



**COMMENTS REGARDING H.2169
AN ACT RELATIVE TO PATIENT ACCESS TO INFORMATION REGARDING
BREAST RECONSTRUCTIVE SURGERY
BEFORE THE JOINT COMMITTEE ON PUBLIC HEALTH
June 6, 2023**

The Massachusetts Medical Society is a professional association of over 25,000 physicians, residents, and medical students across all clinical disciplines, organizations, and practice settings. The Medical Society is committed to advocating on behalf of patients, to provide them a better health care system, and on behalf of physicians, to help them provide the best care possible. The MMS strives for health equity, advocating for vulnerable patients especially during time periods most critical to their health. In pursuing those ends, the Medical Society has policy in support of mandating insurance coverage without cost-sharing for breast reconstruction surgery. As outlined below, the Medical Society supports some aspects of H.2169, *An Act relative to patient access to information regarding breast reconstructive surgery*, and wishes to share the concern regarding some aspects of the approach taken regarding a very important issue.

Surgical mastectomy is a common treatment for breast cancer. Out of 1.2 million women treated for breast cancer in centers associated with the American Cancer Society between 1998 and 2011, 35.5% had a mastectomy.¹ While breast conserving surgery (BCS) has similar rates of survival compared to mastectomy, rates of preventive mastectomy have been continuously rising over the last 20 years. The rate of bilateral mastectomy for unilateral breast cancer increased from 1.9% in 1998 to 11.2% in 2011. Along with this increase in mastectomies, the rate of immediate breast reconstruction (IBR) after mastectomy has risen from 26% in 2005 to 40% in 2011.² IBR is associated with cosmetic and psychosocial benefits. A systematic review of literature published between 2000 and 2019 found increased odds of depression for patients who underwent

¹ Kummerow KL, Du L, Penson DF, Shyr Y, Hooks MA. Nationwide trends in mastectomy for early-stage breast cancer. *JAMA Surg.* 2015;150(1):9. doi:10.1001/jamasurg.2014.2895

² Butler PD, Nelson JA, Fischer JP, et al. Racial and age disparities persist in immediate breast reconstruction: an updated analysis of 48,564 patients from the 2005 to 2011 American College of Surgeons National Surgery Quality Improvement Program data sets. *Am J Surg.* 2016;212(1):96-101. doi:10.1016/j.amjsurg.2015.08.025

mastectomy alone compared to mastectomy with breast reconstruction.³ Only 45% of women treated surgically for breast cancer undergo breast reconstruction in the United States and this rate is not distributed equally across races.⁴ Black women are 0.57–0.71 times as likely to undergo breast reconstruction compared to white women.^{5 6} An analysis of a large national cohort of women diagnosed with breast cancer found that 26.8% of Black patients diagnosed with breast cancer underwent IBR after mastectomy in comparison to 39.4% of white patients. Advanced disease amongst Black women does not explain the gap, as disparities persist in early-stage disease.⁷ A Surveillance, Epidemiology, and End Results (SEER) Program database study of women diagnosed with stage 0–III breast cancer between 1998 and 2014 found that non-Hispanic Black women and Hispanic women were significantly less likely to undergo reconstruction. A Nationwide Inpatient Sample (NIS) from 2002 through 2006 additionally found uninsured women and those with public coverage were less likely to have reconstruction than privately insured women. Racial/ethnic disparities were less prominent within insurance types.

Black, publicly insured, and low-socioeconomic women are significantly less likely to receive either immediate or delayed breast reconstruction after bilateral breast mastectomy for breast cancer.^{8 9 10} Benefits of reconstruction include increased self-esteem, decreased anxiety and depression, and improved sexual function and quality of life. The Women’s Health and Cancer Rights Act of 1998 mandated insurance coverage of reconstructive procedures following

³ Padmalatha S, Tsai YT, Ku HC, et al. Higher risk of depression after total mastectomy versus breast reconstruction among adult women with breast cancer: a systematic review and meta-regression. *Clin Breast Cancer*. 2021;21(5):e526-e538. doi:10.1016/j.clbc.2021.01.003

⁴ Butler PD, Familusi O, Serletti JM, Fox JP. Influence of race, insurance status, and geographic access to plastic surgeons on immediate breast reconstruction rates. *Am J Surg*. 2018;215(6):987-994. doi:10.1016/j.amjsurg.2017.09.037

⁵ Sergesketter AR, Thomas SM, Lane WO, et al. Decline in racial disparities in postmastectomy breast reconstruction: a surveillance, epidemiology, and end results analysis from 1998 to 2014. *Plast Reconstr Surg*. 2019;143(6):1560-1570. doi:10.1097/PRS.0000000000005611

⁶ Shippee TP, Kozhimannil KB, Rowan K, Virnig BA. Health insurance coverage and racial disparities in breast reconstruction after mastectomy. *Womens Health Issues*. 2014;24(3):e261-e269. doi:10.1016/j.whi.2014.03.001

⁷ Lang JE, Summers DE, Cui H, et al. Trends in post-mastectomy reconstruction: a SEER database analysis. *J Surg Oncol*. 2013;108(3):163-168. doi:10.1002/jso.23365

⁸ Kwok AC, Goodwin IA, Ying J, Agarwal JP. National trends and complication rates after bilateral mastectomy and immediate breast reconstruction from 2005 to 2012. *Am J Surg*. 2015;210(3):512-516. doi:10.1016/j.amjsurg.2015.03.019

⁹ 2 Offodile AC, Tsai TC, Wenger JB, Guo L. Racial disparities in the type of postmastectomy reconstruction chosen. *J Surg Res*. 2015;195(1):368-376. doi:10.1016/j.jss.2015.01.013

¹⁰ 3 Schumacher JR, Taylor LJ, Tucholka JL, et al. Socioeconomic factors associated with post-mastectomy immediate reconstruction in a contemporary cohort of breast cancer survivors. *Ann Surg Oncol*. 2017;24(10):3017-3023. doi:10.1245/s10434-017-5933-0

mastectomy for breast cancer.¹¹ Despite growing rates of reconstruction, the racial disparity between white and non-white patients persists.

The Medical Society strongly supports initiatives aimed at addressing systemic racism in our health care system and reducing disparities in health care access and outcomes. As such, the MMS supports the intent of this legislation, which aims to rectify a racial disparity in breast reconstruction procedures following mastectomy. However, we have concerns with the legislation as written, which mandates specific counseling for patients. While the aim is important, and the MMS supports the goals of the conversation intended, we believe this mandate is misguided, and interferes with the physician-patient relationship. These aims could be better accomplished through public health guidance and continuing medical education. As discussed above, while insurance coverage improves access to breast reconstruction services, the Medical Society believes it's critical to address the impact of *equitable* insurance benefits and the impact of cost-sharing as a barrier to access to care. As such, we support coverage without cost-sharing for breast reconstructive surgery to reduce affordability barriers and improve equitable access to this critical procedure.

Thank you for your consideration of our comments and for your work on this important issue.

¹¹ WHCRA — Women's Health and Cancer Rights Act. American Cancer Society. Published May 13, 2019. Accessed July 27, 2022. www.cancer.org/treatment/finding-and-paying-for-treatment/health-insurancelaws/womens-health-and-cancer-rights-act.html