AMERICAN SOCIETY OF PLASTIC SURGEONS ®
THE PLASTIC SURGERY FOUNDATION ™
444 East Algonquin Road • Arlington Heights, IL 60005-4664
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AWHCA

FREQUENTLY ASKED QUESTIONS

How does the new *Advancing Women's Health Coverage Act* (AWHCA) improve upon the *Women's Health and Cancer Rights Act of 1998* (WHCRA)?

The bill has three primary goals:

1. Ensure that coverage extends beyond patients who have had a mastectomy to include all those who have undergone breast cancer treatment.
2. Ensure that a right to breast reconstruction clearly applies to all current and future variations of the procedures.
3. Broaden the definition of required coverage to include complications that may arise after breast reconstruction.

This is accomplished by:

1. Explicitly extending coverage to reconstruction required after any type of breast cancer treatment (e.g., mastectomy, lumpectomy) and requiring that there is an in-network surgeon available for every approach, iteration or variation of every type of breast reconstruction;
2. Explicitly stating that the coverage requirement extends to all breast reconstruction modalities, types, and techniques; and
3. Requiring coverage of mechanical, medical, and surgical treatment of complications, even if they may be incident to another part of the cancer treatment process that is affecting a reconstruction.

These changes are designed to modernize and strengthen the existing law while preserving the protections that are already effective.

In some parts of the country, WHCRA has been working quite well. Is ASPS hearing about cases where breast cancer reconstruction is not adequately covered?

Yes. ASPS has received outreach from members across the nation showcasing issues with prior authorization, denials, post-payment reviews, and reimbursement clawbacks by payers. These hurdles force patients and providers to fight for the standard of care to be covered, even when coverage for these procedures is required.

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Why does the bill mention Level I of the Healthcare Common Procedural Coding System (HCPCS)?

HCPCS Level I is mentioned for three reasons:

1. It is already used throughout the Code of Federal Regulations (CFR), making the technical approach of the legislation simpler for policymakers;
2. HCPCS Level I codes are structured in a way that works with and advances the concept of the "modality → type → technique" taxonomy the bill uses to ensure all breast reconstruction techniques are covered; and
3. HCPCS Level I provides a mechanism for automatically adding new breast reconstruction modalities, types, and/or techniques to what's covered under the *Advancing Women's Health Coverage Act* (AWHCA).

Does this bill limit coverage to codes listed in Level I of the HCPCS?

No. The bill uses the breast reconstruction modalities, types, and techniques listed in HCPCS Level I – which mirrors the AMA's Current Procedural Terminology (CPT)® – as a way of specifying ***minimum*** coverage that is required for any plan that offers breast cancer treatment. In other words, it is not the codes themselves that are required to be covered, but instead the different breast reconstruction approaches and techniques *that are described by the codes* that must be covered.

Does the bill exclude the S-codes 2066, 2067, and 2068?

No. This bill has no impact on the Centers for Medicare and Medicaid Services' (CMS) ability to maintain separate S-codes for some microsurgical breast reconstruction techniques.

Additionally, HCPCS Level I includes all the procedures covered by S2066-68, therefore they are required under the AWHCA to be covered by plans that cover breast cancer treatment. The S-codes will still be fully available as an optional methodology for surgeons to contract with and bill individual insurance companies. As has always been the case, it is up to insurance companies whether they want to use those codes and up to CMS to determine whether they remain available.

Even if the bill does not exclude the S-codes 2066, 2067, and 2068, won't insurance companies try to use it to get rid of the S-codes?

Maybe. Insurance companies often prioritize cost containment over patient access, so it shouldn't be considered outside of the realm of possibility. But there is nothing stopping them from abandoning S-codes right now. What matters most is that this legislation is very thoughtfully and intentionally structured to disincentivize them from abandoning the S-codes and position reconstructive surgeons better if they come to a moment where they are renegotiating their contracts with payers.

