REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

Senate Bill 1248
Mandated Notification of Information on Obesity

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

COMMONWEALTH OF VIRGINIA
RICHMOND
2004

December 19, 2003

To: The Honorable Mark Warner
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 2.2-2504 and 2.2-2505 of the Code of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and the medical efficacy of Senate Bill 1248 regarding a proposed mandate of notification for obesity.

Respectfully submitted,

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

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EXECUTIVE SUMMARY

The Senate Committee on Commerce and Labor referred Senate Bill 1248 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) during the 2003 Session of the General Assembly. Senate Bill 1248 was introduced by Senator Yvonne B. Miller.

The Advisory Commission held a public hearing on July 9, 2003, in Richmond to receive public comments on Senate Bill 1248 in its substitute form. In addition to the patron, Senator Miller, two speakers addressed the proposal. 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 opposition to Senate Bill 1248 were provided by the VAHP and the HIAA.

If enacted, the bill would add § 38.2-3418.14 to the Code of Virginia. The substitute bill would require insurers to offer and make available to a subscriber information regarding obesity. The provisions would be applicable to insurers 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; corporations providing subscription contracts; and health maintenance organizations (HMOs) providing health care plans. The information may be distributed by direct mailings or made available by posting the information to a website. The information may also be available by establishing a link on an insurer's existing website to the Office of the Surgeon General's overweight and obesity website at www.surgeongeneral.gov/topics/obesity (Appendix B).

The bill defines "obesity" as having a body mass index (BMI) greater than 30, calculated by dividing weight, measured in kilograms, by height that is measured in meters, squared. The bill states that "educational information regarding obesity" includes, but is not limited to, the definition of obesity set forth above, a listing of potential health risks associated with obesity, possible causes of obesity, and the relationship between obesity and inactivity.

The bill does not apply short-term travel, accident-only, limited or specified disease policies, or contracts designed for people eligible for Medicare or similar state or government plans, or short-term nonrenewable policies of not more than six months' duration.

The bill applies to insurance policies, contracts, and plans delivered, issued for delivery, reissued, or extended on or after July 1, 2003, or at any time thereafter when the term of the policy, contract, or plan is changed or the premium adjustment has occurred.

The Advisory Commission voted unanimously (9- No, 0 – Yes) on August 13, 2003 to recommend that Senate Bill 1248 not be enacted. The members of the Advisory Commission agreed that obesity is a very serious health issue. The members believed that some insurance companies are already providing educational information regarding obesity. The members concluded that many companies are taking the responsibility and the initiative of educating their employees about health related issues on obesity, nutritional disorders, and weight control along with fitness programs, and a mandate is not necessary at this time.

INTRODUCTION

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SUMMARY OF PROPOSED LEGISLATION

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THE CODE OF VIRGINIA

Section 38.2-3418.13 requires accident and sickness insurance policies to offer coverage for 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 section applies to individual and group policies providing hospital, medical and surgical or major medical coverage on an expense-incurred basis and subscription contracts and health care plans provided by HMOs. The section applies to policies, contracts and plans delivered or issued for delivery or renewal after July 1, 2000.

The section 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 section also requires that coverage shall have durational limits, dollar limits, deductibles, copayments 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 criterion that is inconsistent with the clinical guidelines recognized by the NIH.

The section 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. The section 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.

OBESITY

The National Heart, Lung, and Blood Institute (NHLBI), in collaboration with the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), released the first federal guidelines in 1998 on the identification, evaluation, and treatment of overweight and obese individuals. The NHLBI and NIDDK reported that approximately 97 million adults in the United States were

overweight or obese. They noted that being obese or overweight substantially increases the following health risks: morbidity from hypertension, dyslipidemia, type 2 diabetes, coronary heart disease, stroke, gallbladder disease, osteoarthritis, sleep apnea and respiratory problems, and endometrial, breast, prostate, and colon cancers.[1]

According to the Office of the Surgeon General's Fact Sheet entitled, "Overweight and Obesity: At a Glance," being overweight may result from an imbalance involving excessive calorie consumption or inadequate physical activity. Behavioral and environmental factors are also contributors to being overweight or obese. These factors provide the greatest opportunity for actions designed for prevention and treatment of this condition to avoid psychological disorders, such as depression. Body weight is the result of a combination of genetic, metabolic, behavioral, environmental, cultural, and socioeconomic influences.[2]

