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Insuring Breast Reconstruction

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ABSTRACT

Women who are faced with a devastating diagnosis of breast cancer often confront a grueling treatment regimen, typically involving some combination of surgery, chemotherapy, and radiation. Many of these women desire reconstruction and have a right to insurance coverage for it under the Women's Health and Cancer Rights Act (WHCRA). However, because of an unduly narrow interpretation of the Act, such women are often presented with a false dichotomy between a full mastectomy with reconstruction and a partial mastectomy or lumpectomy without. This Article uses legislative history, plain meaning, and state case law on similar issues to show that the WHCRA is properly interpreted as providing a right to insurance coverage for reconstruction after partial, as well as full, mastectomies. The author's experiences with breast cancer treatment are used to illustrate the problem. Additionally, the Article argues that the question of whether the WHCRA contains a private right of action separate from ERISA should be revisited.

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INTRODUCTION

In the late summer of 2015, I happened to feel a mosquito-bite-like lump deep in the tissue of my underarm. It did not itch but it felt the slightest bit tender. I did not have a doctor at the time, having recently moved from another state. I talked to my spouse about whether it was anything to be concerned about, and we both thought it was a good idea to go to a doctor. Cancer was not on my mind, much less breast cancer. I did not know then that the underarm or axilla is actually the tail of the breast. I found a doctor and got in to see her by mid-September. Although she was not very concerned—also believing that the small lump did not look like cancer—she referred me for further testing. And so, a few weeks later, I had a diagnostic mammogram and an ultrasound followed by a biopsy. On November first of that year, I received a definitive diagnosis of breast cancer, specifically invasive lobular carcinoma.[1]

After that, I was confronted with many decisions regarding treatment. In terms of breast cancer surgery, I ultimately chose a lumpectomy, also referred to as a partial mastectomy. Lumpectomies can have vastly different effects on the breast, depending on factors such as the size and location of the tumor or tumors, the use and extent of radiation, and the person's breast size. For me, because I had multiple small tumors removed, followed by radiation, the surgery had a significant effect, changing the shape and size of my breast.

A lumpectomy was not a type of surgery that the surgeons and the other cancer doctors I consulted with seemed to associate with reconstruction. But, because I instinctively knew that I wanted to keep my breast and have it look as much like it did before surgery as possible, I had begun to research what type of reconstruction to have before the partial mastectomy. During the process of researching reconstruction and the availability of insurance coverage for it, I learned of a law—the Women's Health and Cancer Rights Act of 1998 (WHCRA)[2]—that requires insurance companies that cover mastectomies to cover reconstruction. The law does not explicitly answer the

1. Invasive lobular carcinoma is a type of breast cancer that begins in the breast lobules, or milk-producing organs of the breast. The term "invasive" means that it has spread beyond those organs. *See Invasive Lobular Carcinoma (ILC)*, BREASTCANCER.ORG, http://www.breastcancer.org/symptoms/types/ilc [https://perma.cc/6Q6U-PKRW].
2. Pub. L. 105-277, 112 Stat. 2681-436 §§ 901–903 (codified as amended at 29 U.S.C. § 1185b, 42 U.S.C. §§ 300gg-27, 300gg-52 (2012)).

central question of this Article—are those who undergo partial mastectomies also entitled to coverage for reconstruction? Based on legislative history and the ordinary meaning of the term "mastectomy" at the time of the WHCRA's passage, I argue that the law should be interpreted to cover reconstruction after partial mastectomies as well as after full mastectomies.

In America today, one in eight women can be expected to be diagnosed with breast cancer in her lifetime.[3] A diagnosis of breast cancer is a terrifying occurrence for most women. Indeed, presumably because of the stress and anxiety the diagnosis typically elicits, breast cancer diagnoses often lead to posttraumatic stress disorder (PTSD),[4] as well as to impaired cognitive functioning, irrespective of whether the patient receives chemotherapy.[5] While white women are diagnosed with this devastating disease at higher rates than African Americans, Asians and Pacific Islanders, American Indians and Alaska Natives, and Latinas, alarmingly, African American women die of the disease at considerably higher rates than those of other racial and ethnic groups.[6] Disabled women who develop breast cancer also die at higher rates from the disease than do nondisabled women and are less likely to receive the full spectrum of treatments that other women receive.[7] One small glimmer of hope is that rates of mortality from breast cancer have decreased among women from all racial and ethnic groups in the last several years.[8] Although rarely talked about, a small number of men develop breast cancer as well.[9] While there have not yet been studies on this question, transgender men and women may be at increased risk of breast cancer.[10] Transgender and gender-

3. *See, e.g.*, *Breast Cancer Risk in American Women*, NAT'L CANCER INST., https://www.cancer.gov/types/breast/risk-fact-sheet [https://perma.cc/S4ZA-LP7H].
4. Kerstin Hermelink et al., *Chemotherapy and Post-Traumatic Stress in the Causation of Cognitive Dysfunction in Breast Cancer Patients*, J. NAT'L CANCER INST., Oct. 2017, at 1, 2.
5. *Id.* at 12–13. Interestingly, the posttraumatic stress disorder (PTSD) symptoms only partially explained the limited impaired cognitive functioning that was observed among the patients in the Hermelink *et al.* study. *Id.* at 13.
6. *See, e.g.*, *Breast Cancer Rates by Race and Ethnicity*, CTRS. DISEASE CONTROL & PREVENTION, *https://www.cdc.gov/cancer/breast/statistics/race.htm* [https://perma.cc/5Z4C-NN9L].
7. Ellen P. McCarthy et al., *Disparities in Breast Cancer Treatment and Survival for Women With Disabilities*, 145 ANNALS INTERNAL MED. 637, 641–42 (2006).
8. *Breast Cancer Trends*, CTRS. DISEASE CONTROL & PREVENTION, https://www.cdc.gov/cancer/breast/statistics/trends.htm [https://perma.cc/5F2Y-AUUV].
9. FENWAY HEALTH, KNOW YOUR RISKS: BREAST CANCER FACTS FOR TRANSGENDER MEN & WOMEN, http://www.thecentersd.org/pdf/health-advocacy/breast-cancer-facts-for.pdf ("Two percent of all breast cancer occurs in the breast tissue of non-transgender men."); *Male Breast Cancer*, NAT'L BREAST CANCER FOUND., INC., http://www.nationalbreastcancer.org/male-breast-cancer [https://perma.cc/CC7V-XRQ5] (reporting that less than 1 percent of breast cancers develop in males).
10. FENWAY HEALTH, *supra* note 9.

nonconforming persons undergoing breast cancer treatment may also have additional difficulty getting the type of reconstruction they prefer.[11]

In 1998, Congress enacted a modest mandate directed at insurance companies to ensure that insured women undergoing breast cancer treatment would have access to reconstructive surgery as needed. This mandate—the WHCRA—is one of a very few federal statutes that substantively regulate the content of insurance plans.[12] However, the WHCRA has not lived up to its promise, particularly for women who undergo partial rather than full mastectomies. The goal of this Article is to show that the WHCRA was intended to apply to women who undergo partial mastectomies and that they are entitled to benefit from the insurance coverage it requires. In the

11. *See* Chase Joynt, *RESISTERECTOMY by Chase Joynt*, YOUTUBE (Aug. 31, 2012), https://www.youtube.com/watch?v=nPLdJMm0TPA; *cf.* Kerstin Sandell, *Stories Without Significance in the Discourse of Breast Reconstruction*, 33 SCI. TECH., & HUM. VALUES 326, 333–34 (2008) (describing the difficulty that cisgender female breast cancer patients who wanted double mastectomies faced in one study in convincing their doctors to perform them); *id.* at 339 (describing how breast cancer patients, who underwent full mastectomies and refused reconstruction were conceptualized as irrational within the discourse of breast reconstruction). If cisgender female patients have difficulty convincing doctors to perform a mastectomy on the nondiseased breast and are viewed as irrational for refusing reconstruction, one can only assume that, due to discrimination and lack of knowledge of transgender patients' needs, trans patients would face similar or more heightened difficulties in having their medical choices respected. *See* Karnoski v. Trump, Case No. C17-1297-MJP, 2018 WL 1784464, *10 (W.D. Wash. Apr. 13, 2018), *app. filed* Case No. 18-35347 (9th Cir. Apr. 30, 2018) (noting that transgender people "continue to suffer endemic levels of . . . discrimination in employment, education, housing, criminal justice, and access to health care").

12. *See* NAT'L WOMEN'S LAW CTR., REFORM MATTERS: MANDATED INSURANCE BENEFIT LAWS: IMPORTANT HEALTH PROTECTIONS FOR WOMEN &THEIR FAMILIES 2–3 (2015), https://www.nwlc.org/wp-content/uploads/2015/08/Mandated%20Benefit%20Laws.pdf [https://perma.cc/3EAF-63S8]; Sylvia A. Law, *Do We Still Need A Federal Patients' Bill of Rights*, 3 YALE J. HEALTH POL'Y, L. & ETHICS 1, 6 (2002) (describing Employee Retirement Income Security Act of 1974 (hereinafter ERISA), Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.), as having created a state and federal regulatory vacuum). These federal mandate laws include, in addition to the Women's Health and Cancer Rights Act (WHCRA): (1) the Pregnancy Discrimination Act of 1978, Pub. L. No. 95-555, 92 Stat. 2076 (codified as amended at 42 U.S.C. § 2000e(k) (2012)); (2) the Newborns' & Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935 (codified as amended in scattered sections of 29 and 42 U.S.C.); (3) the Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944 (codified as amended at 29 U.S.C § 1185a and 42 U.S.C. § 300gg-5); and (4) Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511-512, 122 Stat. 3881 (codified as amended in scattered sections of 29 and 42 U.S.C.). *See* NAT'L WOMEN'S LAW CTR., *supra*, at 2–3; Ellen Weber, *Equality Standards for Health Insurance Coverage: Will the Mental Health Parity and Addiction Equity Act End the Discrimination?*, 43 GOLDEN GATE U. L. REV. 179, 182 (2013).

traditions of feminist theory and critical race theory, I utilize my own experience as a breast cancer survivor to illustrate the problem, while relying on the Act's plain language and legislative history to demonstrate the intent and proper interpretation of the Act.

