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**Status Report on the Study of  
Proposed Mandatory Health  
Insurance Coverage for Post-  
Mastectomy Breast  
Reconstructive Surgery**

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A Report to the  
Governor  
and the  
Legislature of  
the State of  
Hawaii

Report No. 99-2  
January 1999

**THE AUDITOR**  
STATE OF HAWAII

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Submitted by

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## Foreword

Sections 23-51 and 23-52, Hawaii Revised Statutes, require the State Auditor to study the social and financial impacts of measures that propose to mandate health insurance benefits. House Concurrent Resolution No. 14, House Draft 1, Senate Draft 1 of the 1998 legislative session requested a study on the impacts of mandating health insurance coverage for post-mastectomy breast reconstructive surgery as proposed in House Bill No. 620 of the 1997 legislative session. However, in light of recently enacted federal legislation mandating insurance coverage for post-mastectomy breast reconstructive surgery, the need to proceed with this study as we ordinarily would was questionable. Therefore, our report focuses on a description of the health issue and a synopsis of the enacted federal law.

We wish to express our appreciation for the cooperation and assistance of those state agencies and organizations whom we contacted in the course of this report.

Marion M. Higa  
State Auditor



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# Chapter 1

## Introduction

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Sections 23-51 and 23-52, Hawaii Revised Statutes (HRS), require the Legislature to pass concurrent resolutions requesting the State Auditor to study the social and financial effects of any proposed legislative measure that would mandate health insurance for specific services, diseases, or providers. The law stems from legislative concern over the increasing number of these proposals in recent years and their impact on the cost and quality of health care.

House Concurrent Resolution (H.C.R.) No. 14, House Draft (H.D.) 1, Senate Draft (S.D.) 1 of the 1998 legislative session requests the State Auditor to study the social and financial impacts of requiring all employer group health policies, contracts, plans, or agreements—issued or renewed in Hawaii, on a group or individual basis—to provide coverage for post-mastectomy breast reconstructive surgery. Coverage for the cost of care is to be provided for all stages of reconstruction as well as symmetry operations on the noncancerous breast. The resolution set forth House Bill (H.B.) No. 620 of the 1997 legislative session as the vehicle to mandate health insurance coverage as prescribed under H.C.R. No. 14, H.D. 1, S.D. 1.

However, in light of recently enacted federal legislation mandating insurance coverage for post-mastectomy breast reconstructive surgery, the need to proceed with this study as we ordinarily would is questionable. Consequently, our assessment focuses on a description of the health issue and a synopsis of the federal law.

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### Background on Mandated Health Insurance

Since the 1960s, states have enacted a variety of laws mandating the health coverage that insurers must provide. These laws have required insurers to cover specific medical conditions and treatments, particular groups of people, and services of certain health practitioners. By 1997, there were at least 1,044 state mandatory health insurance coverage laws.

Laws mandating health insurance in Hawaii affect three main types of private insurance: (1) Blue Cross and Blue Shield plans, (2) health maintenance organizations (HMOs), and (3) commercial insurance plans. By 1996, private insurance plans covered over 80 percent of Hawaii's civilian population.

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## **Background on Post-Mastectomy Breast Reconstructive Surgery**

Breast reconstructive surgery may be performed after a mastectomy—the surgical removal of breast tissue. Each year thousands of women are affected by this procedure as they are diagnosed with breast cancer. Depending on various factors, a mastectomy is the primary treatment option for some women with breast cancer. Breast reconstructive surgery is performed after a mastectomy as an option to minimize the deformity caused by the mastectomy and improve the quality of life of cancer survivors.

### ***Breast cancer data and mandated coverage***

Next to skin cancer, breast cancer is the most common cancer among women. Statistics from the American Cancer Society indicate that a woman in the United States has a 12.5 percent (or 1 in 8) lifetime risk of developing breast cancer and a 3.5 percent (or 1 in 29) lifetime risk of dying from it. The National Alliance of Breast Cancer Organizations (NABCO) states that 178,700 new cases of female breast cancer and 37,000 cases of preinvasive breast cancer will be diagnosed in 1998. The organization also states that 43,500 women will die of breast cancer during that same year.

Currently, breast cancer cannot be prevented. Risk factors for developing the disease include increasing age and having a personal or a family history of breast cancer, the breast cancer gene, or a history of benign breast disease, and certain hormonal factors. However, it is estimated that 70 percent of breast cancers occur in women who have no identifiable risk factors.

