Senate

General Assembly

File No. 364

January Session, 2021

Senate Bill No. 1007

Senate, April 8, 2021

The Committee on Insurance and Real Estate reported through SEN. LESSER of the 9th Dist., Chairperson of the Committee on the part of the Senate, that the bill ought to pass.

AN ACT REQUIRING HEALTH INSURANCE AND MEDICAID COVERAGE FOR THE TREATMENT OF SEVERE OBESITY.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. (NEW) (*Effective January 1, 2022*) (a) For the purposes of this section:

(1) "Body mass index" means the number calculated by dividing an individual's weight in kilograms by the individual's height in meters squared; and

(2) "Severe obesity" means a body mass index that is:

(A) Greater than forty; or

(B) Thirty-five or more if an individual has been diagnosed with a comorbid disease or condition, including, but not limited to, a cardiopulmonary condition, diabetes, hypertension or sleep apnea.

(b) Each individual health insurance policy providing coverage of the

type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for:

(1) Each surgical procedure that is:

(A) Performed to treat severe obesity, including, but not limited to, gastric bypass surgery, sleeve gastrectomy and duodenal switch surgery;

(B) Recognized by the National Institutes of Health, American Society for Metabolic and Bariatric Surgery and American College of Surgeons as providing long-term weight loss; and

(C) Consistent with treatment guidelines issued by the National Institutes of Health as applied to the insured; and

(2) Each outpatient prescription drug that is approved by the federal Food and Drug Administration to treat severe obesity if such policy includes coverage for outpatient prescription drugs.

(c) The benefits required by subsection (b) of this section shall be subject to the same terms and conditions that apply to all other benefits covered under a policy that is subject to this section.

Sec. 2. (NEW) (*Effective January 1, 2022*) (a) For the purposes of this section:

(1) "Body mass index" means the number calculated by dividing an individual's weight in kilograms by the individual's height in meters squared; and

(2) "Severe obesity" means a body mass index that is:

(A) Greater than forty; or

(B) Thirty-five or more if an individual has been diagnosed with a comorbid disease or condition, including, but not limited to, a

cardiopulmonary condition, diabetes, hypertension or sleep apnea.

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2022, shall provide coverage for:

(1) Each surgical procedure that is:

(A) Performed to treat severe obesity, including, but not limited to, gastric bypass surgery, sleeve gastrectomy and duodenal switch surgery;

(B) Recognized by the National Institutes of Health, American Society for Metabolic and Bariatric Surgery and American College of Surgeons as providing long-term weight loss; and

(C) Consistent with treatment guidelines issued by the National Institutes of Health as applied to the insured; and

(2) Each outpatient prescription drug that is approved by the federal Food and Drug Administration to treat severe obesity if such policy includes coverage for outpatient prescription drugs.

(c) The benefits required by subsection (b) of this section shall be subject to the same terms and conditions that apply to all other benefits covered under a policy that is subject to this section.

Sec. 3. (NEW) (*Effective July 1, 2021*) (a) For the purposes of this section:

(1) "Body mass index" means the number calculated by dividing a Medicaid beneficiary's weight in kilograms by the Medicaid beneficiary's height in meters squared; and

(2) "Severe obesity" means a body mass index that is:

(A) Greater than forty; or

(B) Thirty-five or more if a Medicaid beneficiary has been diagnosed with a comorbid disease or condition, including, but not limited to, a cardiopulmonary condition, diabetes, hypertension or sleep apnea.

(b) The Commissioner of Social Services shall provide Medicaid reimbursement for:

(1) Each surgical procedure that is:

(A) Performed to treat severe obesity, including, but not limited to, gastric bypass surgery, sleeve gastrectomy and duodenal switch surgery;

(B) Recognized by the National Institutes of Health, American Society for Metabolic and Bariatric Surgery and American College of Surgeons as providing long-term weight loss; and

(C) Consistent with treatment guidelines issued by the National Institutes of Health as applied to the Medicaid beneficiary; and

(2) Each outpatient prescription drug that is approved by the federal Food and Drug Administration to treat severe obesity.

(c) The commissioner shall seek federal approval of a Medicaid state plan amendment or Medicaid waiver, if necessary, to implement the provisions of this section. Any submission of a Medicaid state plan amendment or Medicaid waiver shall be in accordance with the provisions of section 17b-8 of the general statutes.

