

Insurance Coverage for Bariatric Surgery

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Issue

This report addresses questions regarding health insurance coverage for bariatric surgery (e.g., gastric bypass) to treat obesity. It identifies states that (1) require commercial health insurance policies to cover bariatric surgery, (2) proposed a bariatric surgery insurance coverage mandate in the past five years and any identified fiscal impact, and (3) require coverage of bariatric surgery under state Medicaid plans. The report also briefly summarizes some relevant studies on the cost effectiveness of bariatric surgery.

Summary

According to the National Conference of State Legislatures, 23 U.S. states require commercial health insurers to cover bariatric surgery to treat obesity by including coverage in their benchmark plan, which is required by the federal Affordable Care Act (ACA). Two of these states, Maryland and New Hampshire, mandate this coverage by statute. (Connecticut does not mandate this coverage or cover it in its benchmark plan.) Additionally, three states—Georgia, Indiana, and Virginia—statutorily allow or require certain insurers to offer bariatric surgery coverage but policyholders may opt out of the coverage.

Based on an online search by the Legislative Library, three states proposed legislation in 2019 to mandate health insurance coverage of bariatric surgery: Connecticut, Georgia, and Mississippi. We found no other examples of similar proposed legislation in the last five years.

In the United States, 49 out of 51 state Medicaid programs cover one or more surgical procedures to treat obesity. Connecticut's Medicaid program covers bariatric surgery when an enrollee meets certain criteria (e.g., meets comorbidity requirements based on body mass index (BMI)).

A 2011 study coordinated by the Connecticut Insurance Department estimated the cost of requiring commercial group health insurance policies to cover gastric bypass surgery was less than 0.2% of premium. Additionally, a 2019 study of the cost effectiveness of bariatric surgery found that the surgery is cost effective for people with obesity (defined as a BMI of at least 35 kilograms per meter squared, kg/m²) who have type 2 diabetes, but the author acknowledged more research is needed.

States that Require Insurers to Cover Bariatric Surgery

States that Mandate Coverage by Statute

Maryland. Maryland law requires insurers, including HMOs, providing hospital, medical, or surgical benefits to individuals or groups in the state to cover surgical treatment of morbid obesity that is (1) recognized by the National Institutes of Health (NIH) as effective for the long-term reversal of morbid obesity and (2) consistent with NIH guidelines ([MD Cod Ann., Ins., § 15-839](#)). The law took effect October 1, 2001, predating the ACA.

Under the law, "morbid obesity" means a BMI that is (1) greater than 40 kg/m² or (2) equal to or greater than 35 kg/m² with a comorbid medical condition, including hypertension, cardiopulmonary disease, sleep apnea, or diabetes.

The Maryland Health Care Commission periodically studies and publishes a report on the cost of mandated benefits. Its [2012 report](#), the most recent one evaluating the cost of the morbid obesity mandate, indicates that the benefit costs 0.3% and 0.4% of total premium for group and individual health insurance policies, respectively (page 5). The report also found that insurers would cover 61% of the required morbid obesity covered services without the mandate, so the marginal cost of the mandate is 0.1% of premium for both group and individual policies (page 14). (The commission was unable to provide utilization data for the benefit.)

New Hampshire. In New Hampshire, state law requires health insurers issuing or renewing individual or group health insurance policies, plans, or contracts to cover the treatment of obesity and morbid obesity, including bariatric surgery. The (1) covered person must be at least 18 years old and (2) prescribing physician must issue a written order stating the treatment is medically necessary and in accordance with standards set forth by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons ([N.H. Rev. Stat. §§ 415:6-o & 415:18-t](#)). The law took effect September 14, 2008, predating the ACA.

According to the director of Health Care Analytics for the New Hampshire Insurance Department, the state has not collected cost and utilization data associated with this mandated benefit.

Benchmark Plan Coverage States

The ACA requires most health plans in the individual and small group markets to offer a core package of health care services, known as essential health benefits (EHBs). (EHBs are 10 broad categories of health services, ranging from outpatient care to preventive and wellness services.) The ACA also requires each state to select an EHB-benchmark plan, which serves as a reference plan on which individual and small group insurers may base their benefit packages. A benchmark plan more fully defines a state's EHBs.