Breast reconstruction and the use of breast prostheses have been harshly criticized by radical feminists such as Audre Lorde on the premises that women have been pushed into using these tools to make others feel more comfortable and that their use diverts the survivors' attention from true healing and an investigation of their own mortality.[13] I believe there is some merit to these claims. For example, some women receiving cancer treatment have expressed a duty to protect others from evidence of the disease. As one woman undergoing chemotherapy reported in a Danish study: "You show consideration for others by wearing a wig and make up. You don't want to remind people of death."[14] In addition to the general societal pressure on women to be attractive to heterosexual men, this respondent's perspective is reinforced by—and perhaps was partially constituted by—institutional programs for female cancer patients that encourage them to think about, as well as improve, their appearance by masking not only the amputation of all or part of the breast, but also the side-effects of cancer treatment such as the loss of hair and eyebrows.[15] These programs were in their infancy in Lorde's day but now are quite well established.[16]

Although saying so does not alleviate societal pressures in and of itself, I do not believe that breast cancer patients, on top of their own physical and emotional suffering, should be burdened with either protecting others from being reminded of death or upholding stereotypical notions of womanhood.

13. AUDRE LORDE, THE CANCER JOURNALS 65–72 (special ed. Autre Lute Books 1997) (1980).
14. Helle Ploug Hansen & Tine Tjørnhøj-Thomsen, *Cancer Rehabilitation in Denmark: The Growth of a New Narrative*, 22 MED. ANTHROPOLOGY Q. 360, 374 (2008).
15. *Id.* at 374 (describing the "Look Good—Feel Better" workshops for female cancer patients that were offered to all the women in one of the two cohorts in the Danish study); *see also About the Program*, LOOK GOOD FEEL BETTER, http://lookgoodfeelbetter.org/about/about-the-program [https://perma.cc/9VZL-3W4M] ("Look Good Feel Better is a non-medical, brand-neutral public service program that teaches beauty techniques to people with cancer to help them manage the appearance-related side effects of cancer treatment.").
16. *Cf.* LORDE, *supra* note 13, at 41–42. What Lorde describes as "Reach for Recovery" appears to be the American Cancer Society's Reach to Recovery Program, which began in the 1950s in New York City and later was affiliated with the American Cancer Society and expanded nationwide. *See* OneCoastAdmin, *Reach to Recovery 1969 – 1999 American Cancer Society*, YOUTUBE (Nov. 18, 2008), https://www.youtube.com/watch?time_continue=196&v=at2Fm-nGbpY; *see also* Hansen & Tjørnhøj-Thomsen, *supra* note 14, at 374.

Thus, I wholeheartedly agree with Lorde that women should not be pushed into reconstruction or the use of other measures to hide the effects and side-effects of treatment. At the same time, however, women who want reconstruction should not be denied the chance to have it regardless of whether the mastectomy they had was full or partial. It should be the cancer patient's choice, not the insurance company's, whether to proceed with reconstruction. This is so because, for many women who are fortunate enough to have insurance, a denial of coverage for reconstruction would foreclose the option due the often exorbitant expense of such procedures.[17] While beyond the scope of this Article, uninsured women also deserve better access to healthcare, including reconstruction. As the WHCRA provides no assistance to those who lack insurance, broadening options for these women may be best effected through community organizing and political campaigns to increase the availability of government-subsidized insurance.

Although Lorde objected to reconstruction in part because it served to mask the disease and all of its implications about the toxicity of the environment,[18] feminist theorist Diane Price Herndl has argued that the landscape has profoundly changed since Lorde wrote about breast cancer—in large part due to Lorde's own writing—in that the disease as a general matter has become highly visible.[19] Thus, choosing reconstruction today does not have the same effect of contributing to the societal masking of breast cancer as it once did.[20] This statement is undoubtedly correct, but I still see the decision to refuse reconstruction as having radical potential. That decision has the ability to very powerfully make breast cancer physically visible on a personal level as well as the potential to challenge narrow and largely unachievable conceptions of beauty. Women who make that choice are doing important work for all of us. Yet it is not fair or realistic to ask all breast cancer patients to refuse reconstruction on principle. When essentialist strains of feminism demand unwavering adherence to certain standards of action of all women across every aspect of their lives, they arguably become just as oppressive as patriarchy when it makes its unrealistic demands on women, whether having to do with virtue, beauty, a nurturing personality, or something else.

17. *See Breast Reconstruction: Cost*, REALSELF, https://www.realself.com/breast-reconstruction/cost [https://perma.cc/EYM5-LRNV].
18. LORDE, *supra* note 13, at 14–15.
19. Diane Price Herndl, *Reconstructing the Posthuman Feminist Body Twenty Years After Audre Lorde's* Cancer Journals, *in* DISABILITY STUDIES: ENABLING THE HUMANITIES 149–50 (Sharon L. Snyder et al. eds., 2002).
20. *Id.* at 150–52.

The fact that the demands of this more old-fashioned form of feminism have sometimes meshed with my worldview has, at some points in my life, made my inability to meet them all the more painful. Indeed, Price Herndl notes that she originally saw her decision to choose reconstruction as a personal failure: "I thought [refusing reconstruction] was the right choice. I thought it was the feminist choice. And I couldn't do it. Feminist theorist fails, I told myself at first."[21] As a shy, feminine-appearing, bisexual woman, I have long ago made peace with not meeting many of essentialist feminism's demands, so I did not feel like a failure when I was diagnosed with breast cancer and decided that I wanted reconstruction. Rather, as Price Herndl notes in another passage of her essay, I knew at once that I had "to measure how much loss I [could] stand," and, also like Price Herndl, I understood in a very personal, immediate way that "preserv[ing] as much of my [body as physically] intact as I [could]" was important to me.[22]

While Price Herndl's initial characterization of her desire for reconstruction as a feminist failure is understandable, especially in light of her obvious admiration for Audre Lorde, Third-Wave feminists in fact often emphasize the ability to actualize personal choice as one of the benefits and successes of feminism.[23]

All of this is a long way of explaining that, decontextualized from an individual patient's story, reconstruction strikes me as impossible to evaluate. Accordingly, I do not advocate for breast reconstruction as a societal good in and of itself. Rather, it is a tool that many women desire to use, just as I did, and an unduly narrow interpretation of the WHCRA hampers access to this tool among women who want to use it or at least consider it. The goal of this Article is to explain why a broad interpretation of the WHCRA is warranted.

As shown below, the legislative history of the WHCRA, the plain language of the statute, and state law analyses of similar questions all militate in favor of a broad interpretation of the WHCRA as requiring coverage for reconstruction after partial mastectomies. Affirming that the WHCRA

21. *Id.* at 149.
22. *Id.*
23. *See* MARTHA CHAMALLAS, INTRODUCTION TO FEMINIST LEGAL THEORY 116–21 (3d ed. 2013) (discussing Third-Wave feminist Kathryn Abrams and her work *Complex Claimants and Reductive Moral Judgments: New Patterns in the Search for Equality*, 57 U. PITT. L. REV. 337, 348–49 (1996)); *see also* Bridget J. Crawford, *Toward a Third-Wave Feminist Legal Theory: Young Women, Pornography & the Praxis of Pleasure*, 14 MICH. J. GENDER & L. 99, 120 (2007) (discussing the sentiments of Third-Wave Feminists like Jennifer Baumgardner and Amy Richards, as expressed in their work *The Number One Question About Feminism*, 29 FEMINIST STUD. 448, 450 (2003)).

requires coverage for reconstruction after a partial mastectomy is important for two key reasons. First, women who elect partial mastectomies to treat breast cancer are currently not being informed about their congressionally created right to coverage for reconstruction. Because there is no medical reason to deny reconstruction to women who undergo partial mastectomies,[24] this failure to inform cancer patients appears to be due to a misinterpretation of the WHCRA on the part of doctors and insurance companies. Secondly, it is likely that many women are being presented—as I was—with a false dichotomy in treatment options of a full mastectomy with reconstruction on the one hand or partial mastectomy without reconstruction on the other.[25] Therefore, some women who have a viable medical choice between a partial or full mastectomy are undoubtedly choosing a full mastectomy in order to receive coverage for reconstruction. Thus, an unduly

24. *See* Steven J. Kronowitz et al., *Lipofilling of the Breast Does Not Increase the Risk of Recurrence of Breast Cancer: A Matched Controlled Study*, 137 PLASTIC & RECONSTRUCTIVE SURGERY 385 (2016) (describing a study affirming that fat grafting after a partial or full mastectomy does not increase the risk of recurrence of breast cancer); Debra L. Monticciolo et al., *Autologous Breast Reconstruction With Endoscopic Latissimus Dorsi Musculosubcutaneous Flaps in Patients Choosing Breast-Conserving Therapy: Mammographic Appearance*, 167 AM. J. ROENTGENOLOGY 385, 386 (1996) (describing a study on whether mammography was impeded by latissimus dorsi flap reconstruction among women who had undergone lumpectomies that found that "[i]n no case did mammographic findings from reconstruction interfere with evaluation of the surgical site"); *see also Breast Reconstruction After Lumpectomy*, BARNES JEWISH HOSP., https://www.barnesjewish.org/Medical-Services/Plastic-Reconstructive-Surgery/Breast-Reconstruction/Breast-Reconstruction-After-Lumpectomy [https://perma.cc/LBB9-T5HF] (affirming that breast cancer patients have many options for breast reconstruction after a lumpectomy); *Reconstruction After Lumpectomy*, BREASTCANCER.ORG., http://www.breastcancer.org/treatment/surgery/reconstruction/types/lumpectomy [https://perma.cc/U9N9-ZTCE] (summarizing options for reconstruction after lumpectomy).

25. *See* SUSAN M. LOVE, DR. SUSAN LOVE'S BREAST BOOK 243 (6th ed. 2015) (suggesting that women may be choosing full mastectomies over lumpectomies because of a fear of being left with a poor cosmetic result after a lumpectomy and a lack of awareness that reconstruction would be available in such a case); *see also* Letter from Richard M. Rainsbury, Consultant Oncoplastic Breast Surgeon, Royal Hampshire Cty. Hosp. & Fiona MacNeil, Consultant Oncoplastic Surgeon, Royal Marsden Hosp. to British Medical Journal, *reprinted in Surgery for Breast Cancer: Oncoplastic Surgery Is Promising*, 338 BRIT. MED. J. 1028, 1028 (2009) ("[C]osmetic deformity after [a type of partial mastectomy called a] quadrantectomy is common and distressing. For this reason, many women facing such extensive resections are advised to undergo mastectomy."). A "quadrantectomy" is defined as "a partial mastectomy involving excision of a tumor along with the involved quadrant of the breast including the skin and underlying fascia." *Quadrantectomy*, MERRIAM-WEBSTER, http://unabridged.merriam-webster.com/medical/quadrantectomy (using the online definition of *Webster's Third New International Dictionary, Unabridged* (2018)).

cramped reading of the WHCRA is artificially limiting their options and affecting their medical decisionmaking.

