

Dear Chair and Members of the Committee,

For the record, my name is Gail Menasco, and I am here today as both a breast cancer survivor and an advocate for women seeking access to quality breast reconstruction. In 2023, at the age of 38, I was diagnosed with breast cancer—no family history, no genetic markers. My case was reviewed by a tumor board, and given my age and other factors, a double mastectomy was recommended.

A mastectomy alone was life-altering, but the decisions that followed were even more daunting. Like many women, I had to navigate reconstruction options that would affect my body for the rest of my life. I explored aesthetic flat closure, implants, and autologous reconstruction, where a woman's own tissue is used to rebuild the breast. After extensive research, I set my sights on the DIEP flap, which is considered the gold standard because it preserves muscle while using natural tissue. I was 38 when diagnosed and didn't want foreign material in my body or worry about implant exchanges every 7-10 years.

However, when I consulted with local surgeons, I was told that due to my blood vessel anatomy, they would need to take part of my abdominal rectus muscle—converting my DIEP into a MS-TRAM flap. TRAM flaps increase the risk of core weakness, bulging, and other complications. You can't regrow muscle and I wanted an option to reconstruct that didn't compromise my muscle.

Determined to find a better option, I reached out to surgeons across the country. Through patient support groups, medical journals, and white papers, I learned about **APEX and SIEA**, techniques that could preserve my muscle while reducing complications—but would require more advanced skills from experienced microsurgeons. I also discovered alternative flaps such as SGAP, PAP, TDAP, and LAP, which use tissue from other areas of the body that don't take muscle. These options are essential for women who lack abdominal tissue, have had previous surgeries, or options for thin women with radiated skin as implants may not hold well to heavily radiated skin. Many women are told they are "too thin" for DIEP, only to later find surgeons who can successfully perform DIEP on very thin patients or offer an alternative flap that doesn't take muscle. Others are told their BMI is too high for reconstruction, only to find that more experienced surgeons can safely operate.

I contacted every DIEP flap provider in Oregon, Washington, Idaho, and Utah—every surgeon within my Regence network—and not a single one offered APEX, SIEA, or these alternative flaps and was also quoted extremely long wait times for surgeons in the Portland area, which I didn't have the time to wait for with active cancer and not wanting expanders. The only surgeons regularly performing advanced DIEP techniques—doing it four days a week, refining their skill with every case—were out of state and out of network.

That's when I realized how broken our system is. My marketplace EPO plan restricted me to the Pacific Northwest and provided no out-of-network benefits. I requested a single-case

agreement, but my caseworker told me it would be denied because a surgeon locally was willing to perform a version of DIEP—even though that version would take muscle. To insurance, the difference between a muscle-sparing DIEP and an MS-TRAM wasn't significant enough to justify an exception.

I then changed jobs just to get a PPO plan, thinking it would allow me access to the care I needed—only to discover that hidden plan limitations still left me facing six-figure balance billing.

The **Women's Health and Cancer Rights Act (WHCRA) of 1998** promised that breast reconstruction would be covered, but it was written before many of today's advanced reconstructive techniques even existed and doesn't list out specific procedures. While WHCRA ensures insurance covers reconstruction, it doesn't specify access to techniques that preserve muscle, nor does it guarantee access to alternative flaps for those who can't have DIEP. Additionally, it covers areola tattooing, yet many trained areola tattoo artists are out-of-network, leaving patients to pay out of pocket for a service that is technically "covered." Insurance companies comply with WHCRA on paper while still restricting access to the procedures and specialists that women actually need.

Women shouldn't have to change jobs, fight through denials, or navigate single-case agreements just to access reconstruction that doesn't compromise their muscle. And women with active cancer shouldn't have to waste valuable time waiting for denials before being told to try again with another appeal.

This is why SB 1137 is so critical. It ensures that health benefit plans provide real access to DIEP and alternative flaps—not just a checkbox for reconstruction coverage. It also allows women to go **out-of-network at in-network rates unless insurance companies can prove they have an adequate network**. This provision not only protects patients but also encourages more reconstructive surgeons to establish practices in Oregon, creating the adequate network we so desperately need.

I never imagined I would be involved in advocacy or policy work, but my experience—and the stories of so many other women

Thank you,

Gail