(d) The commissioner shall adopt regulations, in accordance with chapter 54 of the general statutes, to implement the provisions of this section. The commissioner may adopt policies or procedures to implement the provisions of this section while in the process of adopting regulations, provided such policies or procedures are posted on the Internet web site of the Department of Social Services and on the eRegulations System prior to the adoption of such policies or procedures.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2022*	New section
Sec. 2	*January 1, 2022*	New section
Sec. 3	*July 1, 2021*	New section

INS *Joint Favorable*

The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 22 $	FY 23 $
ACA – State Mandate	GF - Cost	Significant	Significant
Social Services, Dept.	GF - Potential Cost	See Below	See Below

Note: GF=General Fund

Municipal Impact:

Municipalities	Effect	FY 22 $	FY 23 $
Various Municipalities	STATE MANDATE[1] - Cost	See Below	See Below

Explanation

The bill does not result in a cost to the state employee and retiree health plan as the state health plan currently provides coverage in accordance with the provisions of the bill.

The bill will result in a cost to fully-insured municipal health plans that do not currently provide coverage for surgical procedures to treat severe obesity. The cost to fully insured municipal plans will be reflected in premiums for policy years beginning on and after January 1, 2022 and be based on the risk profile of the covered members. Pursuant to federal law, self-insured plans are exempt from state health

[1] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

insurance mandates.

In addition, many municipal health plans are recognized as "grandfathered" health plans under the Affordable Care Act (ACA).[2] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under the ACA.

Lastly, the bill will result in a cost to the state pursuant to the ACA, as the coverage requirements in the bill are not currently provided under the state exchange's benchmark plan.[3] The cost will depend on the utilization and cost of services for exchange plans. Based on the experience of the state employee health plan, the cost to the state for exchange plans is approximately $4.4 million.[4] Based on the most recent data available, the active state employee health plan covers approximately 90,500 members between the ages of 18-65.[5] Exchange plans provide coverage for approximately 106,000 members in the same age range.[6] For context, $4.4 million reflects 0.5% of total annualized 2020 premiums for exchange members. Assuming median average procedure cost of approximately $20,000 – the impact assumes approximately 220 Exchange members would undergo the procedure or 0.2% of enrollees in the applicable age cohort.

While states are allowed to mandate benefits in excess of the essential health benefit (EHB), federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the Exchange, by reimbursing the carrier or the insured for the excess coverage. Absent further federal guidance, state mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB

[2] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.
[3] The Exchange benchmark plan is the Connecticare Flex POS Plan. (Source: https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/Updated-Connecticut-Benchmark-Summary.pdf)
[4] Estimate based on state employee health plan expenditures for applicable services for calendar year 2018.
[5] Source: Office of the State Comptroller, 2017.
[6] Source: Access HealthCT 2020 Open Enrollment Summary (February 20, 2020, Presentation to the Board of Directors).

unless they are already part of the benchmark plan.

Section 3 could result in increased costs to the Department of Social Services (DSS) associated with requiring Medicaid reimbursement for all outpatient prescription drugs approved by the federal Food and Drug Administration to treat severe obesity. The impact to DSS depends on the extent to which such drugs would be utilized and their associated net cost.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to an increase in premiums.

OLR Bill Analysis

SB 1007

AN ACT REQUIRING HEALTH INSURANCE AND MEDICAID COVERAGE FOR THE TREATMENT OF SEVERE OBESITY.

SUMMARY

This bill requires certain commercial health insurance policies to cover surgical procedures performed to treat severe obesity, including gastric bypass, sleeve gastrectomy, and duodenal switch. The procedures must be (1) recognized by the National Institutes of Health (NIH), American Society for Metabolic and Bariatric Surgery, and American College of Surgeons as providing long-term weight loss and (2) consistent with NIH treatment guidelines.

The bill requires that if the policies cover outpatient prescription drugs, they must also cover outpatient prescription drugs approved by the federal Food and Drug Administration to treat severe obesity.

Under the bill, coverage is subject to the same terms and conditions that apply to all other benefits covered under the policy.

The bill also requires the Department of Social Services (DSS) commissioner to provide Medicaid coverage reimbursement for the surgical procedures and outpatient prescription drugs described above to treat severe obesity.

The bill requires the DSS commissioner to (1) seek federal approval of a Medicaid state plan amendment or waiver for this, if necessary, in accordance with state law and (2) adopt implementing regulations. It authorizes her to adopt policies and procedures to implement these provisions while in the process of adopting regulations, as long as the policies and procedures are posted on the DSS website and the state eRegulations system.

EFFECTIVE DATE: January 1, 2022, except the Medicaid provisions are effective July 1, 2021.

SEVERE OBESITY DEFINED

Under the bill, a person with severe obesity has a body mass index (BMI) that is (1) over 40 or (2) at least 35 if he or she is also diagnosed with a comorbidity such as a cardiopulmonary condition, diabetes, hypertension, or sleep apnea. BMI is calculated by dividing a person's weight in kilograms by the square of their height in meters.

COMMERCIAL INSURANCE POLICY APPLICABILITY

For commercial insurance purposes, the bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut on or after January 1, 2022, that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 18 Nay 0 (03/22/2021)