This wrongful incentivization of full mastectomies over lumpectomies leads to other problems as well. For instance, some women who choose a full mastectomy instead of a lumpectomy experience less satisfaction with body image after surgery.[26] Full mastectomy also has other significant detrimental effects for some women, such as precluding or limiting the ability to breastfeed and reducing sexual pleasure. Perhaps most disturbingly, women who undergo full mastectomies are also more likely to experience complications than those who undergo lumpectomies, and, as might be expected, such complications tend to cause increased anxiety for the patient and may lead to treatment delays as well.[27] For all of these reasons, the artificial constraint on women's choices caused by an overly narrow reading of the WHCRA is improper, unfair, and has negative consequences for the very women whom WHCRA is designed to protect.

I. THE WOMEN'S HEALTH AND CANCER RIGHTS ACT (WHCRA)

Originally introduced as Senate Bill 249,[28] the proposed legislation that formed the basis of the WHCRA was championed in 1997 and 1998 by

26. Neil K. Aaronson et al., *#1290/The Effect of Surgery Type on the Body Image of Women with Primary Breast Cancer: A Question of Age?*, *as reprinted in* 13 QUALITY LIFE RES. 1518 (2004). Younger women for the purposes of this study were defined as those under fifty-five years old. *Id.*

Also see Carly L. Paterson et al., *Body Image in Younger Breast Cancer Survivors: A Systematic Review*, 39 CANCER NURSING E39, E53 (2016) (describing studies that found that younger women experienced better outcomes in terms of body image after having breast conserving surgery and studies showing that "[s]urgery type was found to have an impact on appearance satisfaction").

27. *See* Zahraa Al-Hilli et al., *Reoperation for Complications After Lumpectomy and Mastectomy for Breast Cancer From the 2012 National Surgical Quality Improvement Program (ACS-NSQIP)*, 22 ANNALS SURGICAL ONCOLOGY S459, S467–68 (2015); *see also* Karuna Jaggar, *SABCS 2015: Comparing Lumpectomy vs. Mastectomy: Survival, Complications and Cost*, BREAST CANCER ACTION (Dec. 11, 2015), https://bcaction.org/2015/12/11/sabcs-2015-comparing-lumpectomy-vs-mastectomy-survival-complications-and-cost [https://perma.cc/WB5N-7C8E] (discussing the greater likelihood of complications for those undergoing full mastectomies compared with lumpectomies).

28. Women's Health and Cancer Rights Act of 1997, S.B. 249, 105th Cong.; *see also* 143 CONG. REC. E159 (daily ed. Feb. 5, 1997) (statement of Rep. Molinari) (reflecting the introduction of the bill); *see also* Women's Health & Cancer Rights Act of 1997, H.R. 616, 105th Cong. (introducing a companion bill in the U.S. House of Representatives a few days after Senate Bill 249).

Senator Alfonse D'Amato of New York and twenty-six cosponsors[29] as a way to remedy unjust denials of insurance coverage—for reconstructive surgery, overnight hospital stays when needed, and second opinions—that many women who had breast cancer were then commonly experiencing.[30] One of only a few federal mandates as to the content of insurance plans,[31] the bill was modeled after the Newborns' and Mothers' Health Protection Act of 1996.[32] Companion legislation was introduced in the U.S. House of Representatives and was similarly the subject of ardent advocacy.[33] Despite the valiant efforts of the bills' sponsors, both bills died in U.S. Congress without coming to a vote. However, after Senators D'Amato, Dianne Feinstein, and others vowed to "offer [the WHCRA] as an amendment on every piece of legislation that goes through here that is vital,"[34] the U.S. Senate enacted a considerably scaled-down version, focused solely on insurance coverage for breast reconstruction and complications ensuing from mastectomies, in October 1998 as a rider to the Omnibus Consolidated and Emergency Supplemental Appropriations Act.[35]

The late Audre Lorde would likely have taken a particularly dim view of the WHCRA's final form, given that most of the provisions protecting women's health and rights to medical treatment were dropped, and only the portions addressing reconstruction and a right to coverage for mastectomy

29. *S.249-Women's Health and Cancer Rights Act of 1997*, CONGRESS.GOV, https://www.congress.gov/bill/105th-congress/senate-bill/249/cosponsors?r=1 [https://perma.cc/ADA2-GFM8] (listing the bill's twenty-six co-sponsors).
30. *See* 144 CONG. REC. S4875–76 (daily ed. May 14, 1998) (statement of Sen. D'Amato); 144 CONG. REC. S4876–77 (daily ed. May 14, 1998) (statements of Sen. Feinstein & Sen. D'Amato); 144 CONG. REC. S3008 (daily ed. Apr. 1, 1998) (statement of Sen. Murkowski); 143 CONG. REC. S5884 (daily ed. June 17, 1997) (statement of Sen. Dodd); 143 CONG. REC. S820 (daily ed. Jan. 29, 1997) (statement of Sen. Snowe).
31. *See* NAT'L WOMEN'S LAW CTR., *supra* note 12, at 2–3; Weber, *supra* note 12, at 182.
32. Pub. L. No. 104-204, 110 Stat. 2935 (codified as amended in scattered sections of 29 and 42 U.S.C. (2012)); Anna Elento-Sneed & Joanne L. Grimes, *Group Health Plans: Tips for the Careful Employer*, PRAC. L., Jan. 2000, at 45, 48.
33. Women's Health & Cancer Rights Act of 1997, H.R. 616, 105th Cong.; *see, e.g.*, 143 CONG. REC. E2103 (daily ed. Oct. 28, 1997) (statement of Rep. Kelly); (advocating for Women's Health & Cancer Rights Act); 143 CONG. REC. H1961, H1962–63 (daily ed. Apr. 29, 1997) (statement of Rep. Meek); 143 CONG. REC. E170–71 (daily ed. Feb. 5, 1997) (statement of Rep. Kelly).
34. 144 CONG. REC. S4875–4876 (daily ed. May 14, 1998) (statement of Sen. D'Amato); *see also* 144 CONG. REC. S4644, S4650 (daily ed. May 12, 1998) (statement of Sen. D'Amato) ("I intend to hold hostage . . . important legislation that moves through until we get a vote on [the WHCRA] . . . .").
35. *Compare* Women's Health and Cancer Rights Act of 1997, S.B. 249, 105th Cong., *with* Omnibus Consolidated and Emergency Supplemental Appropriations Act, Pub. L. 105–277, tit. IX, §§ 901–903, 112 Stat. 2681, 2681-436 to 2681-439 (1998).

complications remain.[36] Lorde's critiques of reconstruction do raise the question of whether the reconstruction provisions survived while the rights to overnight hospital visits and second opinions were jettisoned because reconstruction is a way to make female cancer survivors more "palatable" to society generally, and to heterosexual men in particular. Although the discussions on the floor of the Senate suggest that it was the insurance lobby and its concern about the extra cost of the overnight hospital stays and second opinions that led to the narrowing of the bill when it was finally enacted,[37] it may also be true that the emotional appeal of reconstruction provisions facilitated their enactment and that this emotional appeal was partially fueled by societal stereotypes of womanhood and concomitant demands upon women to be available to—and pleasing to—heterosexual men. Regardless of whether the legislation ended up the way it did in part because of straight-male desires, reconstruction is a tool that many women who are diagnosed with breast cancer want to access. Therefore, the WHCRA is an important piece of legislation even in its diminished, final form.

The final version of the WHCRA provides, seemingly straightforwardly, that:

> A group health plan . . . that provides medical and surgical benefits with respect to a mastectomy shall provide, in a case of a participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for—
>
> (1) all stages of reconstruction on the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.[38]

Other portions of the WHCRA require that insurance companies provide notice of this coverage to those who are insured; explain how the requirements of the law affect collective bargaining agreements; mandate application of the law to individually purchased insurance; and provide guidance on issues such as preemption of state law, the Act's relationship to

36. *See* LORDE, *supra* note 13, at 65–72.
37. 144 CONG. REC. S4644, S4646 (daily ed. May 12, 1998) (statements of Sen. Kennedy & Sen. Boxer) (discussing the power of the insurance industry with respect to the WHCRA and another bill).
38. 29 U.S.C. § 1185b(a) (2012).

certain other provisions of Employee Retirement Income Security Act of 1974 (hereinafter ERISA),[39] and other matters.[40]

There is little case law on the WHCRA. Indeed, this may be partly because, as has been widely reported in treatises, practice guides, and journals,[41] the Eighth Circuit held in 2002 that, separate from ERISA, there is no private right of action for damages under it.[42] Thus, under the Eighth Circuit's view, the only way to enforce the WHCRA's requirement of coverage for reconstruction through a lawsuit would be to sue under Section 502 of ERISA to enjoin the insurance company to cover reconstruction or to seek related equitable relief.[43] Still, given the availability of an injunctive remedy under ERISA, the relative lack of case law remains surprising.

