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Original Article

Q3 Covering bariatric surgery has minimal effect on insurance premium costs within the Affordable Care Act

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Abstract

Background: Currently, of the 51 state health exchanges operating under the Affordable Care Act, only 23 include benchmark plans that cover bariatric surgery coverage. Bariatric surgery coverage is not considered an essential health benefit in 28 state exchanges, and this lack of coverage has a discriminatory and detrimental impact on millions of Americans participating in state exchanges that do not provide bariatric surgery coverage.

Objectives: We examined 3 state exchanges in which a portion of their plans provided coverage for bariatric surgery to determine if bariatric surgery coverage is correlated with premium costs.

Setting: State health exchanges; United States.

Methods: Data from the 2015 state exchange plans were analyzed using information from the Centers for Medicare & Medicaid Services' Individual Market Landscape file and Benefits and Cost Sharing public use files.

Results: Only 3 states (Oklahoma, Oregon, and Virginia) in the analysis have 1 or more rating regions in which a portion of the plans cover bariatric surgery. In Oklahoma and Oregon, the average monthly premiums for all bronze, silver, and gold coverage levels are higher for plans covering bariatric surgery. Only 1 of these states included platinum plans that cover bariatric surgery. The average difference in premiums was between $1 to $45 higher in Oklahoma, and $18 to $32 higher in Oregon. Conversely, in Virginia, the average monthly premiums are between $2 and $21 lower for each level for plans covering bariatric surgery. Monthly premiums for plans covering versus not covering bariatric surgery ranged from 6% lower to 15% higher in the same geographic rating region.

Conclusions: Across all 3 states in the sample, the average monthly premiums do not differ consistently on the basis of whether the state exchange plans cover bariatric surgery. (Surg Obes Relat Dis 2016;∎:00–00.) © 2016 American Society for Metabolic and Bariatric Surgery. All rights reserved.

Keywords: Affordable Care Act; Insurance premiums; Premiums; Cost; Health exchange; Geographic rating region

Obesity is the largest epidemic of a chronic disease in human history [1]. The prevalence of obesity in U.S. adults more than doubled between 1980 and 2010, from 15.0% to 36.1% [2]. The well-publicized Look AHEAD (Action for Health in Diabetes) study analyzed intensive lifestyle Q5

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intervention on obesity and related cardiovascular co-morbidities, but was halted prematurely due to futility at interim analysis. In contrast, there is overwhelming evidence proving efficacy of bariatric surgery in the treatment of morbid obesity [3]. In particular, there is much emphasis on the obesity-related co-morbidity of type 2 diabetes. According to James O. Hill, Ph.D., director of the Center for Human Nutrition at the University of Colorado Health Sciences Center, at current rates, obesity-related diabetes alone "will break the bank of our healthcare system" [4]. Several recent studies find that the treatment of type 2 diabetes with bariatric surgery is more efficacious than intensive medical therapy [5]. Because of this ability to reduce co-morbid disease and return patients to a healthy, productive lifestyle, economic analysis shows bariatric surgery can provide a return on investment within 2–4 years and a significant decrease in healthcare costs [6,7].

Unfortunately, some insurers and managed care entities continue to deny access to bariatric surgical services. The arguments against universal coverage range from concerns of morbidity and mortality, initial cost of surgery, and weight recidivism. The reality is that obesity is a chronic, insidious disease process that is cumulative in its course. For every 1 point the average citizen's body mass index increases, the direct medical cost to the U.S. healthcare system increases by $6 billion [8]. The lack of and delay in obesity treatment has a detrimental effect on society and on patients who suffer from obesity.

The Patient Protection and Affordable Care Act (ACA) was intended, in part, to address disparities in access to healthcare across socioeconomic classes. However, its implementation has led to a patchwork of healthcare exchanges that provide inconsistent benefits. In particular, of the 51 state health exchanges operating under the ACA, only 23 have benchmark plans that include bariatric surgery coverage [9]. In contrast, Medicare and the vast majority of Medicaid and federal and state employee plans provide coverage for bariatric surgery. The remaining 28 states do not consider obesity treatment an essential health benefit (EHB) and have decided not to include bariatric surgery coverage in its benchmark plans. We feel this has a discriminatory and detrimental impact on millions of Americans.

Three states (Virginia, Oregon, and Oklahoma) have some exchange plans that offer bariatric surgery coverage and some that do not. This allows us an opportunity to analyze the cost difference between plans to determine if bariatric surgery coverage is correlated with premium costs.

Methods

Avalere, an advisory company focused on healthcare business strategy and public policy, provided summary statistics from their analysis of the 2015 Centers for Medicare & Medicaid Services' Individual Market Landscape File and Plan Attributes Public Use File (Plan-PUF). These files present a variety of benefit design and plan information for exchange plans operating in a state with an exchange run by the federal government. To provide the summary statistics on "Bariatric Surgery," Avalere combined both PUFs from 2015 and cleaned up the cost-sharing data to allow for analysis. All premiums were selected for a nonsmoking, 50-year-old individual. For the cost-sharing analysis, the data reflect after-deductible amounts.

State and plan selection methodology

Each state has a set number of geographic rating regions that all issuers in the state must uniformly use as part of their rate setting. Only 3 states (Oklahoma, Oregon, and Virginia) in the PUF had one or more rating regions with plans both covering and not covering bariatric surgery. In total, there are 15 geographic rating regions used in the analysis: Oklahoma, with 5 rating regions; Oregon, with 7 rating regions; and Virginia, with 3 rating regions. We compared premiums between plans that cover and plans that do not cover bariatric surgery.

Results

Bariatric surgery coverage

Overall, Oklahoma and Virginia provide greater access to bariatric surgery than Oregon. However, the majority of plans in each state do not cover bariatric surgery. In Oregon, only 10.5% of all plans cover bariatric surgery (46 of 436 plans). In Oklahoma, 36.7% of all plans cover bariatric surgery (73 of 199 plans). In Virginia, 44.6% of all plans cover bariatric surgery (41 of 92 plans).

Notably, none of the platinum plans in Oklahoma and Oregon cover bariatric surgery. In contrast, all platinum plans in Virginia cover bariatric surgery.

The breakdown of coverage across all coverage levels (bronze, silver, gold, and platinum) is shown in Table 1.

Average monthly premiums

The average premiums did not differ dramatically for plans that covered and those that did not cover bariatric

Table 1
Number of plans per coverage level in each state

State	Oklahoma		Oregon		Virginia	
Plan level	C (% C)	NC	C (% C)	NC	C (% C)	NC
Bronze	21 (35.6)	38	8 (7.1)	104	13 (37.1)	22
Silver	26 (40.6)	47	23 (12)	169	13 (42)	18
Gold	26 (40)	39	15 (12.6)	104	10 (47.6)	11
Platinum	0 (0)	2	0 (0)	13	5 (100)	0
Total plans	73 (36.7)	126	46 (10.5)	390	41 (44.6)	51

NC = bariatric surgery not covered; C = bariatric surgery covered; % C = percentage of all plans covering bariatric surgery.