The Report of the Special Advisory Commission on Mandated Health Insurance Benefits, "Mandated Coverage for Morbid Obesity", Senate Document No. 33 (2000) reported that the Medical Services Organization, L.L.C. (MSO) defined obesity as being 20% or more over ideal body weight. Obesity is recognized by the National Institutes of Health as a disease. 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.[3]

SOCIAL IMPACT

The Office of the Surgeon General's Fact Sheet stated that approximately 61% of adults in the United States were overweight or obese (BMI>25) in 1999. The increases in overweight and obesity includes all ages, racial and ethnic groups, and both genders. It was reported that approximately 300,000 deaths each year in the United States are associated with obesity.[4]

FINANCIAL IMPACT

According to the USA TODAY Website entitled "Weighing the Cost of Obesity," obesity cost the country approximately $118 billon annually in 2002, including direct health care costs for diseases related to obesity and indirect costs, such as the loss of productivity.[5]

USA TODAY stated that just one trip to the doctor per year, based on a $60 doctor's visit, costs $810 million a year for approximately 14 million obese Americans. Year-long basic nutrition or behavior modification treatment

programs cost $450 per person, and prescription diet medications cost approximately $80 a month. The article stated that if severely obese people had gastric bypass surgery, which creates a much smaller stomach and rearranges the intestine, it would cost approximately $24,000 for the surgery. [6]

MEDICAL EFFICACY

The Office of the Surgeon General's Fact Sheet reported that many people live sedentary lives; 40% of adults in the United States do not participate in any leisure physical activity and 43% of adolescents watch more than 2 hours of television per day.[7] It was reported that less than 33% of adults engage in the recommended amounts of physical activity. Physical activity is important in preventing and treating overweight and obese people. It is also extremely helpful in maintaining weight loss, especially when a person is eating healthier. Some people may need more physical activity to prevent weight gain, to lose weight, or to maintain weight loss. The Fact Sheet recommended that Americans adults or children should spend at least 30 or 60 minutes engaging in moderate physical activity several days per week.[8]

According to the Senate Document No. 33 (2000), MSO stated that there are a wide variety of weight-loss programs that fall into three basic categories: 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.[9]

CURRENT INDUSTRY PRACTICES

The State Corporation Commission Bureau of Insurance surveyed 60 of the top writers of accident and sickness insurance in Virginia regarding each of the bills to be reviewed by the Advisory Commission. Forty-nine companies responded by June 16, 2003. Thirteen 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 36 respondents that completed the survey, 18 reported that they currently provide the information required by Senate Bill 1248.

Eighteen companies reported that they did not provide information regarding obesity to their subscribers as outlined in Senate Bill 1248. The survey asked the respondents how they would anticipate providing the information on obesity and the annual cost. Seven companies indicated that they would utilize an existing website, five companies stated they would use direct mailings, and six companies indicated that they would use a website link to provide information regarding obesity. Two companies reported that it would cost them from $2,500 to $10,000 per year to provide the information through an existing website. Four companies reported costs that included $5, $16, $30 and $100 per year, and two companies reported costs of $1,500 and $40,000 annually to distribute the information by direct mailings. Two companies reported an annual cost of $5,000 and $10,000 per year to establish a link on their website.

Principal Life Insurance Company provided a copy of their Principal Health News website regarding the topic "Obesity." Principal Health News is administered by Consumer Health Interactive, a company that customizes web sites for major health plans. The company has issued various chronicles on health topics, along with interactive health tools and quizzes, a health encyclopedia and drug and herb database, health plan information, and news and journal articles on the latest health and medicine issues.

SIMILAR LEGISLATION IN OTHER STATES

According to information published by the National Association of Insurance Commissioners, no state requires insurance carriers to provide a notice containing educational information regarding obesity.

Four states, including Georgia, Indiana, Maryland, and Virginia, have mandates for morbid obesity. Georgia requires health benefit policies that provide major medical benefits to offer coverage for the treatment of morbid obesity. Indiana requires insurers that issue an accident and sickness insurance policy to offer coverage for nonexperimental, surgical treatment by a health care provider of morbid obesity. Maryland requires insurers to provide coverage for morbid obesity through gastric bypass or other surgical treatment. Virginia, as previously mentioned, requires health insurers to provide an offer of coverage for 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.