The Department of Health reports that 110 Hawaii women residents died of breast cancer in 1997. Hawaii's age-adjusted death rate (standardized with respect to age) due to breast cancer is 12.8 per 100,000 women. While it cannot be prevented, routine mammography screening and early detection offer the best opportunity for decreasing the risk of dying from breast cancer. A mammography is a low-dose x-ray procedure that allows visualization of the breast's internal structure so that cancer can be detected several years before physical symptoms become apparent.

In 1990, the Legislature mandated coverage for breast cancer mammography screening through Act 112, Session Laws of Hawaii 1990. The law required insurers to provide coverage for one baseline mammogram for any woman 35 to 39 years of age; a mammogram every two years for women 40 to 49 years of age; and an annual mammogram for women 50 years of age and older. Additionally, upon a physician's recommendation, a mammogram is required to be covered for a woman of any age with a history of breast cancer or whose mother or sister has had a history of breast cancer.

***Breast cancer treatments***

Numerous treatment options for breast cancer are available for the patient and her doctor depending on the type of cancer, the stage at which the cancer is found, the risks posed by each option, and the patient's own preferences. Treatment options include surgery (lumpectomy or mastectomy), radiation therapy, chemotherapy, hormone therapy, or a combination of these treatments.

Surgery is the oldest form of cancer therapy and is considered the primary treatment for breast cancer. A mastectomy is a surgical operation in which all or part of a woman's breast is removed. The type of mastectomy required depends on a number of factors, such as the size and location of the tumor, how much the cancer has spread, and the age and general health of the patient. A radical mastectomy, the most extensive type of mastectomy which is now used less frequently, is the removal of the muscle underlying the breast in addition to all the breast tissue and lymph nodes. A modified radical mastectomy is the removal of the breast tissue along with all of the lymph nodes in the armpit. For a small tumor, a more conservative mastectomy procedure, a lumpectomy, can be used. A lumpectomy is the removal of the cancerous tumor and some surrounding tissue. There are other types of mastectomies used in the treatment of breast cancer. Reconstructive surgery of the breast follows a mastectomy and can be done during the same operation.

***Post-mastectomy breast reconstructive surgery***

In 1989, the American Medical Association adopted definitions to differentiate reconstructive surgery from cosmetic surgery. Cosmetic surgery is performed to reshape normal structures of the body to improve the self-esteem or the appearance of the patient. Reconstructive surgery is performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, traumas, infections, tumors, or diseases and may be performed to approximate normal appearance as well as to improve function.

Most post-mastectomy patients are medically appropriate candidates for reconstructive surgery. Cancer patients seek breast reconstruction with hopes of creating symmetrical, natural-looking breasts. Reconstructive surgery can improve a woman's self-esteem and self-confidence after a mastectomy. Since each breast cancer is different, various mastectomy conditions may limit or determine the reconstructive options available to the patient. In the past, delays of up to several years for reconstructive surgery were not uncommon. However, today some reconstructive surgery is done during the same time as the mastectomy. Reconstructive surgery that is not performed simultaneously with mastectomy is usually done within nine months after the original surgery.

Breast reconstruction can be viewed as a two stage process: (1) the breast mound, composed of skin and supporting soft tissue, is constructed through various types of procedures depending on the patient's medical

condition, body and breast shape, and desires, (2) reconstruction is done to create symmetry with the intact breast. The nipple-areolar complex can be created (from the patient's own tissue or by tattoo) several months after the initial breast mound construction. In addition, lifting the opposite breast or making it smaller or larger to match the reconstructed breast can be done to achieve symmetry.

The breast mound surgery is categorized under two general types: internal prosthesis (implant) and flap reconstruction. The internal prosthesis reconstruction places an implant filled with silicon or saline (both are permitted for breast reconstruction by the Food and Drug Administration) beneath the skin and pectoral muscles, sometimes accompanied by a skin expansion procedure. The flap reconstructive surgery accommodates patients who require or want to use their own tissue. Flap reconstruction uses skin, fat, and muscle from another part of the body—usually from the back, abdomen, or buttocks—to contour it into a breast. The length of surgery, recovery time, hospital stay, possible complications, and other factors depend on the type of surgery performed. Generally, breast reconstruction is performed under general anesthesia. Flap reconstruction is more complicated than implant surgery, therefore requiring a longer recuperative period. In addition, since most or all breast tissue is removed in a mastectomy, it is unlikely that a reconstructed breast can produce milk, respond to hormonal signals, or experience normal sensory perception.

