SENATE BILL REPORT
SB 6052

As of February 25, 2009

Title: An act relating to health benefit plans offering coverage for surgical treatment of morbid obesity.

Brief Description: Requiring health benefit plans to offer coverage for surgical treatment of morbid obesity.

Sponsors: Senator Pflug.

Brief History:
Committee Activity: Health & Long-Term Care: 2/24/09.

SENATE COMMITTEE ON HEALTH & LONG-TERM CARE

Staff: Mich'l Needham (786-7442)

Background: A body mass index (BMI) between 18.5 and 25 kilograms per meter squared is considered normal, while individuals with a body mass index of 35 kilograms per meter squared are generally considered morbidly obese. A range of approaches for covering surgery for morbid obesity exists. The Centers for Medicare and Medicaid (CMS) has allowed Medicare coverage for four types of bariatric surgery for enrollees with a BMI of 35 or higher and at least one co-morbidity related to obesity. Just last week, CMS announced that it will expand coverage for bariatric surgery for those enrollees with a BMI of 35 who have Type 2 diabetes.

The state medical assistance programs provide coverage for bariatric surgery, with prior authorization, for those individuals with a BMI of 35 or greater with diabetes, or osteoarthritis of weight-bearing joints requiring joint replacement surgery, or documentation of a rare condition. Enrollees must also demonstrate six months of care under a physician with diet/nutrition, mental health, or medical consultations, and a 5 percent weight reduction to ensure the best post-operative morbidity.

The Public Employees Benefits Board self-insured plans cover surgery for morbid obesity for enrollees with a BMI of 40 or greater and identified co-morbidities. A number of insurance plans, including the Basic Health program, have benefit exclusions that prevent coverage for surgery for obesity and morbid obesity.

This analysis was prepared by non-partisan legislative staff for the use of legislative members in their deliberations. This analysis is not a part of the legislation nor does it constitute a statement of legislative intent.

Summary of Bill: All health insurance plans issued or renewed after December 31, 2009, must follow the evidence-based standard of care and coverage practices for treatment of morbid obesity. Insurance carriers must develop a policy that allows a conditional waiver of contractual benefit exclusions for nonexperimental, medically necessary, surgical treatment when the condition has persisted for at least five years and nonsurgical treatment that has been supervised by a physician has been unsuccessful for at least six consecutive months.

Morbid obesity is defined as a body mass index of at least 35 kilograms per meter squared, with co-morbidity or co-existing medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or a body mass index of at least 40 kilograms per meter squared without co-morbidity.

Appropriation: None.

Fiscal Note: Requested on February 18, 2009.

Committee/Commission/Task Force Created: No.

Effective Date: Ninety days after adjournment of session in which bill is passed.

Staff Summary of Public Testimony: PRO: This is not intended to be a mandate, but an option to allow an insurance plan to provide patients with necessary medical care that is less expensive than some other options. It is logical to waive the exclusion on obesity surgery when it is medically appropriate care. The surgery is the evidence-based approach to treating morbid obesity now, and helping these patients avoid other costly health impacts, like joint replacements and other co-morbidities that arise from morbid obesity.

CON: It is desirable to address the issue of obesity in society. Insurance plans for large groups do offer the option of including obesity surgery, but the fragile nature of the small group and individual markets do not lend themselves to including this benefit option. Any plan that included coverage for the obesity surgery in the individual and small group markets would be adversely selected against and premiums would become unsustainable. We recommend the benefit go through a formal sunrise review with the Department of Health to fully assess the cost-benefit impacts.

Persons Testifying: PRO: Senator Pflug, prime sponsor.

CON: Sydney Smith Zvara, Association of Washington Health Care Plans; Mel Sorensen, America's Health Insurance Plans; Carrie Tellefson, Regence; Jack McRae, Premera.