Federal and state network-adequacy standards, ERISA fiduciary principles, and Medicaid access rules generally require insurers to authorize out-of-network care at in-network cost-sharing when a medically necessary service cannot reasonably be obtained in-network or in-state.

Comprehensive Breast Reconstruction Coverage Act

HB453 by Rep. Jennifer Fidler

WHAT DOES THIS BILL DO*?*

⇒ Consistent Access to Breast Reconstruction Coverage Across All Plans

What it does:

Ensures *all* health insurance plans operating in Alabama cover breast reconstruction as medically necessary care, beginning January 1, 2027. This includes private insurance, Medicaid, the State Employees' Health Insurance Plan, and the Public Education Employees' Health Insurance Plan.

- If group health plans provide coverage for mastectomies, the federal **Women's Health and Cancer Rights Act** (WHCRA) of 1998 generally **ensures that the plan also covers reconstructive surgery** associated with that procedure, recognizing it as part of medically necessary care for breast cancer patients.

Where found in the bill:

- General coverage mandate: **§27-50A-3(a)** (Page 11)
- Effective date: **§27-50A-3(a)** and **Section 5** (Pages 11, 20)
- Public Education Employees' Plan: **§16-25A-6.1** (Page 20)
- Medicaid coverage: **§22-6-11.1** (Page 20)
- State Employees' Plan: **§36-29-4.1** (Page 20)

⇒ Breast reconstruction is medical care, not cosmetic

What it does:

Defines breast reconstruction as medically necessary treatment following cancer, disease, trauma, or prophylactic surgery — not cosmetic surgery. *Reference the WHCRA of 1998 above*

Where found in the bill:

- Legislative findings and intent: **§27-50A-1** (Page 8)
- Broad medical definition of breast reconstruction: **§27-50A-2(1)** (Pages 8–9)

⇒ Patient choice of reconstruction method and surgeon

Insurance companies should not override medical decisions based on cost or network rules

What it does:

Allows patients, in consultation with their physicians, to choose:

- The reconstruction modality, type, and technique
- Their surgeon and facility, including out-of-network providers
    - The **type of reconstruction** that works best for their body and health
    - The **surgeon** they trust
- Insurers may not require the use of in-network surgeons or facilities.

Where found in the bill:

- Choice of modality and technique: **§27-50A-3(b)** (Page 11)
- Use of in-network or out-of-network providers: **§27-50A-3(c)** (Page 11)
- Presumption of medical necessity for physician-selected care: **§27-50A-3(d)** (Page 11)
- Prohibition on requiring in-network providers: **§27-50A-6(a)** (Page 13)

⇒ Coverage of the full course of reconstruction care

What it does:

Covers *all stages* of breast reconstruction, not just one surgery, including:

- Initial reconstruction
- Revision surgeries
- Symmetry procedures
- Nipple reconstruction
- Flat closure
- Treatment of complications
- Follow-up care

Where found in the bill:

- Comprehensive definition of covered services: **§27-50A-2(1)** (Pages 8–9)
- Coverage of all subsequent and related surgeries: **§27-50A-3(e)** (Page 11)

⇒ Addresses the network deficiency and gap in care

What it does:

There are currently only two physicians in Alabama qualified to perform muscle-sparing, natural reconstructive procedures. This reflects a clear and significant gap in access to care.

This provision does not expand insurers' substantive coverage obligations. Rather, it requires insurers to **acknowledge** the **limited availability** of qualified providers in certain geographic areas and to permit patients to **access** appropriately **qualified physicians**—even when services must be provided by out-of-network providers—while limiting patient cost-sharing to in-network deductibles, copayments, and coinsurance.

The federal No Surprises Act (enacted in 2020 and effective beginning in 2022) protects patients when there are limited or no in-network providers available in a geographic area by requiring insurers to treat certain care as in-network for cost-sharing purposes**,** even when the provider is technically out-of-network. It also prohibits insurers from penalizing patients for network inadequacy (i.e., when there are too few qualified providers reasonably available)

Coverage for reconstructive services may not be used to reduce other covered benefits or affect policy renewal eligibility.

Where found in the bill:

- In-network cost-sharing requirement: **§27-50A-5(a)** (Page 12)
- Protection of other benefits and renewal rights: **§27-50A-5(b)–(d)** (Pages 12–13)

⇒ Prevents insurance delays and improper denials

What it does:

- Requires prior authorization decisions within **three business days**
- Presumes doctor-selected reconstruction is medically necessary
- Prohibits denials based on cost, network status, or cheaper alternatives
- Sets **clear timelines and standards** so women are not left waiting during cancer recovery

Today, insurers:

- Delay approvals
- Push cheaper but less appropriate options
- Deny care because a surgeon is out of network

Where found in the bill:

- Three-day prior authorization deadline: **§27-50A-4(a)** (Page 11)
- Medical necessity presumption: **§27-50A-3(d)** (Page 11)
- Prohibited bases for denial (cost, network, cheaper options): **§27-50A-4(c)** (Pages 12–13)

⇒ Fair payment rules for out-of-network surgeons

What it does:

Requires insurers to negotiate single-case agreements in good faith. If negotiations fail, a neutral, market-based reimbursement standard applies. Insurers that underpay face penalties.