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## **Proposed State Mandated Coverage**

The Legislature in H.C.R. No. 14, H.D. 1, S.D. 1 found that while insurance companies do provide coverage for reconstructive surgery of a diseased breast and may cover initial reconstructive surgery of a nondiseased breast, they may not provide coverage for subsequent reconstructive surgery of the nondiseased breast unless medically necessary. The Legislature also found that some companies limit coverage to the first stage of reconstruction, refusing to cover the rebuilding of the nipple-areolar area or surgical operations on the noncancerous breast to create symmetry between the two breasts.<sup>1</sup>

H.C.R. No. 14, H.D. 1, S.D. 1 of the 1998 legislative session requested the State Auditor to conduct a study on the social and financial impacts of requiring health insurance coverage for post-mastectomy breast reconstructive surgery for all stages of breast reconstruction as well as symmetry operations on the noncancerous breast. H.B. No. 620 of the 1997 legislative session was cited in the resolution as the vehicle to provide this coverage.

H.B. No. 620 of the 1997 legislative session would add new statutory sections entitled "Post-mastectomy breast reconstructive surgery; notice"

to Article 431:10A, Accident and Sickness Insurance Contracts, and Chapters 432, Benefit Societies, and 432D, Health Maintenance Organization Act, of the Hawaii Revised Statutes. Under the respective article and chapters, the new sections would require insurers who provide reimbursements for mastectomies to also provide coverage for hospital expenses, medical expenses, and health care services for all stages of breast reconstruction following any mastectomy which has been performed to treat a disease, illness, or injury. In addition, after the final reconstruction of the diseased breast has been performed, the new statutory sections would require insurers to provide coverage for reconstruction of the nondiseased breast to create the appearance of symmetry (in a manner chosen by the patient and physician, and upon the election of reconstruction by the patient).

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## Enacted Federal Law

Prior to Hawaii's health insurance coverage proposed measure, there was a national movement for the passage of a post-mastectomy breast reconstructive surgery mandate.

The national Breast Reconstructive Advocacy Project began in 1994 to promote passage of this health mandate in all 50 states. Currently, 29 states have passed laws requiring coverage for breast reconstruction after a mastectomy: Arizona, Arkansas, California, Connecticut, Florida, Illinois, Indiana, Kentucky, Louisiana, Maine, Maryland, Michigan, Minnesota, Missouri, Montana, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oklahoma, Pennsylvania, Rhode Island, South Carolina, Tennessee, Texas, Virginia, Washington, and Wisconsin.

In addition to the push for state mandates, movement for federal legislation to mandate coverage for post-mastectomy breast reconstructive surgery saw positive results. The Reconstructive Breast Surgery Benefits Act of 1997 and the Women's Health and Cancer Rights Act of 1997, which included a provision requiring coverage for breast reconstruction, were introduced in both houses of Congress.

State and federal efforts to pass a post-mastectomy breast reconstruction mandate resulted in the inclusion of the Women's Health and Cancer Rights title within the Omnibus Appropriation Act of 1998.

### *Federal law defined*

The Omnibus Appropriations Act of 1998, which includes the Woman's Health and Cancer Rights title, was signed into law on October 21, 1998. The cancer rights law requires health insurance issuers (of group and individual plans) who issue plans providing medical and surgical benefits for mastectomies to provide, upon election by the patient, coverage for reconstruction of the breast on which the mastectomy was performed and

reconstructive surgery on the other breast to produce a symmetrical appearance. In addition, coverage must be provided for prostheses and for physical complications which may occur in all stages of mastectomy, including lymphedemas. Coverage for services are to be determined following consultation with the attending physician and the patient. The title also prohibits a plan or issuer of a plan from (1) denying a patient eligibility, or continued eligibility, to enroll in or renew coverage in order to avoid the coverage mandate and (2) penalizing or limiting the reimbursement of a provider, or providing incentives to induce the provider not to give the care listed above. This coverage is applicable to plan years beginning on or after October 21, 1998, the date of enactment.

