons who pay fees shall not be required to pay, directly or indirectly, for the share of the costs of administering this chapter of those persons for whom fees are waived.

(b) A local agency participating in a negotiated agreement pursuant to Section 25810 shall be fully reimbursed for direct and indirect costs based upon activities governed by Section 25817.1. With respect to these agreements, any salaries, benefits, and other indirect costs shall not exceed comparable costs of the department. Any changes in the frequency of inspections or the level of reimbursement to local agencies made by this section or Section 25817.1 during the 1985–86 Regular Session shall not affect ongoing contracts.

(c) The fees paid by persons possessing sources of ionizing radiation shall be adjusted annually pursuant to Section 113.

SEC. 5. Section 25817.1 of the Health and Safety Code is amended to read:

25817.1. The average inspection frequency for ionizing radiation machines shall be once each year for mammography X-ray units, once every three years for high priority sources of ionizing radiation, and once every four and one-quarter years for medium-priority sources. Sources of ionizing radiation used in dentistry shall be screened for defects by mail or other offsite methodology not less frequently than once every five years, with physical inspection of the 50 percent, determined by the department to be most in need of inspection, to average at least once every six years.

SEC. 6. Section 10123.8 of the Insurance Code is amended to read:

10123.8. Every group policy of disability insurance or self-insured employee welfare benefit plan which provides for the surgical procedure known as a mastectomy and which is issued, amended,

delivered or renewed in this state on or after July 1, 1980, shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to other benefits. As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Any provision in any contract issued, amended, delivered or renewed in this state on or after July 1, 1980, which is in conflict with this section shall be of no force or effect.

As used in this section, "prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician and surgeon.

SEC. 7. Section 11512.10 of the Insurance Code is amended to read:

11512.10. Every nonprofit hospital service contract which provides for the surgical procedure known as a mastectomy and which is issued, amended, delivered or renewed in this state on or after July 1, 1980, shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy, and all other terms and conditions applicable to other benefits. As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon.

Any provision in any contract issued, amended, delivered or renewed in this state on or after July 1, 1980, which is in conflict with this section shall be of no force or effect.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs which may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, changes the definition of a crime or infraction, changes the penalty for a crime or infraction, or eliminates a crime or infraction. Notwithstanding Section 17580 of the Government Code, unless otherwise specified in this act, the provisions of this act shall become operative on the same date that the act takes effect pursuant to the California Constitution.

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FORWARD
E PLURIBUS UNUM

AB 965

THE BREAST RECONSTRUCTION ADVOCACY PROJECT

Background: Estimates are that in 1995, 182,000 women were diagnosed with breast cancer, and 46,000 women died from this disease, making it the second major cause of death among women.

A significant number of women with breast cancer must undergo mastectomy or amputation of their breast in order to treat their disease appropriately. The breast plays an important role in the self-image of women of all ages. The loss of a breasts as a result of cancer can mean the loss of part of their sexual identity. For these women, breast reconstruction is extremely important in restoring their sense of wholeness and well-being.

Unfortunately, some insurance companies have decided to deny women coverage for breast reconstruction surgery. As a result, patient and physician organizations are organizing a national campaign to pass legislation in all states requiring insurance coverage for breast reconstruction. Organizers of this effort include the American Cancer Society, the Breast Cancer Coalition, and the American Society of Plastic and Reconstructive Surgeons. In December 1995, the AMA House of Delegates approved a resolution calling on the AMA to draft model legislation requiring breast reconstruction after mastectomy.

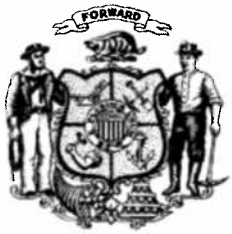
To date, the following eleven states have passed laws requiring breast reconstruction coverage after mastectomy: Arizona, California, Connecticut, Florida, Illinois, Maine, Michigan, Minnesota, Nevada, New Jersey and Washington.

- Studies have documented that fear of losing a breast is a leading reason why many women do not participate in early breast cancer detection programs. With breast reconstruction available as a viable option, more women would not be afraid to detect their cancer at an early stage.

- Insurance carriers pay for prosthetic eyes, hips, and nasal reconstructions after tumor incisions. Similarly, breast reconstruction is a reconstructive, not cosmetic procedure. It is performed on abnormal structures to restore them to a more normal state. Insurers should not be allowed to discriminate against the female breast for reconstructive coverage.

- States should pass legislation that insures coverage for the costs associated with all stages of breast reconstruction, as well as symmetry operations on the opposite breast in order to restore a woman's body into wholeness.


WISCONSIN STATE LEGISLATURE


FORWARD

Research

Name of companies —

Cost - how extensive

Choice — prosthesis — reconstruction

70% response -

100% HMOs

100% - covered Mastectomies -

Rep. Baldus -

Implants

Cost would go up -

Companies now represent discourage implants -

9% of benefit package -

Your companies provide coverage for all choices.

Crone

Attitude mind & body connect —

Dean didn't cover all costs — care 4

what year 1991

Implant Scare Pay to visit w/ Dr Love University —

Bill Wood Dealing daily w/ women who find

2 year limit —

Ins only covered implants —

what is cosmetic what is not

Wood - Provides Services to HMOs —

Listing of the sorts of things $4,000

No nipple — Tram $16,000

$6,000

Viatical Bill

Opting out – signing out at 30 days or 15 days after receiving cash payout –

Gifford – 90% Aids related

Seniors with the beneficiaries of this

Uses The NAIC model

Analogy to Reverse mortgage –

Viatical

OCI –

DOR – Provide tax exemption – to broker providers –

Difference between full settlement amount –

Does The Commissioner
Want to
support The increase —

~~HER bill~~
Caps at 150%
doesn't require GPR —

have

finding an alt —

Rosati —
Some concerns
very The categories
Two bands —

37 OK
Make it clear that
GPR is ~~to~~ funded
the new category —

~~SSA~~ HMO's —
Squad across The base

Certificate of layoff a
person of penalty
18 mo - Covered —