There is considerable variation in state benchmark plans in terms of covered services and benefit scope. For example, some state benchmark plans include bariatric surgery as a covered service while others do not. Information on each state's benchmark plan is available on the Centers for Medicare and Medicaid Services' webpage found [here](#).

The following 23 states have benchmark plans for the years 2017 to 2021 that include coverage of bariatric surgery: Arizona, California, Colorado, Delaware, Hawaii, Illinois, Iowa, Maine, Maryland, Massachusetts, Michigan, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, North Dakota, Rhode Island, South Dakota, Vermont, West Virginia, and Wyoming.

Optional Coverage States

Three states—Georgia, Indiana, and Virginia—statutorily allow or require certain insurers to offer bariatric surgery coverage to certain policyholders who may reject the optional benefit.

Georgia. Every health benefit policy delivered, issued, executed, or renewed in the state or approved for issuance or renewal by the insurance commissioner that provides major medical benefits may offer coverage for the treatment of morbid obesity ([Ga. Code Ann. § 33-24-59.7](#)).

Indiana. An accident and sickness insurance policy must offer coverage for nonexperimental, surgical treatment of morbid obesity that has persisted for at least five years and for which physician-supervised, nonsurgical treatment has been unsuccessful for at least six consecutive months. An insurer cannot provide coverage for the surgical treatment of morbid obesity for an insured person under age 21 unless two licensed physicians determine it is necessary to (1) save the person's life or (2) restore the person's ability to maintain a major life activity ([Ind. Code Ann. §§ 27-8-14.1-1 to 27-8-14.1-4](#)).

Virginia. Each insurer and HMO in the large group market issuing accident and sickness insurance policies must offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or other methods recognized by NIH as effective for the long-term reversal of morbid obesity ([Va. Code Ann. § 38.2-3418.13](#)). The mandate does not apply to individual, small group market, or qualified health benefit exchange policies.

States that Proposed Bariatric Surgery Coverage Mandates

Through an online search, the Legislative Library identified three states that proposed legislation in 2019 to mandate health insurance coverage of bariatric surgery: Connecticut, Georgia, and Mississippi. We found no other examples of similar proposed legislation in the last five years.

Connecticut

[SB 317](#) would have required individual and group health insurance policies to cover surgical procedures performed to treat severe obesity, including gastric bypass, sleeve gastrectomy, and duodenal switch. The procedures would have to be (1) recognized by the NIH, American Society for Metabolic and Bariatric Surgery, and American College of Surgeons as providing long-term weight loss and (2) consistent with NIH guidelines. Under the bill, a person has “severe obesity” if he or she has a BMI that is (1) over 40 kg/m² or (2) at least 35 kg/m² and a diagnosed comorbidity such as a cardiopulmonary condition, diabetes, hypertension, or sleep apnea.

The Insurance and Real Estate Committee favorably reported the bill on March 14, 2019, but the Senate took no action on it. The [fiscal note](#) indicates a cost of approximately \$4.4 million annually for FYs 20 and 21, as well as an undetermined cost to municipalities.

Georgia

The Georgia legislature considered two related bills in 2019: [HB 160](#) and [HB 187](#). HB 160 would have reinstated a pilot program covering bariatric surgery for employees covered by the state health insurance plan. It passed the House in February but the Senate never considered it. HB 187 would have reinstated a pilot program to cover the treatment and management of obesity and related conditions, including medications and counseling. It passed both chambers but the governor vetoed it on May 10, 2019.

According to the [House Budget and Research Office](#), official fiscal analyses of the two bills were not completed. However, the governor specifically indicated cost as the primary reason for vetoing HB 187 (the veto statement is available from [here](#)).

Mississippi

In 2019, the Mississippi legislature considered [HB 317](#), which would have required individual and group health insurance policies to cover “diseases and ailments caused by obesity and morbid obesity,” including treatment by bariatric surgery. The bill died in committee on February 5, 2019. The legislature did not conduct a fiscal analysis of the bill.

Medicaid Coverage of Bariatric Surgery

Other States

According to the [Stop Obesity Alliance at George Washington University](#),⁴⁹ out of 51 state Medicaid programs (including the District of Columbia) cover one or more surgical procedures to treat obesity as of 2016. Montana and Mississippi are the only states with Medicaid programs that exclude coverage for bariatric surgery.

