REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS

MANDATED COVERAGE FOR MORBID OBESITY

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

SENATE DOCUMENT NO. 33

COMMONWEALTH OF VIRGINIA
RICHMOND
2000

COMMONWEALTH OF VIRGINIA

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SENATE

January 10, 2000

To: The Honorable James S. Gilmore, III
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 9-298 and 9-299 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) to assess the social and financial impact and the medical efficacy of 1999 Senate Bill 770 regarding mandatory coverage for the treatment of morbid obesity.

Respectfully submitted,

Stephen H. Martin
Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

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INTRODUCTION

During the 1999 Session of the General Assembly, the Senate Committee on Commerce and Labor referred 1999 Senate Bill 770 (SB 770) to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). Senate Bill 770 is patroned by Senator Benjamin J. Lambert, III.

The Advisory Commission held a hearing on July 28, 1999 in Richmond to receive public comments on SB 770. In addition to the patron, 17 speakers addressed the proposals. Representatives from Commonwealth Surgeons Ltd., Richmond Surgical Group, a surgeon, and 11 concerned citizens spoke in favor of the bill. Representatives from the Virginia Association of Health Plans (VAHP) and the Health Insurance Association of America (HIAA) spoke in opposition to the bill. In addition, written comments in support of the bill were provided by Commonwealth Surgeons Ltd., Medical College of Virginia, two surgeons, and 73 concerned citizens. The VAHP, Virginia Chamber of Commerce, Virginia Manufacturers Association, and Trigon Blue Cross Blue Shield submitted comments in opposition to the bill.

At the August 24, 1999 meeting of the Advisory Commission, the patron of the bill, Senator Benjamin J. Lambert, III, submitted two options for the amendments of SB 770. The first option includes language that limits the coverage of morbid obesity. The amended bill requires coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health (NIH) as effective for the long-term reversal of morbid obesity. The amended bill also clarifies the term morbid obesity. The bill defines "morbid obesity" as (i) a weight which is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, or (ii) a body mass index ("BMI") equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared. The amended bill also requires insurers, corporations and health maintenance organizations to offer and make available coverage for the treatment of morbid obesity.

The second option presented by the patron only revises the definition of morbid obesity. The amended bill requires coverage for the surgical treatment of morbid obesity. The amended bill also clarifies the term morbid obesity. The bill defines "morbid obesity" as a body mass index ("BMI") equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or BMI of 40 kilograms per meter squared without such comorbidity. "BMI" equals weight in kilograms divided by height in meters squared.

SUMMARY OF PROPOSED LEGISLATION

Senate Bill 770 amends § 38.2-4319 and adds § 38.2-3418.8 to the Code of Virginia to require each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group subscription contracts; and each health maintenance organization providing a health care plan for health care services to provide coverage for the treatment of morbid obesity.

The bill requires that reimbursement for the treatment of morbid obesity shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. The bill also requires that coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness. Insurers may not restrict access to surgery for morbid obesity based upon dietary or any other criteria not approved by the NIH.

The bill defines "morbid obesity" as a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables (see Appendix C). The bill also defines "morbid obesity" as a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or a BMI of 40 kilograms per meter squared without such comorbidity. BMI equals weight in kilograms divided by height in meters squared.

The types of treatment of morbid obesity would include a wide range of services that may include less intrusive measures other than surgery such as weight-loss programs, dietary therapy, physical activity, and behavior change.

The bill applies to contracts, policies, and plans delivered or issued for delivery or renewed after July 1, 1999. The bill does not apply to short-term travel, accident only, limited or specified disease policies, or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or federal governmental plans or to short-term nonrenewable policies of not more than six months' duration.

OBESITY

According to information provided by the Medical Services Organization, L.L.C. (MSO), obesity is often defined as being 20% or more over ideal body weight. Morbid obesity is a much more severe form of obesity in that a person is 100 pounds or more overweight. According to Commonwealth Surgeons, Ltd.,

morbid obesity is not the result of a behavioral or character defect. It is an inherited disease of the neural hormone and metabolic control of eating and energy expenditure. Obesity is recognized by the National Institutes of Health as a disease.