The handful of cases that have examined the WHCRA have done the following: interpreted the allowance of "deductibles and coinsurance provisions" broadly to also allow insurance companies to apply usual customary and reasonable coverage limits (hereinafter UCR) to reconstruction benefits;[44] determined whether WHCRA's notice requirements were met;[45] held that a plaintiff seeking further reconstruction to attain a symmetrical appearance did not make an objectively supported claim of asymmetry between her breasts;[46] and rejected a plaintiff's claim under the WHCRA because the claim

39. Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).
40. 29 U.S.C. § 1185b(b)–(e) (2012); 42 U.S.C. §§ 300gg-27, § 300gg-52.
41. *See, e.g.*, CORPORATE COUNSEL'S GUIDE TO ERISA § 12:29 (2017); *No Private Cause of Action in Insurance Dispute, 8th Cir. Says*, 9 ANDREWS MED. DEVICES LITIG. REP. 5 (2002).
42. Howard v. Coventry Healthcare of Iowa, Inc., 293 F.3d 442 (8th Cir. 2002). A federal district court in Montana, in an unpublished decision, similarly stated that there is no private right of action. Smith v. Earhart, No. CV–07–143–BLG–RFC–CSO, 2009 WL 62874 (D. Mont. Jan. 9, 2009). However, in *Smith*, the plaintiffs had conceded the lack of a private right of action, so all discussion of the issue in *Smith* is dicta. *See id.*
43. *Howard*, 293 F.3d at 445 (noting the availability of remedies under ERISA); *see also* 29 U.S.C. § 1132(a)(3); Colleen E. Medill, *Resolving the Judicial Paradox of "Equitable" Relief Under ERISA Section 502(a)(3)*, 39 J. MARSHALL L. REV. 827, 890–91 (2006) (stating, based on the court's decision in *Howard* as well as on the lack of statutory language explicitly providing otherwise, that the only suit available under the WHCRA is one under 29 U.S.C. § 1132(a)(3)); *cf.* Weber, *supra* note 12, at 229–30 (describing the scope of relief available under ERISA § 502(a)(3)).
44. Krauss v. Oxford Health Plans, Inc., 418 F. Supp. 2d 416 (S.D.N.Y. 2005) (upholding insurance company's ability to apply usual customary and reasonable coverage limits (hereinafter UCR) to reconstruction benefits under the WHCRA, which resulted in the patient's having to pay a portion of the reconstruction costs).
45. Haag v. MVP Health Care, 866 F. Supp. 2d 137, 145–46 (N.D.N.Y. 2012).
46. J.L.F. v. Ariz. Healthcare Cost Containment Sys., 91 P.3d 1002, 1006–07 (Ariz. Ct. App. 2004).

was directed at a provider rather than an insurer.[47] Although courts have examined similar issues under state law and have sometimes alluded to the WHCRA in those discussions, no case appears to decide whether the WHCRA was intended to cover partial mastectomies.[48] Scholarship on whether the WHCRA covers partial mastectomies is simply nonexistent.

II. REEXAMINING WHETHER THE WHCRA CREATES A PRIVATE RIGHT OF ACTION

In addition to examining the WHCRA's application to women who seek reconstruction coverage after partial mastectomies, this Article closely examines and challenges the Eighth Circuit's rationale for holding that the WHCRA did not create a private right of action for damages. A couple of preliminary points merit attention before delving into an analysis of the court decision, however. First, although some aspects of the statute imply an intent to create a private right of action, the WHCRA itself does not explicitly address this question. Second, neither the Act it was modeled after, the Newborns' and Mothers' Health Protection Act of 1996, nor the very limited case law interpreting that Act shed light on this question.[49]

In *Howard v. Coventry Healthcare of Iowa, Inc.*,[50] based on the WHCRA's legislative history and the fact that the statute is part of ERISA's comprehensive remedial scheme, the Eighth Circuit held that the only way to enforce the WHCRA, which amended ERISA, was through ERISA. As more fully explored below, this holding is arguably supportable, but there are important considerations that cut the other way that the court did not examine. Given that courts require exhaustion of insurance company remedies

47. Peterson v. Wellpoint, Inc., No. 13–933, 2014 WL 1154347, at *1 (E.D. La. Mar. 21, 2014).

48. *See, e.g.*, Carr v. Blue Cross of Wash. & Alaska, 971 P.2d 102, 107–08 (Wash. Ct. App. 1999) (construing Washington state law to require insurance coverage for reconstruction after a partial mastectomy); Coverage for Reconstructive Breast Surgery Following Partial Mastectomy, Op. Tenn. Att'y Gen. No. 07-66 (May 14, 2007), 2007 WL 1558705 (construing Tennessee law to require coverage for reconstruction after most partial mastectomies).

49. *See* Elento-Sneed & Grimes, *supra* note 32 at 45, 48 (describing the WHCRA as having been modeled after the Newborns' and Mothers' Health Protection Act of 1996). An early joint report by the American Law Institute and the American Bar Association stated without elaboration that both statutes contained private rights of action. Phyllis C. Borzi, *Health Care Legislation: Implementing HIPAA, the Newborns' and Mothers' Health Protection Act, the Mental Health Parity Act, and the Women's Health and Cancer Rights Act*, 993 ALI-ABA VIDEO L. REV. 53, 105 (2000).

50. 293 F.3d 442 (8th Cir. 2002).

before bringing most ERISA claims and that some courts require exhaustion before bringing any type of ERISA claim, courts should specify, at a minimum, that exhaustion is not required before bringing a WHCRA claim.

In *Howard*, cancer survivor Lisa Howard sued for tortious breach of a statute, the WHCRA, and for pendent state law claims after her insurer refused to allow her to receive the specific type of implants recommended by her doctor at a Minnesota facility that was relatively close to her home.[51] The type of implants at issue were not widely available and appear to have been recommended because Ms. Howard had twice had complications with previous implants and, as a result, had already undergone several reconstruction operations.[52] She preferred the Minnesota facility to the Missouri facility at which she had previously planned—and obtained her insurer's approval—to receive the implants because of the former's proximity to her residence.[53]

Her claims were dismissed, and the court, in a per curiam opinion, based its determination that the WHCRA contained no private cause of action separate from ERISA on two points: (1) that it did not view the legislative history of the WHCRA as providing evidence of intent to create a private cause of action and (2) that the nature of ERISA as "a comprehensive remedial scheme . . . shows that Congress did not intend to create a private, independent cause of action."[54] The court viewed these two bases as negating the second and third factors set forth in *Cort v. Ash*[55] for determining whether legislation should be read to include a private right of action.[56] These four

51. *Id.* at 443–44.
52. *Id.*
53. *See id.* at 444.
54. *Id.* at 445.
55. 422 U.S. 66 (1975). The four factors from *Cort* are as follows:

> In determining whether a private remedy is implicit in a statute not expressly providing one, several factors are relevant. First, is the plaintiff "one of the class for whose especial benefit the statute was enacted,"—that is, does the statute create a federal right in favor of the plaintiff? Second, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one? Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? And finally, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?

Id. at 78 (citations omitted) (quoting Tex. & Pac. Ry. Co. v. Rigsby, 241 U.S. 33, 39 (1916)).

56. *Howard*, 293 F.3d at 444–45 (citing *Cort*, 422 U.S. at 78); *see also* CHARLES ALAN WRIGHT ET AL., 13A FEDERAL PRACTICE AND PROCEDURE JURISDICTION AND RELATED MATTERS § 3531.6 (3d ed. 2017) (discussing the standards for finding an implied private cause of action in a statute and the four factors established in *Cort v. Ash*).

Cort v. Ash factors are (1) whether the plaintiff is part of the class for whose benefit the statute was enacted, (2) whether there is any indication of legislative intent to create or deny a private right of action, (3) whether it is consistent with the underlying purposes of the legislative scheme to imply a remedy, and (4) whether the cause of action is traditionally relegated to state law.[57]

While the court's determination under the third *Cort* factor that ERISA constitutes a comprehensive remedial scheme appears reasonable, its assessment of the WHCRA's legislative history is lacking in depth and does not reckon with the elements of the legislative history that cut the other way.[58] To be sure, the legislative intent is not completely free from doubt, but there are certainly a number of passages in it that support a private cause of action.

The *Howard* court concluded that the WHCRA's legislative history showed that "it was 'intended to ban drive-through mastectomies' and to require insurance companies to cover the costs of breast reconstruction surgeries," and that, therefore, the statute was not intended to create a private right of action.[59] However, the court took an overly simplistic view of the legislative history in reaching this conclusion. Along with the statutory language itself, which requires coverage for reconstruction and specifies the patient and the doctor rather than the insurance company as the decisionmakers,[60] various statements in the Conference Report for the WHCRA and elsewhere in the Congressional Record imply an intent for a private right of action. For example, in referencing one patient's experience with a prolonged and expensive internal appeal under ERISA as an example of why the WHCRA was needed, the Conference Report suggests that the Act will obviate the need for lengthy and expensive internal appeals under ERISA.[61] The implicit suggestion that such internal appeals would no longer be necessary under the WHCRA supports a congressional intent to create a private right of action separate from that available under ERISA generally,

57. *Cort*, 422 U.S. at 78.
58. *See infra* notes 61–66.
59. *Howard*, 293 F.2d at 445 (quoting Howard v. Coventry Health Care of Iowa, Inc., 158 F. Supp. 2d 937, 941 n.6 (S.D. Iowa 2001)).
60. 29 U.S.C. § 1185b(a) (2012).
61. 144 CONG. REC. S12825 (daily ed. Oct. 21, 1998) (statement of Sen. D'Amato); *see also* Carson D. Phillips-Spotts, Comment, *Exhausted Yet?* Stephens v. Pension Benefit Guaranty Corporation *and the Application of the Exhaustion Doctrine to Statute-Based ERISA Claims*, 67 ME. L. REV. 377, 383 (2015) (noting that courts are split as to whether exhaustion is required when a patient claims a statutory violation of ERISA). A statutory claim under ERISA is the type that would be pursued to allege a violation of the WHCRA.

especially given that some jurisdictions require exhaustion of the insurance company's appeals process before one may bring a court action alleging violation of ERISA's statutory language.[62]

The Conference Report also describes the Act as ensuring that "no woman will ever be denied reconstructive surgery again."[63] Senator D'Amato's conception of the WHCRA as a hammer that would prevent all future denials of reconstruction coverage also suggests an intent to create a private right of action because the WHCRA becomes much less effective at creating such assurance if ERISA's exhaustion requirements and other procedural barriers are applied. Similarly, in the Senate, a statement by Dr. Sarah Troxel was repeatedly cited that: "Women who are not able to receive reconstructive surgery suffer from depression, a sense of loss, and need more cancer and survivor counseling . . . ."[64] This statement reflects a legislative desire to remove obstacles to reconstruction in order to speed up breast cancer survivors' psychological recovery. Requiring breast cancer survivors to litigate their right to reconstruction only through the highly flawed vehicle of ERISA, however, does not further this goal.[65] Finally, the WHCRA's emphasis on the fact that treatment options for reconstruction and breast cancer surgery complications are to be formulated "in a manner determined in consultation with the attending physician and the patient" also suggests that insurance companies should take a backseat to treating physicians with respect to determining whether and which type of reconstruction is

62. *See* John Bourdeau et al., *Need to Exhaust Plan Claims Procedures Prior to Actions Under ERISA*, 27 FED. PROC., LAW. EDITION § 61:301 (2018) ("[C]ourts generally require exhaustion of plan claims procedures as a prerequisite to bringing a suit for benefits under ERISA."); *cf.* Phillips-Spotts, *supra* note 61, at 383, 387 (describing the view that exhaustion is required before alleging a statutory violation of ERISA, as opposed to a violation of a benefit plan, as the minority view); Weber, *supra* note 12, at 230 & n.213 (noting that courts are split on whether exhaustion is required for a 29 U.S.C. § 1132(a)(3) claim).