Ohio has reintroduced a bill that is still pending that would provide coverage for morbid obesity. Ohio would require health insuring corporations, and sickness and accident insurers to offer coverage for the surgical treatment of morbid obesity as for any other medically necessary surgical procedure, and to require that such coverage be included in the medical assistance program and

public employee benefit plans. South Carolina requires health insurance issuers to offer an optional rider or endorsement to provide for the treatment of morbid obesity.

REVIEW CRITERIA

SOCIAL IMPACT

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

In 1998, the NHLBI and NIDDK estimated that 97 million adults in the United States are overweight or obese.[10] According to the Office of the Surgeon General's Fact Sheet entitled, "Overweight and Obesity: At a Glance," approximately 61% of adults in the United States were overweight or obese (BMI>25) in 1999. The increase in individuals who are overweight or labeled as obese includes all ages, both genders, and racial and ethnic groups. It was reported that approximately 300,000 deaths each year in the United States are associated with obesity.[11]

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

In a 2003 State Corporation Commission's Bureau of Insurance survey of the top sixty writers of accident and sickness insurance in Virginia, 36 companies currently writing applicable business in Virginia responded. Of that number, 18 companies (50%) already provide the coverage required by Senate Bill 1248 to their Virginia policyholders.

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.

Insurers contend that coverage is generally available. In written comments, the VAHP stated that its health plan community has long been engaged in efforts to encourage their enrollees to lead a healthy lifestyle, advising members on behaviors related to exercise, nutrition, smoking, and alcohol consumption.[12]

According to NIDDK, the Weight-in-control Information Network (WIN) is a service of the NIDDK, part of the National Institutes of Health, under the U.S. Public Health Service. WIN is authorized by Congress (Public Law 103-43), and collects and distributes health information to professionals and the public on

weight control, obesity, and nutritional disorders. WIN responds to requests for educational information, distributes publications, and develops communications strategies to encourage individuals to achieve and maintain a healthier lifestyle. [13]

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.

In its written comments, the VAHP stated that its member-plans are already providing subscribers information regarding obesity. It was noted that the information is easy to read and comprehensive in nature. Some health plans offer online discussion forums where some members may communicate with other members with similar issues and concerns, and also receive feedback from nurses and physicians. Some plans offer multi-lingual hotlines to members for nutrition counseling. Health plans acknowledge that preventing obesity may lead to the prevention of other serious chronic illnesses, such as diabetes, heart disease, and cancer.[14]

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

Information was not presented as to the level of demand in Virginia for information regarding obesity. Senator Miller, patron of Senate Bill 1248, testified at the public hearing that this bill was introduced because of a series of articles, group discussions, and various meetings in the communities. She believes that additional educational information about the health risks of being overweight will help to reduce the number of people that are obese.[15]

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

Information was not presented as to the level of public demand in Virginia for individual or group insurance coverage for notification of information on obesity. However, written comments from the HIAA stated that many insurers already provide information on the dangers of obesity, and there are scores of public and private educational resources on obesity. This mandate was seen to have only a small impact on the number of people that are labeled obese.[16]

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 a state health planning agency or appropriate health system agency relating to the social impact of this proposal.

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.

It is not anticipated that the cost of providing educational information regarding obesity would be significantly impacted by the proposed mandate. A representative from HIAA testified at the public hearing that many insurers already provide subscribers information regarding the dangers of being obese. The opponent stated that there are scores of public and private educational resources on obesity. A mandate will have a small impact on the number of people that are obese because they would be less likely to visit a website for educational information regarding obesity. [17]

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

No information was provided by the opponents that would suggest that Senate Bill 1265 would increase the appropriate or inappropriate service of providing educational information regarding obesity. However, the patron believes that the bill would increase information regarding obesity received and read by the consumers.

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

In written comments, the VAHP noted a recent article in Health Affairs that indicated the conditions of being overweight or obese are contributing as much as $93 billion to the nation's yearly medical bills, and that public payers, including Medicare and Mediciad, finance approximately half of these costs. The VAHP testified at the public hearing that this analysis demonstrated that the per capita cost increase associated with obese individuals includes $1,486 annually for Medicare recipients, $864 for Medicaid and $423 for private insurance.[18]

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.

A requirement that insurers provide subscribers information about obesity through direct mail, websites, or a hyperlink to the Office of the Surgeon General's overweight and obesity website is not expected to affect the number or types of providers over the next five years.

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.