Obesity is a common condition that poses major health and social challenges. The medical problems caused by obesity are numerous, serious, and often life-threatening. Common problems associated with obesity include diabetes, shortness of breath, gallbladder disease, hypertension, elevated blood cholesterol levels, some cancers, arthritis, other orthopedic problems, reflux esophagitis (heartburn), snoring, sleep apnea, menstrual irregularities, infertility, and heart trouble. These problems can be relieved or improved by permanent significant weight loss. Obesity is considered a serious disease and has been linked to shortened life expectancy. According to C. Everette Koop, former Surgeon General of the United States, obesity is the second leading cause of preventable death in America.

TREATMENT OF MORBID OBESITY

According to the MSO, there are a wide variety of weight-loss programs that fall into three basic categories including do-it-yourself programs, non-clinical programs, and clinical programs. Do-it-yourself programs include individual efforts and groups of like-minded people such as Overeaters Anonymous and Take Off Pounds Sensibly (TOPS). These programs typically do not use outside resources for individualized or personalized care. Non-clinical programs are sometimes franchised with a parent company. These programs rely heavily on variably trained counselors that are typically not health care providers to provide services to clients. Clinical programs are provided by licensed professionals that may or may not have had specialized training to treat obese patients. Clinical programs include such services as nutrition, medical care, behavior therapy, exercise and psychological counseling, and low-calorie diets, medications, and surgery.

The NIH stated that dietary therapy that is individually planned and takes into account the patient's overweight status in order to help create a deficit of 500 to 1,000 calories per day should be an integral part of any weight loss program. They stated that reducing the percentage of dietary fat alone will not produce weight loss unless total calories are also reduced. NIH noted that frequent contacts with the practitioner during dietary therapy helps to promote weight loss and weight maintenance at a lower weight. Physical activity increases the number of calories the body uses and promotes the loss of body fat instead of muscle and other nonfat tissue. Research shows that people who include physical activity in their weight-loss programs are more likely to keep their weight off than people who change their diet. For most obese patients, exercise should

be initiated slowly and then intensity should be increased gradually. Behavior change focuses on learning eating and physical activity behaviors that will help the person lose weight and keep it off.

According to the American Journal Clinical Nutrition 1992, "Gastrointestinal Surgery for Severe Obesity: National Institutes of Health Consensus Development Conference Statement," a number of operations have been tried and discarded as inefficacious or because of complications. Two procedures dominated practice in the early 1990s and have advanced beyond the experimental stage. Vertical banded gastroplasty (see Appendix D, figure 1) and related techniques consist of constructing a small pouch with a restricted outlet along the lesser curvature of the stomach. The outlet may be externally reinforced to prevent disruption or dilation. Gastric bypass procedures (see Appendix D, figure 2) involve constructing a proximal gastric pouch whose outlet is a Y-shaped limb of the small bowel of varying lengths (Roux-en Y gastric bypass). The surgeon will choose between these procedures based on preference and consideration of the patient's eating habits. There is a greater weight loss after the gastric bypass procedure. However, it has a higher risk of nutritional deficiencies, especially of micronutrients. The biliary-pancreatic bypass includes a gastric restriction and diverts bile and pancreatic juice into the distal lieum. The experience with this procedure in the United States is limited.

SOCIAL IMPACT

The MSO stated that obesity affects an estimated 34 million Americans and morbid obesity affects an estimated four million Americans. Commonwealth Surgeons, Ltd. reported that approximately 1,500 obesity surgeries are performed yearly in Virginia. The social problems associated with obesity include access to employment and insurance. The unemployment rate among those who are 100 pounds or more overweight is approximately 50%. For those who do have jobs, discrimination occurs when there is an opportunity for promotion or increased responsibility in the workplace. Proponents make the argument that heavy people are discriminated against by their insurance carriers and the insurers often refuse to provide therapy that would help relieve the obesity. MSO stated that insurers ignore scientific literature relating to surgery than may prevent, diminish, and often cure diseases and conditions associated with obesity.