Where found in the bill:

- Single-case agreement requirements and timelines: **§27-50A-8(b)** (Pages 14–15)
- Default reimbursement standard (80th percentile): **§27-50A-8(c)** (Page 15)
- Penalties for failure to pay (treble damages + interest): **§27-50A-8(d)–(e)** (Page 15)

⇒ Protects patients if coverage changes mid-reconstruction

What it does:

Ensures that reconstruction and related care must continue even if a patient's insurance coverage changes during treatment.

Where found in the bill:

- Continuity of coverage provision: **§27-50A-9** (Page 15)

⇒ Enforcement, appeals, and accountability

What it does:

Allows patients and providers to seek relief if insurers violate the law and grants enforcement authority to the Attorney General and Insurance Commissioner.

Where found in the bill:

- Civil actions and remedies: **§27-50A-10** (Pages 15–16)
- Enforcement authority: **§27-50A-11** (Page 16)

⇒ Required notice to patients

What it does:

Requires insurers to provide clear, plain-language notice of patient rights at enrollment, renewal, and diagnosis.

Where found in the bill:

- Notice requirements: **§27-50A-12** (Pages 16–17)

Bottom Line — this bill is grounded in statute

- Treats breast reconstruction as essential medical care
- Preserves patient and physician decision-making
- Prevents insurer delay, denial, and cost-shifting
- Applies evenly across private and public plans
- Uses clear statutory guardrails rather than vague standards

Why do we need this bill?

The federal **Women's Health and Cancer Rights Act of 1998 (WHCRA)** generally requires health insurance plans to cover breast reconstruction following a mastectomy, and the **Affordable Care Act (ACA)** further requires insurers to maintain provider networks that are adequate for patients to meaningfully access covered care. Despite these protections, many patients enrolled in Alabama insurance plans report significant difficulty locating in-network breast reconstruction surgeons. These challenges often result in prolonged coverage appeals, substantial delays in care, the need to seek treatment out of state, or, in some cases, the absence of reconstruction care altogether.

Breast reconstruction is a highly specialized field, and these procedures are frequently unavailable through in-network providers in Alabama. Insurance carriers have taken limited steps to expand or support access to these specialists. As a result, patients are often forced to pursue out-of-network care, face higher out-of-pocket costs, or endure lengthy delays while attempting to obtain medically necessary treatment. Peer-reviewed research demonstrates that certain reconstruction options reduce complications and improve long-term outcomes—benefits that can also lower overall healthcare costs.

Insurers are already legally obligated to maintain networks that provide real access to medically necessary services. When a network cannot meet a patient's needs—because qualified providers are not available within a reasonable distance or cannot provide timely, coordinated care—the insurer is required to approve a gap-in-care exception so the patient may receive care at in-network cost-sharing levels. In practice, however, insurers frequently fail to honor these obligations, particularly for complex procedures such as breast reconstruction.

Rather than leaving patients dependent on discretionary exceptions that are inconsistently granted, this bill takes a clearer and more reliable approach. By requiring coverage for breast reconstruction regardless of whether the treating physician is in-network or out-of-network, the bill directly addresses the reality that many existing provider networks are functionally inadequate for this type of care. In doing so, it effectively ensures access, eliminates unnecessary insurer barriers, and protects patients from delays and unexpected medical bills when in-network options are unavailable.

This provision builds on the intent of existing federal law—including the **Women's Health and Cancer Rights Act of 1998 (WHCRA)**, the **Affordable Care Act (ACA)**, and the **No Surprises Act (NSA)**—by applying those principles specifically and clearly to breast reconstruction care.

How does this bill impact hospitals*?*

This bill is **hospital-friendly**. It strengthens hospitals' financial stability and protects their independence by placing all obligations on insurance companies—not on hospitals or health systems. The bill ensures that hospitals are paid for the care they provide, prevents insurers from denying payment after surgeries have already been approved, and guarantees fair reimbursement for hospital facility services, including when a facility is out of network.

Just as important, the bill protects hospitals from insurer pressure by preserving hospitals' authority over medical staff credentialing and operational decisions. It **does not** change hospital contracts, add administrative burden, or expose hospitals to new legal risk. Instead, it reduces uncertainty, improves payment reliability, and removes insurance barriers that keep patients from accessing hospital-based care. Overall, the bill supports hospitals by reinforcing fair payment, protecting autonomy, and helping ensure patients can receive necessary care in the hospital setting.