**BUDGET WATCH**
**South Carolina Policy Council**
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# Part II: Obesity Coverage Mandate

As the budget goes into conference committee, we will be highlighting issues that currently divide the two chambers. In Part I of this series, we looked at the I-95 Corridor Authority – an economic development initiative backed by the Senate. In this segment, we will look at an obesity treatment coverage mandate being pushed by the House.

*Legislative Background*
Before session began, Sen. Darrell Jackson (D-Richland) prefiled a bill (S 952) that would create an obesity treatment plan that would entail forming a Bariatric Advisory Board (appointed by the legislature) and also require the State Health Plan (read: Budget & Control Board) to implement a program covering morbid obesity treatments, including bariatric surgery. The bill has since languished in the Senate Finance Committee. Thus it came as somewhat of a surprise that the bariatric surgery mandate resurfaced in the House budget (proviso 80A.55). Unlike the initial legislation, the proviso would establish a one-year obesity treatment pilot program (owing to the fact that provisos are, in theory, one-year authorizations). The advisory board was eliminated, but the coverage mandate remained in place. The Senate budget subsequently eliminated this proviso, but the House added it back – thus leaving it to the conference committee to resolve the dispute.

*Three Reasons This Program Is a Bad Idea*
Obesity is a serious health problem in South Carolina. According to the D.C.-based Trust for America's Health, South Carolina has the nation's 5th highest rate of obese adults and 13th highest rate of obese children. That being said, a bariatric surgery mandate is not the best means for combating widespread obesity. Here are three reasons why:

> ***Marginal benefit***. Setting aside the question of whether it is the state's role to reduce obesity, it should be obvious that a bariatric surgery mandate is not the answer. The eligible population for this surgery is very limited, and under the House proviso, coverage would apply to a maximum of 100 participants. In addition, the proviso stipulates that only institutions designated as an ASMBS Center of Excellence for Bariatric Surgery; an American College of Surgeons (ACS) Bariatric Surgery Center Network member; or a Blue Distinction Center for Bariatric Surgery may perform the surgery. To put things into perspective, South Carolina only has 6 ASMBS facilities. (One of these is the Medical University of South Carolina's Weight Management Center, whose director is also vice president of The Obesity Society, a professional advocacy group that supports expanding bariatric surgery coverage.)
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> ***Risky***. Bariatric surgery is a complicated, and sometimes risky, procedure. Yet this surgery seems to be at the center of the obesity treatment plan proposed by S 952. But such surgery should be considered as a last resort, "in cases where other means of controlling obesity have remained ineffective." Numerous studies have noted that

complications are common, with a recent 9-year survey finding that 53 percent of patients "had at least one complication requiring reoperation."

***Costly***. Only six states currently impose an obesity treatment coverage mandate. In part, this is because such treatments raise the overall cost of insurance premiums by 1 percent to 3 percent. It is also because it is not clear bariatric surgery is cost effective from a public health perspective. Here in South Carolina, State Health Plan expenditures have more than doubled over the past few years, with taxpayers responsible for 71 percent of premium costs. For FY10-2011, benefits administration costs for the Employee Insurance Program are expected to reach $12 million; in addition, the FY10-2011 proposed budget appropriates approximately $50 million in employer contributions for the plan.

***Other options***. Two years ago, the Budget & Control Board authorized a $25 monthly premium discount for state employees who don't use tobacco. Subsequently, they added a $40 to $60 surcharge for smokers. While it would be tempting to implement the same incentives/disincentives for obese employees, it would first be necessary to determine what methodology would be used to calculate these discounts/fees. This problem raises deeper questions regarding the state's approach to health care. To begin with, the legislature should not be in the business of requiring coverage mandates. Such mandates have increased the cost of health insurance in South Carolina by as much as 30 percent and eliminating them would open up new, and cheaper, markets for health insurance. In addition, it's worth asking whether the state should be in the insurance business altogether. Perhaps it's time to look at privatizing the State Health Plan. In the meantime, why not create a pilot program that allows state employees to purchase mandate-free insurance on the private market?

*Conclusion*

A bariatric surgery mandate for the State Health Plan is likely a first step toward requiring such coverage for all private policies. The added costs (1 percent to 3 percent increased premiums) would primarily be borne by small businesses and their employees because such mandates do not apply to large firms that self-insure under the Employee Retirement Income Security Act (ERISA). Better than a coverage mandate is to let private employers and insurers decide on their own whether to cover bariatric surgery. If the procedure proves to be a cost-effective means for treating obesity, private insurance companies will begin to cover it – without the state requiring them to do so.