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BULLETIN
OMC 2005-03

TO: **All Health Maintenance Organizations Doing Business in New Jersey**

FROM: **Marilyn Dahl, Deputy Commissioner, New Jersey State Department of Health and Senior Services** ***/s/ MD***

DATE: **June 30, 2005**

RE: **Bariatric Surgery and Weight Reduction Services**

The Department of Banking and Insurance (DOBI) has brought it to the attention of the Department of Health and Senior Services (Department) that some health maintenance organizations (HMOs) have recently submitted policy form filings that include limitations or exclusions of coverage for bariatric surgery, or that would establish cost-sharing for the expenses related to bariatric surgery that are above and beyond the cost-sharing requirements established for other treatments under the policy, or that otherwise significantly limit or exclude benefits for weight loss programs. While not taking a position with respect to the pros and cons of bariatric surgery, or any specific weight loss treatment, the Department is issuing this bulletin to provide further guidance to HMOs regarding those services that HMO policies generally must cover, and the conditions for such coverage.

In accordance with N.J.S.A. 26:2J-2, a "health maintenance organization" is defined to mean an entity that furnishes at least basic health care services. The term "basic health care services" is defined at N.J.S.A. 26:2J-2 to mean emergency care, inpatient hospital and physician care, and outpatient medical services as specified by the Department. N.J.S.A. 26:2J-4.3 further states that basic health care services include surgical services. All HMOs are required to provide at least basic health care services in order to maintain a certificate of authority (N.J.S.A. 26:2J-4.2).[1] The Department has promulgated rules at N.J.A.C. 8:38-5 providing more detail regarding basic health care services. Specifically, the rules at N.J.A.C. 8:38-5.2(a)14 state that HMOs must provide inpatient hospital care, physicians' and surgeons' services, anesthesia, diagnostic services and therapeutic services, among many other things. In other words, HMOs are required to cover costs related to surgery on an inpatient basis.[2]

The Department's rules never specifically mention bariatric surgery, or any other type of surgery. Nevertheless, HMOs are required to cover bariatric surgery just as HMOs would cover any other surgery. That is, the HMO may impose a requirement that bariatric surgery be medically necessary, that the specific surgery not be experimental or investigational, and that the candidate for the surgery meet

[1] The Department is not disputing the right or obligation of HMOs to offer one or more policies in certain markets providing services that may not be entirely consistent with the standards of N.J.S.A. 26:2J-1 et seq., and rules promulgated pursuant thereto, when statutory requirements for participation in those markets essentially necessitates the offering of health benefits plans that may include lesser coverage.
[2] HMOs also are required to cover outpatient surgical care pursuant to N.J.A.C. 8:38-5.2(a)15.

appropriate clinical criteria and protocols. However, HMOs are not authorized to simply exclude coverage of bariatric surgery. Further, the Department reminds HMOs that they must always comply with N.J.A.C. 8:38-8 in developing or relying upon clinical criteria and protocols, and in making utilization management determinations. Among other things, this means that the HMO must periodically review its criteria and protocols, and make changes to them when appropriate.[3]

Traditionally, the Department has not been prescriptive about how coverage is to be offered, and the Department is not inclined to be prescriptive now. However, with respect to the issue of cost-sharing requirements, the Department's position is that the cost-sharing requirement should not be of such a nature that it makes the coverage meaningless. Furthermore, the offer of the coverage for bariatric surgery should not be done in such a way as to effectively prevent access to services. For instance, the Department is hard-pressed to imagine an offering to cover the costs related to treatment of bariatric surgery through a rider that would actually be affordable for either group or nongroup purchasers, effectively making access to the services illusory.

With respect to coverage of weight loss programs, the Department is reminding HMOs that HMOs are obligated to provide supportive services in accordance with N.J.A.C. 8:38-5.4, including nutritional education and counseling, medical social services and preventive health services. Further, the Health Wellness Promotion Act, variously codified, including at N.J.S.A. 26:2J-4.6, requires HMOs to provide coverage for certain services that may be related to weight control. Rules promulgated by DOBI regarding this subject matter specify at N.J.A.C. 11:22-2.3(a)8 that carriers must cover an annual consultation with a health care provider to discuss lifestyle behaviors that promote health and well-being including nutrition and diet recommendations, exercise plans, and weight control. The coverage may be limited to the dollar amounts established by law for categories of members for the health wellness coverage package. Thus, while HMOs may not be required to provide extensive coverage of all weight reduction services, HMOs typically must provide some coverage of services related to weight reduction or control.

Questions regarding this bulletin may be directed to Sylvia Allen-Ware, Director of the Office of Managed Care, by email at Sylvia.Allen-Ware@doh.state.nj.us, by facsimile at (609) 633-0807, or by phone at (609) 633-0660. Questions specifically regarding the interpretation of N.J.A.C. 11:22-2 should be directed to DOBI.

[3] The Department recognizes that national standards on this subject are limited. The National Institute of Health issued guidelines in 1991, and there is some discussion of the issue for Medicare in its National Coverage Determination Manual. Currently, the only surgical treatment for obesity that is covered by a National Coverage Determination for Medicare is gastric bypass, and further, treatment of obesity is otherwise limited to services that are an integral and necessary part of a course of treatment for an enumerated set of medical conditions, pursuant to Sec. 40-5 (2004) of Medicare's National Coverage Determination Manual. Pursuant to a request, the Centers for Medicare and Medicaid Services (CMS) has solicited comments (through June 24, 2005) regarding whether it may be appropriate for these government programs to cover a broader array of bariatric surgical procedures. CMS expects to issue a proposed decision in November of 2005.