An increase in the cost of insurance companies in the administrative expenses is anticipated because of the expenses associated with providing educational information regarding obesity through direct mail, websites, or a hyperlink to the Office of the Surgeon General's overweight and obesity website, including advertising and marketing.

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

The Bureau of Insurance survey asked insurers how they would anticipate providing the information on obesity and the annual cost. Seven companies indicated that they would utilize an existing website, five companies stated they would use direct mailings, and six companies indicated that they would use a website link to provide information regarding obesity. Two companies reported that it would cost them from $2,500 to $10,000 a year to provide the information through an existing website. Four companies reported costs that included $5, $16, $30 and $100 a year and two companies reported costs of $1,500 and $40,000 annually to distribute the information by direct mailings. Two companies reported an annual cost of $5,000 and $10,000 a year to establish a link on their website.

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.

According to NIDDK, if a person is overweight, losing 5 to 10 percent of his body weight may improve a lot of the health problems linked to being overweight, such as high blood pressure and diabetes. A slow and stable weight loss of no more than 1 pound per week is the safest way to lose weight. It was noted that a very rapid weight loss can cause a person to lose muscle instead of fat. A rapid weight loss may also increase a person's chance of developing other health problems, such as gallstones, gout, and nutrient deficiencies. The best way to lose weight is to develop better eating habits and to make physical activity a part of a daily routine. [19]

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 1248 addresses a broad social need of informing and educating individuals regarding obesity.

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

In written comments, the HIAA opposed legislation that mandates specific benefits be provided in health insurance policies. HIAA noted that mandates lock into law what should be a flexible decision about levels of coverage made in the context of rapidly advancing medical knowledge and evolving medical technologies. HIAA noted that studies have repeatedly shown that mandated benefits increase the cost of health insurance, resulting in higher premiums and more uninsureds. At a time when health care costs and insurance premiums are rising at double digit rates, and almost 15% of Virginians lack health insurance coverage, additional mandates will serve only to exacerbate these trends. [20]

HIAA noted that the individual and small group insurance markets could be substantially harmed by additional mandates because they will further limit insurers ability to provide affordable products.[21]

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

In the case of group coverage, the decision whether to select the optional coverage or not would lie with the master contract holder and not the individual insured.

RECOMMENDATION

The Advisory Commission voted unanimously (9- No, 0 – Yes) on August 13, 2003 to recommend that Senate Bill 1248 not be enacted.

CONCLUSION

The members of the Advisory Commission agreed that obesity is a very serious health issue. The members believed that some insurance companies are already providing educational information regarding obesity. The members concluded that many companies are taking the responsibility and the initiative of educating their employees about health related issues on obesity, nutritional disorders, and weight control along with fitness programs, and a mandate is not necessary at this time.

[1] Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults. April 2003. National Institutes of Health Website. www.nh1bi.nih.gov/guidelines/obesity.

[2] Overweight and Obesity: At a Glance. April 2003. The Sugeon General Website. www.surgeongeneral.gov/topics/obesity.

[3] Mandated Coverage For Morbid Obesity. 2000 Senate Document No. 33. Report of the Special Adivosry Commission on Mandated Health Insurance Benefits.

[4] Overweight and Obesity: At a Glance. April 2003. The Sugeon General Website. www.surgeongeneral.gov/topics/obesity.

[5] Weighing the Cost of Obesity. January 2002. USA TODAY Website. Wwwusatoday.com/new/health/2002.

[6] Weighing the Cost of Obesity. January 2002. USA TODAY Website. Wwwusatoday.com/new/health/2002.

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[11] Overweight and Obesity: At a Glance. April 2003. The Sugeon General Website. www.surgeongeneral.gov/topics/obesity.

[12] Virginia Association of Health Plans, July 2003.

[13] Do You Know the Health Risks of Being Overweight?. April 2003. National Institutes of Health Website. www.nh1bi.nih.gov/health/nutrit/ pubs.health.

[14] Virginia Association of Health Plans, July 2003.

[15] Senator Yvonne B. Miller. “Public Meeting,” Richmond, Virginia. 9 July 2003.

[16] Health Insurance Association of America, June 2003.

[18] Virginia Association of Health Plans, July 2003.

[19] Do You Know the Health Risks of Being Overweight?. April 2003. National Institutes of Health Website. www.nh1bi.nih.gov/health/nutrit/ pubs.health.

[20] Health Insurance Association of America, June 2003.

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