63. 144 CONG. REC. S12826 (daily ed. Oct. 21, 1998) (statement of Sen. D'Amato).

64. 144 CONG. REC. S4649 (daily ed. May 12, 1998) (statement of Sen. Murkowski); 144 Cong. Rec. S3009 (daily ed. Apr. 1, 1998) (statement of Sen. Murkowski).

65. *See, e.g.*, Law, *supra* note 12, at 6 ("[T]he rise of managed care, together with ERISA's regulatory vacuum with respect to employer-sponsored health insurance, has left tens of thousands of Americans without legal redress for death or injury due to [Managed Care Organizations] providing substandard care *or wrongfully denying or delaying promised care*." (emphasis added)); Tiffany F. Theodos, Note, *The Patients' Bill of Rights: Women's Rights Under Managed Care and ERISA Preemption*, 26 AM. J.L. & MED. 89, 93–95 (2000) (discussing the "major loophole" created by ERISA preemption and a plaintiff's general inability to sue for the harm caused by a wrongful denial of benefits); *see also* Phillips-Spotts, *supra* note 61, at 383 (noting that courts are split as to whether exhaustion is required when a patient asserts a claim asserting a statutory violation of ERISA).

appropriate.[66] Making the patient's rights under the WHCRA solely enforceable through ERISA would detract from this goal.

Two additional structural observations about the WHCRA are also worth noting here. First, the WHCRA specifically provides, under ERISA Section 502, for the nonpreemption of state laws in existence at the time of its passage that require at least the same coverage for reconstruction as does the WHCRA.[67] This provision relating to state law demonstrates that the authors of the WHCRA were supportive of private causes of action in general, since some of those state laws undoubtedly include private causes of action.

Second, the WHCRA's requirement that the scope of its rights be "determined in consultation with the attending physician and the patient"[68] indicates an intent to remove control of the decision about whether the WHCRA's rights are at issue in any given case from the insurance company and instead put it in the hands of the patient and her physician. This reassignment of authority to the physician and patient at a minimum suggests that patients who are denied coverage for reconstruction in violation of WHCRA should not be forced to exhaust plan remedies before bringing suit.[69] The insurance company has no special expertise on whether an individual is entitled to reconstruction coverage under the WHCRA—for patients with insurance coverage for mastectomies, the statute accords that decision to the patient and her doctor.[70] Thus, requiring exhaustion does not serve any substantive end and is inefficient. Moreover, the legislative history reflects a significant level of mistrust of insurance companies and an overriding intent to end unwarranted denials of coverage for reconstruction, noting that these denials continue to occur even in states that require coverage for reconstruction.[71] If exhaustion were required, the insurance

66. 29 U.S.C. § 1185b(a) (2012); *see also* 144 CONG. REC. S12826 (daily ed. Oct. 21, 1998) (statement of Sen. D'Amato) (describing the "sacred" bond between physician and patient and stating that "only that physician . . . can truly determine the best course of action for their patient"); 143 CONG. REC. E170 (daily ed. Feb. 5, 1997) (noting the bill's protection of "the doctor-patient relationship").

67. 29 U.S.C. § 1185b(e)(1). Preemption of state laws remains in effect for self-insured plans under Section 514 of ERISA. *Id.* § 1185b(e)(2) (citing 29 U.S.C. § 1144); *see also* Lois Dehls Cornell, *Managed Care Nuts & Bolts*, 20121028 AHLA SEMINAR PAPERS 18 (2012) (describing the different types of preemption under ERISA).

68. 29 U.S.C. § 1185b(a).

69. *See supra* note 66.

70. 29 U.S.C. § 1185b(a) (2016).

71. 144 CONG. REC. S4651 (daily ed. May 12, 1998) (statement of Sen. D'Amato) (describing the WHCRA as intended to "let the women of America have freedom from the fear of being denied . . . reconstructive surgery"); 143 CONG. REC. E159 (daily ed. Feb. 5, 1997) (statement Rep. Molinari) (stating that denials of coverage for follow-up reconstructive

company, rather than the patient and her physician, would temporarily be able to thwart the patient's access to her rights under WHCRA in contravention of legislative intent. In addition, having to proceed through an internal insurance appeal process while dealing with breast cancer diagnosis and treatment is extremely stressful,[72] and the WHCRA's legislative history demonstrates that it was intended to minimize such stress.[73]

In short, the *Howard* court failed to analyze parts of the legislative history that suggest that the WHCRA was intended to include a private right of action, and it also overlooked two important structural issues. Nonetheless, the fact that Congress intentionally placed the WHCRA in ERISA (the original bills contained statements that they would amend ERISA),[74] does suggest that ERISA's remedial scheme should apply, particularly in light of the lack of any explicit remedy in the WHCRA.[75] Therefore, the part in the *Howard* court's analysis that focuses on ERISA's comprehensive remedial scheme appears to be correct.[76] The question of consistency with a comprehensive remedial scheme, however, is only one of four factors that

procedures "must end," that denials of coverage for reconstructive surgery have occurred "even in States where coverage for reconstructive surgery was mandatory," and finally that "[t]his bill is attempting to provide some sense of security that hospitals and medical providers are able to do the right thing. We will be able to claim success if we can minimize the pain, confusion and trauma following a breast cancer diagnosis . . . ."); 144 CONG. REC. S886 (daily ed. Jan. 30, 1997) (statement of Sen. D'Amato) (quoting the statement of a physician who was also a cancer survivor that "denials for breast [cancer] reconstruction are serious and they are rising" alteration in original)); *see also* 144 CONG. REC. S12826 (daily ed. Oct. 21, 1998) (statement of Sen. D'Amato).

72. *See, e.g.*, mminmich, Post to *Topic: I Won! Oncotype Appeal*, BREASTCANCER.ORG COMMUNITY (Dec. 5, 2007, 4:49 PM), https://community.breastcancer.org/forum/62/topics/696079 [https://perma.cc/UNT2-YZEL] (stating that repeatedly appealing the insurance company's denial of a test that helps shed light on the likely success of treatment options "has been more stressful than having breast cancer"); Sheryl Nance-Nash, *Breast Cancer's Financial Toll: The Cost of Fighting for Your Life*, AOL (Oct. 5, 2011, 11:00 AM), https://www.aol.com/2011/10/05/breast-cancers-financial-toll-the-high-cost-of-fighting-for-yo [https://perma.cc/PJ6U-LPAW] (describing a patient's nine-month fight to get her insurance company to pay for the anesthesia she had during her mastectomy) .

73. *See supra* note 721.

74. Women's Health and Cancer Rights Act of 1997, S.B. 249, 105th Cong. § 3(a) ; Women's Health & Cancer Rights Act of 1997, H.R. 616, 105th Cong. § 3(a) .

75. *See also* WRIGHT, *supra* note 56, § 3531.6 ("'The express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others.' At times the explicit enforcement provisions may defeat other aspects of a statute that seem to create a private right of action." (quoting Alexander v. Sandoval, 532 U.S. 275, 290 (2001))).

76. Howard v. Coventry Healthcare of Iowa, Inc., 293 F.3d 442, 445 (8th Cir. 2002).

need to be addressed under *Cort v. Ash* to determine whether a federal statute creates a private right of action.[77]

Thus, it is clear that, although parts of its analysis are correct, there are holes in the *Howard* court's analysis that warrant looking at the issue anew. In the future, courts addressing this issue should reweigh the *Cort v. Ash* factors, three out of four of which—in light of a more in-depth look at the legislative history than the *Howard* court engaged in—militate in favor of finding a private right of action. Furthermore, the statute's legislative history and the WHCRA's mandate that the patient and doctor be the decisionmakers as to the scope and application of the rights in a given case both strongly indicate that, at a minimum, exhaustion requirements should not apply to WHCRA rights.

III. INTERPRETING THE WHCRA IN THE CONTEXT OF PARTIAL MASTECTOMIES

With regard to the second question of this Article—whether WHCRA's mandated coverage for reconstruction after a mastectomy applies to partial mastectomies as well—several sources of information suggest that the answer is yes. Before discussing those sources of information, however, it is worth pointing out that the lack of case law on this question, combined with my own experience, suggests widespread uncertainty about the application of the WHCRA in the context of partial mastectomies. My own experiences, discussed at the end of Part III, included interactions with doctors who assumed that the WHCRA did not apply in the case of my lumpectomy, and some of whom presented me with a false dichotomy between a full mastectomy with reconstruction and a partial one without reconstruction. I also made extensive phone calls to, and even initiated a formal appeal to, my insurance company. The insurance company gave me inconsistent answers about coverage, and at one point asked whether my medical records described my surgical procedure as a lumpectomy or partial mastectomy, a question that appears to indicate uncertainty about the scope of the WHCRA.

77. 422 U.S. 66, 78 (1975). For a listing of the four factors, see *supra* note 55. Some courts have relied on solely on ERISA's comprehensive remedial scheme to hold that there is no private right of action for other federal mandates incorporated into ERISA. *See, e.g.*, Mills v. Bluecross Blueshield of Tenn., Inc., No. 3:15-cv-552-PLR-HBG, 2017 WL 78488, at *6 (E.D. Tenn. Jan. 9, 2017) (interpreting the Paul Wellstone & and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511-512, 122 Stat. 3881 (codified as amended in scattered sections of 29 and 42 U.S.C.)).