FINANCIAL IMPACT

Information provided by the Department of Surgery, Medical College of Virginia indicated that the surgical fee for a gastric bypass operation is approximately $3,200 and that one insurer's payment to the surgeon is currently

$1,800. The hospital receives $11,000 from the same insurer. According to Commonwealth Surgeons, Ltd., the cost of treatment for an individual not covered by insurance ranges from $12,000 to $25,000. Commonwealth Surgeons stated that this cost effectively precludes most of the people not covered by insurance from obtaining health treatment and preserving their lives. A surgeon stated that during his practice, of all patients screened for surgery, 39% are precluded by their contracts, 11% that meet the required medical standard for morbid obesity were denied coverage by their insurer, and 50% received surgery with complete or partial coverage through commercial and governmental insurance.

MEDICAL EFFICACY

Information provided by the Department of Surgery, Medical College of Virginia, stated that severe obesity has been shown to be associated with an increased mortality rate. However, there are no studies that show long-term (greater than five years) relief of severely obese in patients without surgical treatment. Surgery has been shown to have long-term efficacy with the average loss of excess weight at one year after the operation of 66%, at five years of 60%, and at 10 years of 10%. The operative mortality rate is approximately 0.5%. However, there are possible complications that include marginal ulcers, stomal stenosis, and incisional hernias that would add to the cost of treatment.

The proponents noted that there are studies that document the efficacy of surgically induced weight loss for many obesity-related, co-morbidity problems with either complete resolutions or improvements. They include: 95% relief in obesity hypoventilation (Pickwickian) syndrome, 95% relief in sleep apnea syndrome, two-thirds to three-fourths relief in systemic hypertension, 90% relief in Type II diabetes mellitus, 95% relief in gastroesophageal (heart burn), 95% relief in gastroesophageal reflux (heart burn), 95% relief in pseudotumor cerebri (constant headaches), 95% relief in stress urinary incontinence, 95% relief in heart failure, 95% relief of infertility, 80% relief in venous stasis ulcers on the lower extremities, and 75% improvement in degenerative joint disease pains of the hips, knees, ankles and lower back.

The VAHP raised concern that the proposed mandate does not define the term "treatment of morbid obesity." The original mandate would encompass a host of treatment modalities that may or may not be proven effective in treating morbid obesity, including multiple types of surgical treatments. While the surgical treatment of morbid obesity has resulted in positive outcomes for some individuals, complications can be serious and the weight loss is not always maintained. Under the original wording of the proposed mandate, health plans could be forced to provide unlimited access to weight loss programs, fitness clubs, and pharmaceutical products. These items could have a significant impact on employers' and individuals' health care premiums.

CURRENT INDUSTRY PRACTICES

The State Corporation Commission Bureau of Insurance recently surveyed 50 of the top writers of accident and sickness insurance in Virginia regarding each of the bills to be reviewed by the Advisory Commission this year. Twenty-nine companies responded by April 9, 1999. Five indicated that they have little or no applicable health insurance business in force in Virginia, and therefore, could not provide the information requested. Of the 24 respondents that completed the survey, 12 reported that they currently provide the coverage required by SB 770.

Respondents to the Bureau of Insurance survey provided cost figures that ranged from less than $.01 to $6.00 per month per standard individual policyholder and from $.01 to $12.00 per month per standard group certificate to provide the coverage required by SB 770. Insurers providing coverage on an optional basis provided cost figures of $1.00 to $6.00 per month per individual policyholder and from $.83 to $12.00 per month per group certificate holder for the coverage. One insurer stated that the initial nutritional evaluation and counseling from a participating provider is provided when diet is part of the medical management of a documented disease, including morbid obesity, but all medical and surgical services for the treatment or control of obesity are excluded, unless medically necessary.

SIMILAR LEGISLATION IN OTHER STATES

According to information published by the National Association of Insurance Commissioners and the National Insurance Law Service, only one state currently has a mandate for morbid obesity. Georgia requires that health insurers offer comprehensive medical or surgical coverage for the treatment of morbid obesity when treatment is ordered, conducted or supervised by health care providers specializing in the treatment of such patients.