Combined with the *No Surprises Act*, this legislation would place our members in one of the best contract negotiation positions of any medical specialty. ASPS members have reported successfully negotiating the transition of S-code agreements into agreements that reimburse a multiple of the base RVU for CPT®19364. The bill would only make that sort of transitional negotiation easier.

Does the bill tie reimbursement to the RUC process, which historically undervalues surgical procedures?

No. The AWHCA only dictates the minimum standards for what procedures have to be covered, not what or how they are valued. The coverage requirements apply to commercial health insurance companies, so valuation of specific procedures will occur in the same way that they have always occurred – in a network contracting negotiation between a surgeon and a payer.

What network adequacy requirements does the bill have?

Under the AWHCA, a plan would have to have at least one in-network provider available for ***every*** procedural iteration, variation and approach to breast reconstruction. With this standard, a payer cannot have only surgeons offering implant-based reconstruction and non-muscle preserving tissue-based procedures like a TRAM and have a satisfactory network. They will also need to reach contracting agreements with surgeons who can do every type of perforator free flap reconstruction, surgeons who can do reconstruction that deploys neurotization techniques, surgeons who offer hybrid implant- and tissue-based

procedures, and so on. If it is available under HCPCS Level I, it is a breast reconstruction technique for which patients have a right to covered access.

How will network adequacy be met when not every surgeon is specialized in every area of breast reconstruction?

The bill does not require plans to have one in-network provider who can perform every type of breast reconstruction; instead, the legislation states that there must be one in-network provider "with respect to ***each*** modality, type of reconstruction, ***and*** procedural variation, iteration, and approach described" in the relevant subsection. It is possible that this standard might be met by having one surgeon in-network who can perform each modality, type, and procedural variation, iteration, and approach; however, the likelihood is significantly higher that a payer is going to have to contract with multiple surgeons to meet the requirement.

How will this bill make sure that coverage keeps up with innovation?

The AWHCA automatically recognizes and covers innovations by requiring that additions to HCPCS Level I are covered. This is the mechanism by which new modalities, new types, and/or new procedural iterations, variations and approaches are wrapped into the coverage mandate. By having new things covered when they are recognized with new CPT codes and/or new or updated descriptors for existing codes, we don't have to keep going back to ask for a new law to update what's referenced so that it is sufficiently inclusive of current standards of care.

Is lymphedema treatment addressed in the bill?

Yes. The bill specifically requires coverage of "mechanical, medical and surgical treatment of physical complications of mastectomy, breast reconstruction surgery, chest wall surgery, radiation, and lymph node surgery, including lymphedema compression treatment items (as such term is defined in section 1861(mmm) of the Social Security Act but without regard to the requirement in paragraph (1) of such section that such an item be furnished on or after January 1, 2024)."

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Is coverage for oncoplastic reconstruction, correction of lumpectomy deformities, or symmetry procedures after lumpectomy covered under AWHCA?

Yes. WHCRA currently only applies to reconstruction benefits following a mastectomy, but AWHCA requires a plan to provide coverage for extirpation or medical treatment of diseased or damaged breast tissue, including mastectomy and ***all forms of breast-conserving surgery***; all stages of reconstruction of the breast or chest wall on which the mastectomy ***or breast-conserving surgery*** has been performed; and surgery and reconstruction of the other breast or chest wall to produce a ***symmetrical appearance***.

Why isn't there any language regarding prophylactic mastectomy or risk-reducing surgeries?

The current legislation is specifically a post-cancer reconstruction bill. Feedback indicating that women with cancer diagnoses faced the greatest challenges in obtaining timely and comprehensive coverage prompted the creation of this bill focusing on their specific needs.

Update November 4, 2025: Since the bill's introduction, ASPS has become aware of potential unintended impacts on access to risk-reducing or prophylactic procedures. We are actively engaging with key stakeholders to address these concerns and ensure that all patients maintain access to the care they need.