The WHCRA should be interpreted to apply in the case of a partial mastectomy based on a significant number of statements in its legislative history, contemporaneous dictionary definitions, and analysis of similar state law issues in state case law and a state attorney general opinion. Finally, although analysis of this issue is beyond the scope of this Article, the Affordable Care Act's[78] nondiscrimination provision, which prohibits discrimination based on sex and other protected classes, is another possible basis for interpreting the WHCRA to apply in the case of partial mastectomies.[79]

Turning to the intent of the WHCRA as to partial mastectomies, the most important source of information is the WHCRA's legislative history. Again, the text of the WHCRA as relevant here provides that a group health plan that provides coverage for a mastectomy must also provide to:

> [A] participant or beneficiary who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for—
>
> (1) all stages of reconstruction of the breast on which the mastectomy has been performed;
>
> (2) surgery and reconstruction of the other breast to produce a symmetrical appearance . . . .[80]

Thus, the WHCRA uses the term "mastectomy" without further explanation. The text alone is not entirely clear as to whether a partial mastectomy or lumpectomy (terms which generally mean the same thing) would be covered.[81] Several parts of the legislative history, however, suggest that partial mastectomies are intended to be covered.

One of the clearest indications in the legislative history is the repeated reference to an Alaska study in which it was found that, "of the 324

78. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. §§ 300gg-1 to -94, §§ 18001–18120 and other scattered sections of 42 U.S.C.).

79. 42 U.S.C. § 18116. If the physician's observation quoted by Senator D'Amato that reconstruction is just a matter of course when one loses "an ear or a testicle, or part of your face to cancer" is correct, then it may be possible to argue that an unduly narrow construction of the WHCRA's reconstruction provisions constitutes sex discrimination under 42 U.S.C. § 18116 or that a breast cancer patient should be entitled to coverage for reconstruction after a partial mastectomy without respect to the WHCRA. 144 CONG. REC. S886 (daily ed. Jan. 30, 1997) (statement by Sen. D'Amato).

80. 29 U.S.C. § 1185b(a) (2012).

81. *See* LOVE, *supra* note 25, at 242; *see also infra* note 120.

mastectomies and lumpectomies performed in Alaska in 1996, reconstruction only occurred on 11 of the patients."[82] The fact that Senator Frank Murkowski, a sponsor of the WHCRA, relied on a study that grouped lumpectomies together with full mastectomies and then examined the rates of reconstruction among women in Alaska who had had either type of surgery is highly significant. Given that the group being examined in the study was comprised of both patients who had undergone full mastectomies and those who had undergone lumpectomies, the ensuing discussions of the fact that far fewer breast cancer patients in Alaska appear to undergo reconstruction compared to the national average suggest that the WHCRA is intended to require coverage for reconstruction following lumpectomies as well as full mastectomies.

Another clear indication that the Act was intended to cover reconstruction following lumpectomies comes from a description of the bill by Senator Christopher Dodd, who was also one of its sponsors:

> This bill would also require HMO's [sic] to provide coverage for reconstructive surgery that is necessitated by breast cancer. Currently, this reconstructive surgery may be considered cosmetic, but this categorization is illogical as it ignores the trauma that results from a full mastectomy *and other breast cancer related procedures*.[83]

Because a lumpectomy clearly falls within the class of "other breast cancer related procedures," Senator Dodd, like Senator Murkowski in his discussion of the Alaska study, appears to have understood that the WHCRA would apply to reconstruction following lumpectomies as well as full mastectomies.

Similarly, in discussing the bill, Senator Olympia Snowe, another sponsor, empathized with the "emotional pain" that a "mastectomy patient" must feel due to "losing all *or part of a breast*."[84] While Senator Snowe was not examining the reconstruction portion of the bill in particular when making these comments, her statement shows that she interpreted the term "mastectomy" in the context of the bill to apply to partial as well as full mastectomies. Finally, references in the legislative history to a general right to "reconstruction

82. 143 CONG. REC. S4644 (daily ed. May 12, 1998) (statement of Sen. Murkowski); 143 CONG. REC. S3008 (daily ed. June 17, 1998) (statement of Sen. Murkowski).
83. 143 CONG. REC. S5884 (daily ed. June 17, 1997) (statement of Sen. Dodd) (emphasis added); *see also* Women's Health and Cancer Rights Act of 1997, S.B. 249, 105th Cong. (listing Senator Dodd as a sponsor).
84. 143 CONG. REC. S820 (daily ed. Jan. 29, 1997) (statement of Sen. Snowe) (emphasis added).

following cancer surgery"[85] and to the bill's requirement of coverage for "reconstructive surgery for breast cancer patients—including symmetrical reconstruction"[86] suggest the intent for a broad coverage of reconstruction following different types of breast cancer surgery, rather than a laser focus on full mastectomies.

In addition to legislative history, a second source of information that suggests that the WHCRA was meant to apply to partial mastectomies is contemporaneous dictionary definitions of "mastectomy." Dictionary definitions are frequently used by courts to interpret statutes, and the U.S. Supreme Court in particular appears to have a special penchant for them.[87] While I was not able to gain access to a dictionary published in 1998 (the year the WHCRA was enacted) that contained an entry for "mastectomy," the two roughly contemporaneous dictionaries I found that did contain such an entry both defined the term as encompassing partial as well as full mastectomies.[88] These two nearly identical listings define "mastectomy" as encompassing "surgical removal of all or part of a breast."[89] These definitions clearly support interpreting the WHCRA to include a broad definition of "mastectomy."

One caveat to this analysis of dictionary definitions is that, as explained below, some courts interpreting the WHCRA may apply a deferential standard of review to a plan administrator's decision as to the plan's compliance with the WHCRA, which could make dictionary definitions and other tools of statutory construction less salient. Given that WHCRA amends ERISA, courts would likely differ as to whether they would interpret the statutory provisions of the WHCRA de novo—rather than review a plan's interpretation under an arbitrary and capricious standard—when a plaintiff

85. *Id.*
86. 143 CONG. REC. E2103 (daily ed. Oct. 28, 1997) (statement of Hon. Sue W. Kelly).
87. James J. Brudney & Lawrence Baum, *Protean Statutory Interpretation in the Courts of Appeals*, 58 WM. & MARY L. REV. 681, 704–05 (2017); Matthew R. Christiansen & William N. Eskridge, Jr., *Congressional Overrides of Supreme Court Statutory Interpretation Decisions*, *1967–2011*, 92 TEX. L. REV. 1317, 1330, 1517 (2014).
88. THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE 1077 (4th ed. 2000); WEBSTER'S NEW WORLD COLLEGE DICTIONARY 885 (4th ed. 2000); *see also* Coverage for Reconstructive Breast Surgery Following Partial Mastectomy, Op. Tenn. Att'y Gen. No. 07-66 (May 14, 2007), 2007 WL 1558705, at *3–4 (citing an online dictionary and a 1997 dictionary to support the conclusion that "mastectomy" includes a partial mastectomy); *cf.* Carr v. Blue Cross of Wash. & Alaska, 971 P.2d 102, 107 (Wash. Ct. App. 1999) (citing conflicting dictionary definitions of "mastectomy," all of which were of a considerably earlier vintage than the WHCRA).
89. WEBSTER'S NEW WORLD COLLEGE DICTIONARY, *supra* note 88, at 885; *accord* THE AMERICAN HERITAGE DICTIONARY OF THE ENGLISH LANGUAGE, *supra* note 88, at 1077.

argues that a benefits plan that grants discretionary authority to a plan administrator failed to comply with WHCRA's provisions.[90] Differing standards of review could well affect the result of such a challenge, given that the arbitrary and capricious standard is considered "the least demanding form of judicial review of administrative action."[91] Dictionary definitions would presumably receive less weight in a court applying the arbitrary and capricious standard, provided that the plan could come up with some evidence to support a narrow interpretation of the WHCRA.

However, the seminal Supreme Court case supporting an arbitrary and capricious standard for ERISA review was explicitly limited to relief sought under another subsection of ERISA, § 502(a)(1)(B), pertaining to cases "challenging denials of benefits based on plan interpretations."[92] A claim based on a plain interpretation would presumably address the proper way to construe the actual terms of a health plan, whereas a statutory claim could, for example, allege that a plan's terms failed to comply with statutory requirements. Furthermore, the standard enunciated in this seminal case, *Firestone Tire and Rubber Co. v. Bruch*,[93] should not be extended to cases alleging violations of ERISA itself, or more specifically the WHCRA, because courts, rather than plan administrators, have expertise in interpreting statutes. In addition, it would be unjust to allow conflicting interpretations of the same statutory provision in the WHCRA or another part of ERISA in different cases based on deference to different plan administrators.[94] Finally, one can only assume that plans would interpret ERISA provisions narrowly to their own benefit in direct contravention of ERISA's stated purpose of "promot[ing] the interest of employees and their beneficiaries."[95]

90. *Compare* Hunter v. Caliber Sys., Inc., 220 F.3d 702, 711–12 (6th Cir. 2000) (holding that an arbitrary and capricious standard of review applies to a claim alleging a statutory violation of ERISA), *with* Waupaca Foundry, Inc. v. Gehlhausen, 104 F. Supp. 2d 1052, 1056–58 (S.D. Ind. 2000) (holding that claims for declaratory and injunctive relief under ERISA § 502(a)(3), to enjoin a violation of ERISA or the terms of the plan, are subject to the de novo standard rather than review for arbitrariness and capriciousness).
91. Davis v. Kentucky Fin. Cos. Retirement Plan, 887 F.2d 689, 693 (6th Cir. 1989), *quoted in Hunter*, 220 F.3d at 710.
92. Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 108 (1989).
93. 489 U.S. 101.
94. *Cf.* Miss. Band of Choctaw Indians v. Holyfield, 490 U.S. 30, 45 (1989) (interpreting the Indian Child Welfare Act, 25 U.S.C. §§ 1901–1963 and noting that "Congress could hardly have intended the lack of nationwide uniformity that would result from [incorporating] state-law definitions of domicile" into the federal statute).
95. Shaw v. Delta Airlines, Inc., 463 U.S. 85, 90 (1983), *quoted in Firestone Tire*, 489 U.S. at 102.