REVIEW CRITERIA

SOCIAL IMPACT

a. *The extent to which the treatment or service is generally utilized by a significant portion of the population.*

According to the MSO, obesity affects an estimated 34 million Americans and morbid obesity affects an estimated four million Americans. Commonwealth Surgeons, Ltd. reported that approximately 1,500 obesity surgeries are performed yearly in Virginia.

b. *The extent to which insurance coverage for the treatment or service is already available.*

A survey by the State Corporation Commission Bureau of Insurance found that 12 of 24 respondents (50%) currently provide treatment for morbid obesity.

In its written comments, VAHP stated that coverage for the treatment of morbid obesity appears to be generally available in the marketplace. According to a recent survey conducted by VAHP, several of its member plans currently offer coverage for the treatment of morbid obesity, specifically surgical treatment.

c. *If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.*

Over 73 letters and postcards were received by the Advisory Commission stating support for SB 770. The individuals commented that the bill is greatly needed and would potentially result in the saving of many lives and improve the quality of life for many Virginians.

Two proponents testified at the public hearing that they both were denied coverage because they have no co-morbidity conditions. One of the proponents testified that she is currently on her fourteenth diet and has been fighting arthritis for the last nine years. The other proponent has worn an ankle cast for the last two years. In order for her to have surgery on her ankle, she must lose weight.

One proponent stated that in 1985, the NIH Consensus Conference outlined the following comorbidities associated with morbid obesity: hypertension, heart disease, hyperlipidemia, Type 2 diabetes, cancers, cholelithiasis, obstructive sleep apnea, hypoventilation, degenerative arthritis, and psychosocial impairments.

The NIH Technology Assessment Conference in 1992 concluded that 95% of people that are morbidly obese failed to achieve acceptable long-term weight loss with or without behavioral modification or drug therapy. The 1991 NIH Consensus Development Panel recommended that gastric restriction or bypass surgery be considered for morbidly obese individuals.

d. *If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.*

According to Commonwealth Surgeons, Ltd., the cost of treatment for an individual not covered by insurance ranges from $12,000 to $25,000. They

stated that this cost effectively precludes most of the people not covered by insurance from obtaining health treatment and preserving their lives.

One proponent testified at the public hearing that the she paid $35,000 out-of-pocket for the cost of surgery. She was concerned about the consequences of her weight and stated that surgery provided a tremendous relief.

e. *The level of public demand for the treatment or service.*

Fifteen speakers testified at the public hearing that insurance coverage is important to everyone, especially for the obese community. Patients testified that they lost between 75 and 357 pounds after the surgery. They reported that their weight loss has been associated with improvements in risk factors associated with coronary heart disease (serum cholesterol), hypertension, insulin sensitivity, sleep apnea, joints, and diabetes mellitus. They reported that they were no longer having health problems and consequently, costs for the medication decreased.

f. *The level of public demand and the level of demand from providers for individual and group insurance coverage of the treatment or service.*

Nine patients testified that they lost between 75 and 357 pounds after the surgery. They reported that their weight loss has been associated with improvements in risk factors associated with coronary heart disease (serum cholesterol), hypertension, insulin sensitivity, sleep apnea, joints, and diabetes mellitus. They reported that they were no longer having health problems and as a result, costs for medications decreased. Two concerned citizens testified that they both were denied coverage because they have no co-morbidity conditions. One citizen testified that she is currently on her fourteenth diet and has been fighting arthritis for the last nine years. The other citizen has worn an ankle cast for the last two years. In order for her to have surgery on her ankle, she must lose weight.

Four surgeons testified in favor of the bill at the public hearing. They stated that the NIH's criteria in determining surgery for morbid obesity is based on weight, duration of weight, association of significant co-morbidities, and illnessess. They explained that obesity is the leading cause of preventable deaths in the United States and that the NIH approves this highly effective surgical procedure to control the problems of the morbidly obese. A surgeon reported that 50% of the patients in the Commonwealth of Virginia are being denied treatment by their insurance companies.

g. *The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.*

No information was received from collective bargaining organizations addressing potential interest in negotiating privately for inclusion of this coverage in group contracts.

h. *Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.*

The Advisory Commission is not aware of any findings of the state health planning agency or the appropriate health system agency relating to the social impact of this mandate.