Connecticut

According to the Department of Social Services (DSS), Connecticut’s Medicaid program covers bariatric surgery in cases that meet certain criteria. The Community Health Network of Connecticut (CHNCT), the medical administrative service organization for Medicaid in Connecticut, uses InterQual criteria to assess bariatric surgery requests. Under those criteria, Medicaid covers bariatric surgery if the enrollee:

1. meets comorbidity requirements based on BMI (see Table 1 below);
2. was unable to achieve or maintain weight loss despite participation in a supervised weight loss program;
3. has no significant gastrointestinal symptoms (or symptoms have been evaluated and cleared);
4. has a medical history, physical exam, or lab testing that rules out endocrine causes of obesity;
5. has not abused alcohol or substances (or is alcohol and substance free for one year);
6. has no psychiatric disorders (or disorders are controlled);
7. is cleared by a behavioral health provider;
8. does not use tobacco (or is tobacco free for six weeks before the surgery); and
9. has had a dietary consult.

According to DSS, if an enrollee does not meet these criteria, CHNCT reviews the request from a person-centered perspective to determine whether to consider the procedure medically necessary for other reasons.

Table 1: Connecticut Medicaid Comorbidity Requirements Based on BMI (kg/m²) for Coverage of Bariatric Surgery

	<i>BMI 30 to <35</i>	<i>BMI 35 to <40</i>	<i>BMI 40 or greater</i>
Enrollees must also have at least one of the following conditions:	Type 2 diabetes Metabolic syndrome	Coronary artery disease Diabetes Dyslipidemia Gastroesophageal reflux disease Heart failure Hypertension Idiopathic intracranial hypertension Non-alcoholic fatty liver disease Obesity hypoventilation syndrome Obstructive sleep apnea Osteoarthritis	None

As of November 6, 2019, DSS paid claims for bariatric surgery for 1,094 members in 2017 and 1,128 members in 2018. Claims over both years totaled between \$2.1 million to \$2.4 million depending on the types of claims included.

Cost Effectiveness Studies

2011 Connecticut Study

As authorized by [PA 09-179](#), in 2010, the Insurance and Real Estate Committee chairs directed the Connecticut Insurance Department to review five specific proposed health benefit mandates, including gastric bypass surgery, detailing the social and financial impacts of enacting coverage requirements. The review (available [here](#)), published in March 2011, was a collaborative effort between the department, the UConn Center for Public Health and Health Policy, and Ingenix Consulting.

According to the review, the 2011 estimated medical cost of requiring commercial group health insurance policies cover gastric bypass surgery was \$0.50 per member per month. An additional amount would be charged for administrative costs, making the total estimated 2011 premium increase less than 0.2% of premium. (Due to a lack of data, the review did not estimate costs for individual health insurance policies.)

Although the review concluded that requiring bariatric surgery coverage may increase health care spending by \$8.5 million, “the potential benefit to insurers may be an offset in paid claims over the lifetime of a bariatric patient” (page 92). The review found that some studies estimated that the costs related to comorbid conditions following surgery are “reduced or eliminated to an extent greater than the initial cost of surgery.” On the other hand, some studies “found bariatric surgery to be cost effective but not cost saving.” Further, cost savings may be higher for employers than insurers as employers see improvements in worker productivity following bariatric surgery.

2019 Cost-Effectiveness Study

A 2019 report, [*Economics and Policy in Bariatric Surgery*](#), reviewed and synthesized studies on the cost effectiveness of bariatric surgery. The author concluded that bariatric surgery is cost effective for people with obesity (defined as a BMI of 35 kg/m² or above) who have type 2 diabetes (Hoerger, T.J., *Curr. Diab. Rep.* (2019) 19: 29).

The evidence suggests that in patients with diabetes, bariatric surgery may lead to complete or partial remission and reduction in medications. Studies also found that “patients with severe obesity and diabetes who underwent bariatric surgery experienced significantly lower rates of microvascular (diabetic retinopathy, neuropathy, or nephropathy) and macrovascular (coronary artery disease or cerebrovascular events) events” than patients who did not have the surgery.

According to the report, the average cost of bariatric surgery was approximately \$15,000 in 2016 U.S. dollars. Including costs before and after surgery, it estimated the total cost was \$20,000 to \$24,000. While bariatric surgery increases overall health expenditures initially, the report found that the resulting health benefits—lowered mortality, reduced morbidity, and improved quality of life—may be worth the costs. However, the author noted that more research on this issue is needed.

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