In addition to the plain meaning of WHCRA's language in light of the dictionary definitions discussed above and the WHCRA's legislative history, state law sources examining similar questions have also concluded that state statutes requiring insurance coverage for reconstruction after mastectomies require coverage for reconstruction after partial mastectomies. In *Carr v. Blue Cross of Washington and Alaska*,[96] the Washington Court of Appeals interpreted Washington Revised Code Section 48.44.35,[97] which requires insurance companies to "provide coverage for reconstructive breast surgery resulting from a mastectomy,"[98] to apply in the case of a partial mastectomy.[99] The *Carr* court determined that accepting the defendant's argument that the state statute applied only in the case of a full mastectomy "would reduce the effectiveness of the statute and . . . create an arbitrary demarcation between coverage and no coverage."[100] At least partially in response to the insurer's argument that the mention of "lumpectomy" in an adjacent section of the code militated in favor of interpreting "mastectomy" in Section 48.44.330 to mean only a full mastectomy, the court did limit the coverage required under Section 48.44.330 to "partial mastectomies where the patient's breast is left substantially deformed and a licensed physician determines that reconstruction is necessary for the patient's complete recovery."[101] By contrast, there is no explicit reference to lumpectomies in the version of the WHCRA that was enacted, although the original bills did mention them in an unenacted portion relating to the requirements for inpatient care.[102]

An attorney general opinion from Tennessee interpreting state law but also discussing the WHCRA similarly supports the conclusion that the term "mastectomy" includes partial mastectomies.[103] The opinion relies on dictionary definitions, state legislative history, legislative purpose, and statutory language to conclude that a state statute that requires coverage for reconstruction following a mastectomy also applies to partial mastectomies.[104] One important difference between the Tennessee law,

96. 971 P.2d 102 (Wash. Ct. App. 1999).
97. WASH. REV. CODE § 48.44.330 (2017).
98. *Id.*
99. *Carr*, 971 P.2d at 107–08 .
100. *Id.* at 108.
101. *Id.*
102. Women's Health & Cancer Rights Act of 1997, S.B. 249, 105th Cong. § 3(a); Women's Health & Cancer Rights Act of 1997, H.R. 616, 105th Cong. § 3(a).
103. Coverage for Reconstructive Breast Surgery Following Partial Mastectomy, Op. Tenn. Att'y Gen. No. 07-66 (May 14, 2007), 2007 WL 1558705.
104. *Id.*

Tennessee Code Annotated Section 56-7-2507,[105] and the WHCRA is that Section 56-7-2507 excludes coverage for lumpectomies whereas the WHCRA does not. This complicates matters because partial mastectomies and lumpectomies are usually viewed as identical within the medical profession.[106] Some sources, however, as did the Tennessee attorney general opinion, consider a lumpectomy to be more minor than a partial mastectomy.[107] Given the lack of any statutory exclusion for lumpectomies in the WHCRA, the statute should be interpreted broadly to include all types of partial mastectomies where the patient and physician jointly conclude that reconstruction is warranted.

The Tennessee attorney general opinion also states that its analysis would apply equally to the WHCRA: "While we are not aware of any court decisions that address the question whether 29 U.S.C. § 1185b requires coverage of reconstructive breast surgery . . . it is our opinion that courts would find partial mastectomies to be included within the term 'mastectomy'

105. TENN. CODE ANN. § 56-7-2507 (2017).

106. *See* LOVE, *supra* note 25, at 242; Melissa J. Liu et al., *The Effects of a National Breast and Cervical Cancer Early Detection Program on Social Disparities in Breast Cancer Diagnosis and Treatment in Massachusetts*, 16 CANCER CAUSES & CONTROL 27, 29 (2005) (defining "partial mastectomy" for purposes of the study to include "lumpectomies"); *Lumpectomy or Partial Mastectomy*, CEDARS-SINAI, https://www.cedars-sinai.edu/Patients/Health-Conditions/Lumpectomy-or-Partial-Mastectomy.aspx [https://perma.cc/QY3M-GCXQ] (describing a lumpectomy as "a segmental or partial mastectomy"); *Partial Mastectomy (Lumpectomy)*, YALE SCH. MED. *But see Breast-Conserving Surgery (Lumpectomy or Partial Mastectomy) for Breast Cancer*, UW HEALTH [hereinafter *Breast-Conserving Surgery*], https://www.uwhealth.org/health/topic/surgicaldetail/breast-conserving-surgery-lumpectomy-or-partial-mastectomy-for-breast-cancer/zt1573.html [https://perma.cc/J8X6-ZSKF] (describing a partial mastectomy as "more extensive" than a lumpectomy).

While scientific usage in the field at issue logically would seem to be the preferred authority for interpreting scientific terms in legislation such as the WHCRA, in fact courts often appear to rely on dictionary definitions to interpret scientific terms. *See, e.g.*, Former Emps. of Murray Eng'g v. Chao, 346 F. Supp. 2d 1279, 1285 (Ct. Int'l Trade 2004) (utilizing a specialized dictionary to interpret technical terms); Stephanie Tai, *When Natural Science Meets the Dismal Science*, 42 ARIZ. ST. L.J. 949, 992 (2010) (describing the U.S. Supreme Court in *Rapanos v. United States*, 547 U.S. 715 (2006), as "primarily" relying on dictionary definitions in interpreting the Clean Water Act, 33 U.S.C. §§ 1251–1387 (2012), while also suggesting through a passing reference to a scientific report that more specialized scientific sources may be applicable as well); *cf.* Markman v. Westview Instruments, Inc., 52 F.3d 967, 980 (Fed. Cir. 1995) (noting that expert testimony and learned treatises, in addition to dictionary definitions and other sources, "may be helpful to explain scientific principles, the meaning of technical terms, and terms of art" in the patent context).

107. *See, e.g.*, *Breast-Conserving Surgery*, *supra* note 106, Coverage for Reconstructive Breast Surgery Following Partial Mastectomy Op. Tenn. Att'y Gen. No. 07-66, (May 14, 2007), 2007 WL 1558705, at *4.

based on the analysis set forth above."[108] The opinion notes that the purpose of the WHCRA, similar to that of the Tennessee statute, is to "restore a person's 'wholeness,' both physically and mentally," a purpose which "is not accomplished by denying coverage to those needing reconstructive breast surgery following a partial mastectomy."[109]

In sum, state legal authority also supports interpreting the WHCRA to apply to partial mastectomies. The Tennessee attorney general opinion on the subject, in particular, conducts an in-depth analysis of a very similar question under state law and then concludes that the same analysis should apply to the WHCRA.

In addition to the legislative history, plain meaning, and state law bases discussed above, my personal experiences further illuminate the need to examine and resolve questions as to the scope of the WHCRA particularly for those who receive partial mastectomies. I was diagnosed with breast cancer in November 2015. Initially, I planned to have a lumpectomy (also called a partial mastectomy)[110] to remove two small lumps in the same breast. Both my surgeon and radiation oncologist supported this decision. Because I had heard that radiation shrinkage can be significant even with a relatively modest lumpectomy—and had witnessed my mother's discomfort in wearing an ordinary swimsuit (one that was not specifically designed for breast cancer survivors) after her own lumpectomy—I was already contemplating the possibility of seeking reconstruction and, soon after my diagnosis, had begun researching it on my own. Although in my forties and middle-aged, I still felt fairly young and knew that I didn't want to feel self-conscious about wearing bathing suits or tank tops.

When two additional small masses were discovered in roughly the same area, however, my surgeon began to suggest that maybe a mastectomy would be better because my breast could look deformed if a lumpectomy were performed, given the amount of tissue that would need to be removed. When I sought a second opinion at a well-known cancer hospital, the surgeon I met with was extremely brash in ordering me to get mastectomy because a lumpectomy would "take half my breast." Furthermore, she stated that I would be "allowed" to get reconstruction if I got a full mastectomy and that she and the rest of the team at that hospital had already decided that I was a good candidate for it. I am honestly not sure whether, by saying I would be

108. Coverage for Reconstructive Breast Surgery Following Partial Mastectomy Op. Tenn. Att'y Gen. No. 07-66, 2007 WL 1558705, at *4–5.
109. *Id.* at *5.
110. *See supra* note 120.

allowed reconstruction after a full mastectomy, she meant that insurance would cover it or she meant that she was making all the decisions and would allow me to get reconstruction if I followed her advice on getting a full mastectomy. Either way, she did not acknowledge the availability of reconstruction after a partial mastectomy and seemed to assume that it would be unavailable. Her primary reasoning for insisting upon a full mastectomy was cosmetic, although she also noted in passing that multifocal cancer (cancer that manifests in more than one tumor) is more likely to recur with a lumpectomy. I was outraged by her patronizing attitude and told her that I would have a lumpectomy and reconstruction, but she and the oncology fellow who was working with her continued to treat the idea that I would exercise autonomy as preposterous. Indeed, their approach and incredulity appeared to hearken back to attitudes in the late nineteenth century when doctors routinely removed patients' breasts without their permission or knowledge.[111] This unethical assault on women's bodies would occur immediately after patients were biopsied, while they were still under anesthesia, and thus before the patients had even been informed of their cancer diagnoses.[112]

Needless to say, that was my first and last visit with these two doctors. I left the clinic traumatized, as much by the advice I had received as by their manner and approach. I was not treated as a human being in that space but rather as a diseased object that had to be cured at all costs and without my input.[113] I told a friend later that I believed that this research-oriented clinic viewed patients as a mere nuisance.

My original surgeon was much kinder and more professional, but she too continued to express worry that I would not like the cosmetic result of a

111. *See, e.g.*, Tamsen Valoir, *Breast Cancer, Politics, and Patients*, 44 AIPLA Q.J. 63, 66–67 (2016).

112. *Id.*

113. My feelings at this moment echo those that the late writer Kathy Acker described more eloquently in a 1997 *Guardian* article:

> As I walked out of his office, I realized that if I remained in the hands of conventional medicine, I would soon be dead, rather than diseased, meat. For conventional medicine was reducing me, quickly, to a body that was only material, to a body without hope and so, without will, to a puppet who, separated by fear from her imagination and vision, would do whatever she was told.

Kathy Acker, *The Gift of Disease*, GUARDIAN, Jan. 18, 1997, at 51; *see also* Laura K. Potts, *Publishing the Personal: Autobiographical Narratives of Breast Cancer and the Self*, *in* IDEOLOGIES OF BREAST CANCER: FEMINIST PERSPECTIVES 98, 119–20 (Laura K. Potts ed., 2000) (describing how Acker and other women who write about breast cancer do so in part to construct themselves outside of Western medicine's vision of them as passive victims).

lumpectomy. She did not raise the issue of plastic surgery until I brought it up. I believe that this is because providers and insurers both assume that the WHCRA only applies in the case of a full mastectomy.