FINANCIAL IMPACT

a. *The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.*

No information was provided by either proponents or opponents that would suggest that enactment of SB 770 would either increase or decrease the cost of treatment over the next five years.

b. *The extent to which the proposed insurance coverage might increase the appropriate or inappropriate use of the treatment or service.*

The appropriate use of the treatment may increase if the policies provide coverage for morbid obesity. According to a September 1998 brochure, entitled "Current Problems in Surgery," by John M. Kellum, M.D., Eric J. DeMaria, M.D., and Harvey J. Sugerman, M.D. surgical therapy for severe or morbid obesity has gained support because of the high relapse rate for nonsurgical therapies. It has been estimated that more than 95% of morbidly obese patients, subjected to medical weight-reduction programs, regain all of their lost weight as well as additional excess weight within two years of the onset of therapy.

Proponents testified that their quality of life improved dramatically after the surgery because of the reduction in weight. They were no longer having health problems and as a result, their costs for medications decreased.

VAHP stated that mandates generally increase the utilization of benefits. They believe that mandated benefits encourage people to use their insurance for

procedures not previously covered, partially because they are insulated from the cost of that care. They noted that when people perceive they are getting care for little or nothing, they have an incentive to use more and ultimately, increased utilization leads to higher health care premiums. Opponents raised the concern that open-ended access to surgical treatments may replace more preventive treatment methods such as nutritional counseling and weight control programs.

c. *The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.*

Proponents stated that in order to lose weight, they have tried less expensive services such as counting calories, food exchanges, high protein/low carbohydrate diets, high carbohydrate/low protein diets, weight watchers programs, and phen-phen drugs. Even when dieters had some immediate success, they would eventually gain all their weight they had lost plus more pounds. Staff contacted five weight control services including Jenny Craig, Weight Watchers, Weight Loss Forever, Chesterfield Physical Therapy, and Diet Center of Richmond. Jenny Craig charges $29 for four weeks plus the cost of food that averages about $60 per week. Weight Watchers charges $8.95 a week plus a $15 registration fee. Weight Loss Forever charges 29.95 for a week or $135 for a six-week program. At Chesterfield Physical Therapy, a personnel trainer charges $30 per session. The Diet Center of Richmond charges $35 to $40 a week for a six-week program.

Commonwealth Surgeons, Ltd. noted that being overweight is one of the most pervasive health risks affecting Americans today and is a multibillion drain on the U.S. economy. Medical researchers, studies, and national health statistics put the cost of obesity at more than $100 billion annually including $4.58 billion in direct costs such as hospital care and physician services, or 6.8% of all health care costs. Obesity costs the economy $18.9 billion a year for such indirect costs as lost output caused by death and disability from weight-related diseases. The number of days of work lost to illness attributable to obesity amounts to 53.6 million days per year. Lost productivity costs employers an additional $4.06 billion annually.

d. *The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.*

The number and type of providers of the mandated service are not expected to increase over the next five years as a result of this bill.

e. *The extent to which insurance coverage might be expected to increase or decrease the administrative expenses of insurance companies and the premium and administrative expenses of policyholders.*

Respondents to the Bureau of Insurance survey provided cost figures that ranged from less than $.01 to $6.00 per month per standard individual policyholder and from $.01 to $12.00 per month per standard group certificate to provide the coverage required by SB 770. Insurers providing coverage on an optional basis provided cost figures of $1.00 to $6.00 per month per individual policyholder and from $.83 to $12.00 per month per group certificate holder for the coverage.

f. *The impact of coverage on the total cost of health care.*

Proponents believe that the total cost of health care will decrease because of the provision of surgical treatment for morbid obesity. Proponents believe that failing to emphasize the importance of the surgery and its benefits may result in higher costs to insurers in the long run in hospital care and physician services.