The title adds a new section to the Employee Retirement Income Security Act of 1974 (ERISA) and the Public Health Service Act (PHSA) mandating that the coverage described above be provided to insurance participants governed by these acts. Amendments to these federal laws impact all group health plans, health insurance issuers who provide health insurance coverage through group health plans and in the individual market, including those who provide coverage as mutual benefit societies, and health maintenance organizations. Written notice of coverage availability must be provided to all participants upon enrollment, no later than January 1, 1999, and annually, thereafter. The federal law specifically states that it does not preempt any state law in effect on the date of enactment which requires coverage at least comparable to what is provided under this title.

### ***Implication of the federal mandate***

The recently enacted federal mandate applies to insurers who provide health insurance plans in Hawaii. In light of this, a study to assess the financial and social impacts of a state mandate appears unwarranted. Additionally, while the federal act specifically did not preempt state laws enacted prior to October 21, 1998, it was silent on the issue of state laws passed after that date. It is therefore unclear whether subsequent state laws mandating this type of insurance coverage would be preempted by the federal law. This issue was noted by a representative of the National Association of Insurance Commissioners, who recommended that states defer passage of any subsequent laws on this matter until the preemption issue is resolved.

Upon passage of the federal law, we informally contacted organizations that testified in favor of the proposed mandate, H.C.R. No. 14, H.D. 1, S.D. 1, during the 1998 legislative session. We contacted the American Cancer Society, the Hawaii State Commission on the Status of Women, the Hawaii Medical Service Association, and the Department of Health. Of those contacted, only the American Cancer Society had remaining concerns with this health issue. The other organizations contacted expressed no concerns and indicated that an additional state mandate is unnecessary at this time.

A representative of the American Cancer Society in Hawaii contends that a state mandate is needed to resolve gaps in the federal legislation. The representative stated that the federal law lacks a definition of mastectomy which is needed to clarify whether women who have lumpectomies would also benefit from the law. The cancer society also expressed concern that the federal language requiring health plans to consult the physician and the patient in determining coverage will place doctors in an advocate role with insurers.

The Department of Health, the Hawaii State Commission on the Status of Women, and the Hawaii Medical Service Association did not express similar concerns. The health department and Hawaii Medical Service Association essentially stated that a state mandate was not needed. The Department of Health recommended postponement of a state mandate until a need not being met by the federal mandate arises.

In light of the recently enacted federal mandate requiring health insurers to provide coverage for post-mastectomy breast reconstructive surgery, the recommendations of the state health department and the National Association of Insurance Commissioners, and the unresolved preemption issue, we have deferred further study of the social and financial impacts of a state mandate until such time has elapsed that we may assess the impact of the new federal legislation.



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## Notes

### Chapter 1

1. Senate Standing Committee Report No. 3418 on H.C.R. No. 14, H.D. 1, S.D. 1, Regular Session of 1998.



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## Response of the Affected Agency

### **Comments on Agency Response**

We transmitted a draft of this report to the Department of Health on January 8, 1999. A copy of the transmittal letter to the Department of Health is included as Attachment 1. The department elected not to respond to the draft report.

ATTACHMENT 1

STATE OF HAWAII  
OFFICE OF THE AUDITOR  
465 S. King Street, Room 500  
Honolulu, Hawaii 96813-2917



MARION M. HIGA  
State Auditor

(808) 587-0800  
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January 8, 1999

*COPY*

The Honorable Bruce S. Anderson  
Acting Director of Health  
Department of Health  
Kinau Hale  
1250 Punchbowl Street  
Honolulu, Hawaii 96813

Dear Dr. Anderson:

Enclosed for your information are three copies, numbered 6 to 8 of our draft report, *Status Report on the Study of Proposed Mandatory Health Insurance Coverage for Post-Mastectomy Breast Reconstructive Surgery*. We ask that you telephone us by Tuesday, January 12, 1999, on whether or not you intend to comment on our recommendations. If you wish your comments to be included in the report, please submit them no later than Tuesday, January 19, 1999.

The Governor and presiding officers of the two houses of the Legislature have also been provided copies of this draft report.

Since this report is not in final form and changes may be made to it, access to the report should be restricted to those assisting you in preparing your response. Public release of the report will be made solely by our office and only after the report is published in its final form.

Sincerely,

Marion M. Higa  
State Auditor

Enclosures