Blessed with good insurance and determined to stick with my original plan of electing a lumpectomy, I started to seek out advice from plastic surgeons on my own. Because they all had different advice, I ended up seeing several before finding one that I trusted. All of them had folders of handouts that explained the process of reconstruction after a full mastectomy. None of the folders contained information about reconstruction after lumpectomies. I believe that this practice of handing out information that implicitly portrays reconstruction as an option only after a full mastectomy developed because of the medical profession's understanding that insured patients have a right to seek reconstruction after a full mastectomy, combined with a lack of knowledge that the WHCRA also provides this right to insured patients who undergo partial mastectomies.[114] Indeed, one of the plastic surgeons I met with stated that insurance companies had to cover reconstruction after a full mastectomy but that it was up to the insurance company whether to cover it after a lumpectomy. Furthermore, when I inquired with my insurance company about a particular operation I was considering, they could not tell me whether it was covered or not and simply recommended having the doctor submit a preauthorization request. This demonstrates that the insurance company was uncertain on some level about whether my proposed reconstruction operation would be covered, despite the existence of the WHCRA and its clear requirement of coverage for reconstruction. Thus, it may be inferred that uncertainty about the applicability of the WHCRA to my situation was likely the cause. During the course of the call the customer service representative also asked whether my medical records described my operation as a partial mastectomy or a lumpectomy. I was glad to be able to respond that at least my pathology report described my operation as a partial mastectomy, thus confirming that "mastectomy," the word the WHCRA uses, was reflected in my medical records.

Ultimately, I settled on a fat grafting procedure to reconstruct my breast after my partial mastectomy. I was initially denied coverage for the operation on the theory that it was experimental and investigative, but thankfully was

114. Although it does not appear that the availability of reconstruction is being effectively communicated to patients who elect lumpectomies, substantial medical research on reconstruction after partial mastectomies exists. *See* Monticciolo et al., *supra* note 24, at 385–89; Letter from Richard M. Rainsbury & Fiona MacNeil to British Medical Journal, *supra* note 25, at 1028.

ultimately reimbursed after I had prepaid for the operation. Given that I knew I wanted breast reconstruction, if I had not had a wealth of resources—including a law degree, the determination to research the availability of coverage under the law, and the money to initially to pay the costs of reconstruction myself—I might well have been tempted to undergo an operation that I did not want in order to have the chance to undergo breast reconstruction. Indeed, if I had had fewer resources, I may well have accepted the forceful advice of the surgeon from whom I sought a second opinion or been persuaded by my own surgeon's worry about the cosmetic results. I would have been extremely unhappy in such a case because, if there was one thing I knew from the beginning, it was that I wanted to preserve as much of my breast as possible.

Dr. Susan Love, a well-known breast cancer surgeon who has written an indispensable handbook for women about breast cancer, explains that, although breast conservation surgery (a partial mastectomy or lumpectomy coupled with radiation) has been shown to be just as effective as a full mastectomy, "more and more women are choosing mastectomy or even bilateral mastectomy."[115] She wonders if this is because those who receive lumpectomies often are left with poor cosmetic results, and she expresses concern that women facing these choices may not be "fully aware that the technique of reconstruction, so much associated with [full] mastectomy, is nowadays also available for lumpectomies."[116] She further notes that lumpectomies have the important advantage of "conserving the sensation in your breast."[117] By contrast, Love describes reconstruction after a full mastectomy as being more like "having your prosthesis glued to your chest" than "having breasts."[118] As noted above, lumpectomies are also known to result in better body image among breast cancer patients compared to full

115. *See* LOVE, *supra* note 25, at 243; *see also* Scott Gottlieb, *Lumpectomy as Good as Mastectomy for Tumours up to 5 cm*, 321 BRIT. MED. J. 261 (2000) (describing a study in which lumpectomies were shown to be just as effective as mastectomies as demonstrated by very similar survival and metastization rates among women with larger tumors who underwent lumpectomies compared with mastectomies); Kristy L. Kummerow et al., *Nationwide Trends in Mastectomy for Early-Stage Breast Cancer*, 150 JAMA SURGERY 9 (2015) (finding that rates of mastectomy in women with early-stage breast cancer increased 34 percent in the most recent eight years of the cohort and that rates of reconstruction also increased among women who underwent full mastectomies).

116. LOVE, *supra* note 25, at 243; *see also* Letter from Richard M. Rainsbury & Fiona MacNeil to British Medical Journal, *supra* note 25, at 1028 ("[C]osmetic deformity after quadrantectomy is common and distressing. For this reason, many women facing such extensive resections are advised to undergo mastectomy.").

117. LOVE, *supra* note 25, at 244.

118. *Id.* at 259.

mastectomies, especially among younger women, and to result in fewer surgical complications.[119]

Although, as Dr. Love notes, the notion that a full mastectomy eliminates the risk of recurrence is incorrect because the cancer could still return to the scar, chest wall, or axilla,[120] some women who do not have extensive cancer in their breasts may still choose full mastectomies because of a concern about recurrence or for other reasons.[121] I do not wish to impinge their choices or to suggest that a partial mastectomy or lumpectomy, when available, is preferable to a full mastectomy. This is a very individualized decision that each breast cancer patient must make for her- or himself. Rather, I hope that my research on the legal reach of the WHCRA can assist those who are diagnosed with breast cancer (as well as their providers and insurance companies) to become better informed about their choices when faced with a need for breast cancer surgery. In some cases, even with early stage breast cancer, valid medical reasons will make a mastectomy the most viable option.[122] But in the majority of cases of early stage breast cancer, where those reasons are absent, I hope that women facing breast cancer surgery will get better information from health care providers and insurance companies about their options for reconstruction and that they will consequently be able to make the decisions that are best for their own unique situations. The false dichotomy between a mastectomy with reconstruction and a lumpectomy without must be put to bed.

CONCLUSION

In conclusion, the question of whether the WHCRA includes a private cause of action separate from ERISA must be reexamined in light of the strong clues in the legislative history that the WHCRA was intended to be immediately enforceable and to preclude insurance companies from denying reconstruction. At a minimum, no exhaustion of internal appeals should be required to bring suit for violation of the WHCRA. Courts that currently

119. *See* Al-Hilli et al., *supra* note 27, at S467; Jaggar, *supra* note 27; *see also supra* note 26.
120. LOVE, *supra* note 25, at 242. The "axilla" or armpit includes breast tissue, denominated the "axillary tail of Spence" or "axillary tail" for short. *Anatomy and Physiology of the Breast*, JOHNS HOPKINS MED., http://pathology.jhu.edu/breast/anatomy.php [https://perma.cc/6429-UJA7].
121. *See* Rachel Andersen-Watts, *The Failure of Breast Cancer Informed Consent Statutes*, 14 MICH. J. GENDER & L. 201, 216–18 (2008).
122. LOVE, *supra* note 25, at 248.

have such exhaustion requirements in place for all ERISA statutory claims should abolish them with respect to WHCRA claims.

On the central question of this essay—whether the WHCRA applies to partial mastectomies—the legislative history of the WHCRA, contemporaneous dictionary definitions, and state law sources examining similar issues all lead to the conclusion that the term "mastectomy" in the WHCRA should be interpreted to include a partial mastectomy when the patient and her physician conclude that reconstruction is warranted. While reconstruction is not the right choice for every breast cancer patient, under the WHCRA, it is the patient's choice, in consultation with her physician, whether to pursue it.

Far too many women lack access to the benefits of the WHCRA either because they are uninsured or because their deductibles or other cost-sharing mechanisms in their insurance policies put WHCRA's benefits outside of their financial reach.[123] Moreover, people of color are less likely to be insured than whites, and, "[a]mong non-elderly adults, Hispanics and American Indians and Alaska Natives are more than twice as likely as Whites to be uninsured."[124] And, although they are insured at similar rates to their heterosexual counterparts, lesbian, gay, bisexual, and transgender (LGBT) persons face barriers to accessing medical care—in particular, many lack a usual place to go for medical care and are more likely to forego care due to cost.[125] These problems are particularly pronounced for bisexual adults.[126] Moreover, lack of insurance and obstacles to accessing medical care both stand to increase in this era of presidential and legislative assaults on the Affordable Care Act,[127] including the recently passed federal tax bill

123. 29 U.S.C. § 1185b(a) (2012) (providing that coverage for reconstruction "may be subject to annual deductibles and coinsurance provisions"). *See generally* Krauss v. Oxford Health Plans, Inc., 418 F. Supp. 2d 416 (S.D.N.Y. 2005) (upholding an insurance company's application of UCR to reconstruction benefits).

124. SAMANTHA ARTIGA ET AL., HENRY J. KAISER FAMILY FOUND., KEY FACTS ON HEALTH AND HEALTH CARE BY RACE AND ETHNICITY 17–21 (2016), http://www.kff.org/report-section/key-facts-on-health-and-health-care-by-race-and-ethnicity-section-4-health-coverage [https://perma.cc/ 2VAU-EVLL].

125. JEN KATES ET AL., HENRY J. KAISER FAMILY FOUND., HEALTH AND ACCESS TO CARE AND COVERAGE FOR LESBIAN, GAY, BISEXUAL, AND TRANSGENDER INDIVIDUALS IN THE U.S. 10 (2016), http://files.kff.org/attachment/Issue-Brief-Health-and-Access-to-Care-and-Coverage-for-LGBT-Individuals-in-the-US [https://perma.cc/BDB9-6YE5].

126. *Id.* (reporting that, on measures of access such as having "a usual place to go for medical care and going without medical care due to cost, bisexual adults fared poorer than other groups").

127. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. §§ 300gg-1 to -94, §§ 18001–18120 and other scattered sections of 42 U.S.C.). For a discussion of legislative and presidential attacks on the law, see, for example, Robert Pear, *Years of Attack Leave Obamacare a More*

abolishing the individual coverage mandate.[128] Clearly, uninsured women and those who are insured but cannot afford reconstruction also deserve greater access to options relating to breast cancer care and breast reconstruction, and we must advocate, through community and political organizing, to make insurance coverage more widely available to disadvantaged groups through government subsidies and other means.

Government-Focused Health Law, N.Y. TIMES (Dec. 26, 2017), https://www.nytimes.com/2017/12/26/us/politics/republicans-trump-affordable-care-act-obamacare.html.

128. Act of Dec. 22, 2017, Pub. L. No. 115–97, § 11081, 131 Stat. 2054.