MEDICAL EFFICACY

a. *The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.*

Information provided by the Department of Surgery, Medical College of Virginia, stated that severe obesity has been shown to be associated with an increased mortality rate. However, there are no studies that show long-term (greater than five years) relief of severely obese in patients without surgical treatment. Surgery has been shown to have long-term efficacy with the average loss of excess weight at one year after the operation of 66%, at five years of 60%, and at 10 years of 10%. The operative mortality rate is approximately 0.5%. However, there are possible complications that include marginal ulcers, stomal stenosis, and incisional hernias that would add to the cost of treatment.

The proponents noted that there are studies that document the efficacy of surgically induced weight loss for many obesity-related, co-morbidity problems with either complete resolutions or improvements. They include: 95% relief in obesity hypoventilation (Pickwickian) syndrome, 95% relief in sleep apnea syndrome, two-thirds to three-fourths relief in systemic hypertension, 90% relief in Type II diabetes mellitus, 95% relief in gastroesophageal (heart burn), 95% relief in gastroesophageal reflux (heart burn), 95% relief in pseudotumor cerebri

(constant headaches), 95% relief in stress urinary incontinence, 95% relief in heart failure, 95% relief of infertility, 80% relief in venous stasis ulcers on the lower extremities, and 75% improvement in degenerative joint disease pains of the hips, knees, ankles and lower back.

According to the 1991 NIH Consensus Statement, assessing the risks in the surgical treatment of obesity involves evaluating both perioperative and long-term complications. The report indicated that the immediate operative mortality rate for the vertical banded gastroplasty and Rouxen-Y gastric bypass is relatively low. However, morbidity in the early postoperative period, such as wound infections, dehiscence, leaks from staple line breakdown, stomal stenosis, marginal ulcers, various pulmonary problems, and deep thrombophlebitis in the aggregate, may be as high as 10% or more. In the long-term, micronutrient deficiencies, particularly of vitamin B, folate, and iron, are common after gastric bypass and must be sought and treated.

According to the MSO, there are a wide variety of weight-loss programs that fall into three basic categories including do-it-yourself programs, non-clinical programs, and clinical programs. Do-it-yourself programs include individual efforts and groups of like-minded people such as Overeaters Anonymous and Take Off Pounds Sensibly (TOPS). These programs typically do not use outside resources for individualized or personalized care. Non-clinical programs are sometimes franchised with a parent company. These programs rely heavily on variably trained counselors that are typically not health care providers to provide services to clients. Clinical programs are provided by licensed professionals that may or may not have had specialized training to treat obese patients. Clinical programs include such services as nutrition, medical care, behavior therapy, exercise and psychological counseling, and low-calorie diets, medications, and surgery.

b. *If the legislation seeks to mandate coverage of an additional class of practitioners:*

1) *The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered.*

Not applicable.

2) *The methods of the appropriate professional organization that assure clinical proficiency.*

Not applicable.

EFFECTS OF BALANCING THE SOCIAL, FINANCIAL AND MEDICAL EFFICACY CONSIDERATIONS

a. The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.

Senate Bill 770 addresses the medical need of treating individuals diagnosed as morbidly obese. The benefit is consistent with the role of health insurance.

b. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.

Proponents believe that the need for coverage outweighs the costs of benefits. According to information provided by Commonwealth Surgeons, Ltd., obesity is an independent risk factor for a variety of diseases, including cardiovascular diseases, colon cancer, and gallbladder disease. The total direct costs of obesity-associated disease have been estimated to $45.8 billion in 1990, approximately 6.8% of all health care expenditures in the United States.

The number of physician visits related to obesity has increased 88% in a six-year period. The morbidity cost (lost productivity) and functional capability of the patient with obesity is increasing rapidly (50% increase in lost productivity, 36% increase in restricted activity, and 28% increase in number of bed days).

In its written comments, VAHP stated that some people would receive additional types of benefits under this mandate and the cost will be borne by a more significant number of Virginians, who many not need, want, or be able to pay for such benefits. These costs will fall to those least able to bear the burden, the Commonwealth's individuals and small businesses.

