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SURGERY FOR OBESITY AND RELATED DISEASES

Review article

States variations in the provision of bariatric surgery under affordable care act exchanges

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Abstract The Affordable Care Act (ACA) attempts to reduce healthcare costs while simultaneously providing the means for more Americans to obtain health insurance. Among other things, the ACA expands preventative care for obesity by mandating screening and counseling. However, it permits the states to determine whether to mandate treatments for inclusion in plans offered on the state-run exchanges. Bariatric surgery is a highly cost-effective treatment for obesity, yet states have taken varying stances on whether to mandate its inclusion. In light of the rising cost of obesity and resulting burden placed on the federal government and the economy, this article advocates a comparable mandatory inclusion of bariatric surgery in all plans offered on state and federally run exchanges. (Surg Obes Relat Dis 2015;11:715–720.)

Keywords: Bariatric surgery; Health reform; Obesity; Insurance

Obesity is a significant public health problem in the United States. Currently, a staggering two thirds of adults in the nation are defined as overweight [1], and more than 35% of adults and 16% of children are classified as obese [2]. Assuming such trends continue, the obesity rate for adults could reach more than 40% by 2030 [3]. A number of factors contribute to this unprecedented health crisis, including an overall lack of physical activity and poor nutrition, as well as genetic and environmental factors [4]. Although a complete explanation of the precipitous change in weight nationally has yet to be agreed upon, it is clear that obesity is universally considered to be the greatest impending public health threat facing the United States [5].

Obesity poses a number of very serious public health and economic challenges. From a public health perspective, obesity is associated with several chronic co-morbidities [4] and has also been implicated in a number of cancers [2,6]. These negative health outcomes combine to render obesity one of the leading causes of preventable death in the country [7]. In 2013, the American Medical Association formally recognized obesity as a disease, a change that could motivate health professionals to pay more attention to the condition. The health consequences of obesity create an alarming level of financial strain on the U.S. economy. Researchers estimate that obesity imposes costs on the U.S. healthcare system of more than $190 billion annually [8]. Obesity also negatively affects the broader economy; for instance, U.S. businesses lose productivity at a rate of $4.3 billion per year due to obesity-related absenteeism [9].

In the face of this impending crisis, a number of behavioral, dietary, and pharmaceutical treatments aimed at resolving obesity have been developed but few have been successful at realizing long-term success. Diet studies and therapies attempt to reduce caloric or total food intake [10]; however, most patients regain the weight within 1 to 2

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years. Pharmacologic treatments ranging from appetite suppressants to blockers of fat absorption have also had limited success [10] and have also resulted in serious side effects [11].

Bariatric surgery is a treatment method that seeks to resolve obesity through surgical intervention. Although bariatric surgery refers to many different types of weight loss surgery, all types combat obesity in 2 general ways: (1) restriction—limiting the amount of food the stomach can contain, thereby limiting calorie consumption, and (2) malabsorption—reducing or bypassing part of the small intestine, thereby reducing calorie absorption [12]. Post-operatively, patients experience nutritional, metabolic, and hormonal changes that have important clinical implications [12]. Though bariatric surgery is not a cure-all with respect to obesity, it is widely held to be the most effective means of treating the condition [13] while helping to resolve or lessen the negative effect of several of the most prevalent co-morbidities of obesity, such as sleep apnea, type 2 diabetes, and hypertension [14]. Moreover, bariatric surgery has been described as the only legitimate treatment for morbid obesity [15], with some citing a tenfold reduction in mortality [16]. Bariatric surgery for severe obesity is associated with long-term weight loss and decreased overall mortality [17]. Additionally, preliminary research suggests that bariatric surgery is also cost-effective relative to non-surgical treatments [13]. Studies on the return on investment (ROI) for bariatric surgery show that downstream savings associated with bariatric surgery are estimated to offset the initial costs in 2 to 4 years [18,19], and covering weight loss surgery is worthy of support from payor, employer, and societal perspectives [20].

The Patient Protection and Affordable Care Act (ACA) addresses the obesity epidemic in a number of ways; for instance, all private insurers [21,22] and plans offered on state ACA exchanges must cover obesity screening and counseling for both adults and children [23]. However, the ACA left certain determinations purely up to the states; most notably, bariatric surgery is not federally mandated for private health insurers or as an exchange-offered benefit. Previous research analyzed state requirements for Medicaid and private insurers' coverage of obesity treatments [24]. However, state requirements for exchange-offered plans have not been critically evaluated in the area of obesity treatment. The rest of this paper focuses on the ACA and related state law requirements for bariatric surgery under the state insurance exchanges. This review uses qualitative legal analysis. LexisNexis and PubMed searches were conducted. It finds that obese patients who enroll in ACA exchange-offered plans in certain states may be unable to avail themselves of the clinical and cost benefits of bariatric surgery. It concludes with suggestions for states and insurers to increase the affordability and availability of bariatric surgery for patients seeking insurance on exchanges.

The ACA, state law, and bariatric surgery

It is important to first examine the nature of the ACA to understand the discrepancies in services among states. Section 1302 of the ACA directs the Department of Health and Human Services (HHS) to create a package of Essential Health Benefits (EHBs) that is "equal in scope to the benefits covered by a typical employer plan" and covers services in 10 general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative services, laboratory services, preventative care services, and comprehensive pediatric services [25].

This EHB package serves as a baseline for the insurance plans that states will offer in their respective ACA exchanges. State plans must cover services within the 10 EHBs, and any further services are simply optional within the context of the ACA. Thus, each state is required to select a "benchmark" plan that covers all EHBs and whatever other optional services the individual state might require to be covered [26]. This state benchmark plan is chosen from 1 of 4 sources: (1) the most popular plan in the state's small group market, (2) one of the 3 largest employee health benefit plans, (3) one of the largest national federal employee benefit plans, or (4) the largest non-Medicaid Health Maintenance Organization in the state [26]. States were free to make this determination, although some (such as Maryland, for instance), were forced by preexisting state laws to pick a benchmark plan with certain covered benefits [27]. Indeed traditional healthcare laws in many states require that insurance plans within the state cover certain classes of people [28] States that did not choose a plan (most states) rely on the federally facilitated marketplace [29]. Other than the 10 required EHB categories, the ACA largely respected state authority in healthcare matters by granting states considerable leeway in deciding what further benefits must be included in exchange-offered plans.

The overall result of this federalist system of healthcare provision is that the benchmark plans from different states differ widely in the optional benefits they are required to provide to their residents. Because HHS did not include bariatric surgery within the EHBs—it is one such optional benefit—the actual provision of bariatric surgery on the ACA exchanges varies from state to state [30]. This creates 2 distinct groups of states: (1) states that mandate coverage of bariatric surgery and (2) states that do not. The following 22 states fall within the first category: AZ, CA, DE, HI, IA, IL, MA, MD, ME, MI, NC, ND, NH, NJ, NM, NV, NY, RI, SD, VT, WV, WY [31]. The following 25 states and the District of Columbia fall within the second category: AK, AL, AR, CO, CT, FL, ID, KS, KY, LA, MN, MO, MS, MT, NE, OH, OK, OR, PA, SC, TN, TX, UT, WA, WI [31]; an additional 3 states, with preexisting healthcare laws