One opponent expressed concerns at the public hearing about the breadth of the original language. They believed the bill would encourage people to stop using other programs or other treatments. They stated the $35,000 cost of the procedures would lead to an incremental increase in the cost of premiums resulting in an increase in the number of uninsured Virginians.

c. The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.

Senate Bill770 was amended to make it a mandated offer of coverage.

RECOMMENDATION

The Advisory Commission voted on August 24, 1999 to recommend that SB 770 be enacted, as amended (Yes-5, No-2).

CONCLUSION

Both proponents and opponents of the bill recognize the risks associated with morbid obesity. However, they were concerned that the language in SB 770 was ambiguous. They concluded that the definition of morbid obesity and threshold for treatment should be revised.

The Advisory Commission and the patron, Senator Benjamin Lambert, III, agreed to the first option for the amendment of SB 770. The amended bill requires the offer of coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health (NIH) as effective for the long-term reversal of morbid obesity. The amended bill defines "morbid obesity" as (i) a weight which is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, or (ii) a body mass index ("BMI") equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used in the bill, "BMI" equals weight in kilograms divided by height in meters squared (see Appendix B). It is applicable to state employees. The Advisory Commission believes that the amended bill covers a valid medical condition and that the amended bill addresses many of the concerns raised by the interested parties.

993342693

SENATE BILL NO. 770

Offered January 13, 1999

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia, and to amend the Code of Virginia by adding a section numbered 38.2-3418.8, relating to accident and sickness insurance; coverage for the treatment of morbid obesity.

Patrons—Lambert and Watkins

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 38.2-3418.8, as follows:

§ 38.2-3418.8. Coverage for the treatment of morbid obesity.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the treatment of morbid obesity under any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 1999.

B. The reimbursement for the treatment of morbid obesity shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally. Insurers may not restrict access to surgery for morbid obesity based upon dietary or any other criteria not approved by the National Institutes of Health.

C. For purposes of this section, "morbid obesity" means a weight which is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables. "Morbid obesity" also means a body mass index ("BMI") equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes or a BMI of 40 kilograms per meter squared without such comorbidity. "BMI" equals weight in kilograms divided by height in meters squared.

D. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months' duration.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-203, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.) of this title, 38.2-1057, 38.2-1306.2 through 38.2-1309, Articles 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3407.2 through 38.2-3407.6, 38.2-3407.9, 38.2-3407.10, 38.2-3407.11, 38.2-3407.12, 38.2-3411.2, 38.2-3414.1, 38.2-3418.1 through ~~38.2-3418.7~~ *38.2-3418.8*, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3542, 38.2-3543.2, Chapter 53 (§ 38.2-5300 et seq.) and Chapter 58 (§ 38.2-5800 et seq.) of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

D. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

Senate Bill No. 770

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted, and that the Code of Virginia is amended by adding a section numbered 38.2-3418.8, as follows:

§ 38.2-3418.8. Coverage for the treatment of morbid obesity.

A. Notwithstanding the provisions of § 38.2-3419, each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical, or major medical coverage on an expense-incurred basis; each corporation providing individual or group accident and sickness subscription contracts; and each health maintenance organization providing a health care plan for health care services shall provide coverage for the treatment of morbid obesity ***through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity*** *under any such policy, contract or plan delivered, issued for delivery, or renewed in this Commonwealth on and after July 1, 1999.*

B. The reimbursement for the treatment of morbid obesity shall be determined according to the same formula by which charges are developed for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles and coinsurance factors that are no less favorable than for physical illness generally. Insurers may not restrict access to surgery for morbid obesity based upon dietary or any other criteria not approved by the National Institutes of Health.

C. For purposes of this section, "morbid obesity" means ***(i)*** *a weight which is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables,* ***or (ii)*** *a body mass index ("BMI") equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes,* ***or (iii)*** *a BMI of 40 kilograms per meter squared without such comorbidity.* ***As used herein*** *"BMI" equals weight in kilograms divided by height in meters squared.*

D. The provisions of this section shall not apply to short-term travel, accident-only, limited or specified disease policies or contracts designed for issuance to persons eligible for coverage under Title XVIII of the Social Security Act, known as Medicare, or any other similar coverage under state or governmental plans or to short-term nonrenewable policies of not more than six months' duration.

1983 Metropolitan Life Insurance Tables

Height and Weight Table for Women

Height	Small Frame	Medium Frame	Large Frame
4'10	102-111	109-121	118-131
4'11	103-113	111-123	120-134
5'0	104-115	113-126	122-137
5'1	106-118	115-129	125-140
5'2	108-121	118-132	128-143
5'3	111-124	121-135	131-147
5'4	114-127	124-138	134-151
5'5	117-130	127-141	137-155
5'6	120-133	130-144	140-159
5'7	123-136	133-147	143-163
5'8	126-139	136-150	146-167
5'9	129-142	139-153	149-170
5'10	132-145	142-156	152-173
5'11	135-148	145-159	155-176
6'0	138-151	148-162	158-179

Height and Weight Table for Men

Height	Small Frame	Medium Frame	Large Frame
5'2	128-134	131-141	138-150
5'3	130-136	133-143	140-153
5'4	132-138	135-145	142-156
5'5	134-140	137-148	144-160
5'6	136-142	139-151	146-164
5'7	138-145	142-154	149-168
5'8	140-148	145-157	152-172
5'9	142-151	148-160	155-176
5'10	144-154	151-163	158-180
5'11	146-157	154-166	161-184
6'0	149-160	157-170	164-188
6'1	152-164	160-174	168-192
6'2	155-168	164-178	172-197
6'3	158-172	167-182	176-202
6'4	162-176	171-187	181-207

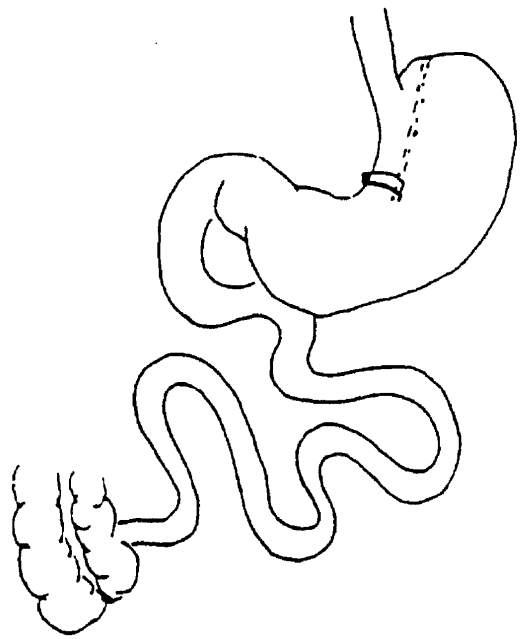

FIG 1. Vertical banded gastroplasty.

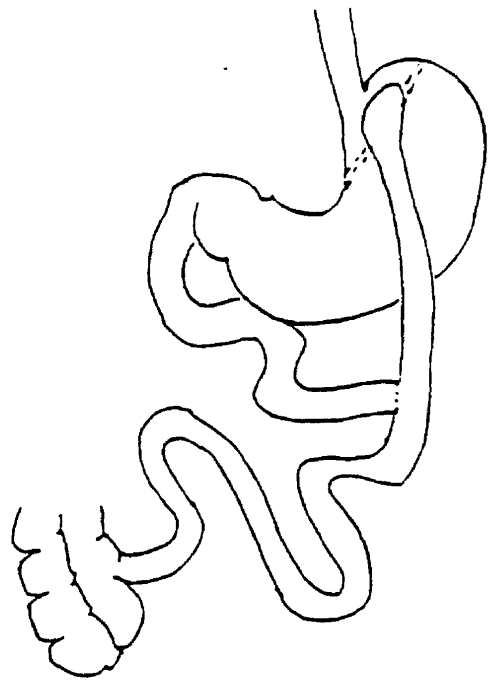

FIG 2. Roux-en-Y gastric bypass.