Approved: 01/23/08
Date

MINUTES OF THE SENATE PUBLIC HEALTH AND WELFARE COMMITTEE

The meeting was called to order by Chairman James Barnett at 1:30 P.M. on January 17, 2008 in Room 136-N of the Capitol.

All members were present.

Committee staff present:
Terri Weber, Kansas Legislative Research Department
Sara Zafar, Kansas Legislative Research Department
Nobuko Folmsbee, Revisor of Statutes
Jan Lunn, Committee Secretary

Conferees appearing before the committee:
Justin Cessna
James Hamilton, MD, FACS - Surgeon, Tallgrass General and Vascular Surgery
Robert St. Peter, MD - Kansas Health Institute
Candace Ayars, PhD - Interim Director Public Health Studies of Kansas Health Institute
Brad Smoot - Legislative Counsel, Blue Cross and Blue Shield
Scott Weber, MD - Medical Director, Blue Cross and Blue Shield
Andy Allison, PhD - Kansas Health Policy Authority

Others attending:
In addition to the attached list there were approximately other 42 attendees with newspaper and television media representatives attending.

Informational Hearing on Bariatric Surgery

Chairman Barnett introduced Justin Cessna who appeared before the committee to request help with his concerns related to his medical need for bariatric surgery and the denial of benefits for weight loss procedures regardless of medical necessity by his insurance company. Mr. Cessna's testimony is attached to these minutes as a matter of record. (Attachment 1).

Chairman Barnett requested that all testimony be heard prior to questions. Chairman Barnett recognized James Hamilton, MD, who spoke to the fact that bariatric surgery is a disease, is a covered benefit for qualified Medicare recipients when performed at Bariatric Centers of Excellence, can reduce co-morbid conditions, and can reduce long-term medical costs. Dr. Hamilton spoke from two perspectives: one, as a surgeon who provides this procedure, and two, as an individual who has had bariatric surgery. Dr. Hamilton's testimony and substantiating literature is attached and is incorporated into this record. (Attachment 2)

Robert St. Peter, MD, from the Kansas Health Institute was recognized by Chairman Barnett. Dr. St. Peter introduced Candace Ayars, Interim Director Public Health Studies of Kansas Health Institute and an obesity epidemiologist, who provided testimony regarding the long-term efficacy of bariatric surgery performed by experienced surgeons following rigorous patient screening. Dr. Ayars testimony (Attachment 3) is incorporated into these minutes.

Brad Smoot, Legislative Counsel for Blue Cross and Blue Shield, was introduced by Chairman Barnett. Mr. Smoot provided comments related to insurance coverage for bariatric surgery, indicated associated complications and varying reports of death rates are reasons why many insurers exclude coverage for weight loss surgeries.. Mr. Smoot's testimony (Attachment 4) is included and considered to be part of this record. Mr. Smoot introduced Dr. Ralph "Scott" Weber, Medical Director for BCBSKS who stood for questions.

Chairman Barnett recognized Andy Allison, PhD, Deputy Director of the Kansas Health Policy Authority. Dr. Allison submitted testimony (Attachment 5) which shall become part of this record. Dr. Allison reported that effective January 2008, the state employee health plan includes coverage for non-surgical obesity treatment, dietician consultations, and expanded coverage for prescription weight loss medications. He indicated an explosion in obesity research has occurred involving knowledge of quality indicators and continued advancement in procedures, etc.

MINUTES OF THE Senate Public Health and Welfare Committee at 1:30 P.M. on January 17, 2008 in Room 136-N of the Capitol.

Medicare but not by other health plans, whether bariatric surgery is considered to be experimental by insurance companies, self-insured groups and small-group markets, and whether studies exist related to long-term efficacy of this procedure.

Written testimony submitted:

Cynthia K. Smith, JD, Advocacy Counsel, Sisters of Charity of Leavenworth Health System (Attachment 6)

Ira Stamm, PhD (testimony received after the meeting but circulated to Committee members on January 18, 2008) (See Attachment 7)

Chairman Barnett indicated continued work in the arena of bariatric surgery will occur through the Public Health and Welfare Committee, conferees, and others who are interested.

The meeting was adjourned at 2:30pm

SENATE PUBLIC HEALTH AND WELFARE COMMITTEE GUEST LIST

DATE: January 17, 2008

NAME	REPRESENTING
Dr. James Hamilton	Bariatric Surgeon our patients Tallgrass Surgical Center, Turning point Weight Loss solutions, St. Francis Hosp.
Nancy Henry	Tallgrass Surgical Center
Michelle Peterson	Capitol Strategies
Jamie Slack	federico Consulting

Justin Cessna
1321 N. Sheridan #102
Wichita, KS. 67203
(316) 945-8694

Testimony before the Senate Public Health and Welfare Committee

1/17/2008

I would like to begin by thinking the Honorable members of the Senate Public Health and Welfare Committee for allowing me to testify at this hearing and especially Senator Jim Barnett for answering my letter and giving me this opportunity to share my story.

My name is Justin Cessna I am a 44 year old proud life long Kansan born and raised in McPherson and now reside in Wichita. I have been married to the love of my life (Karen) 24 years this April. Together we have three children and two grandkids that have become the greatest joy of my life. I am also proud to have served my country as veteran of the United States Air Force.

In my late 20's I began my struggle with obesity, a genetic trait prevalent in my extended family. Over the years I have done everything I can to aggressively treat my obesity medical condition with diets, exercise and weight loss related medicines using physicians, dietitians, counselors, and personal trainers with only marginal success over the last 18 years.

Eight years ago I started to seriously investigate the Lap Band surgical procedure, which is a minimally invasive bariatric weight loss surgery with outstanding results, because exercise was becoming harder due to pain from arthritis. After all my efforts I was getting no beneficial results. At that time my weight ranged from 320 to 380 pounds at its highest point. I was a diabetic with poor control; I had high blood pressure and high cholesterol. All serious health risks

I contacted my companies' health insurance provider at the time to inquire about this surgery. They told me that they do not pay for this surgery explaining to me that they have a ***"written***

exclusion" in their policy's that states they will not pay for weight loss related medical procedures. I was discouraged but continued to fight my weight problem with my physician's help who had me on a low carb diet. When this diet failed with nominal results I began to rapidly regain the weight, which is a very common result of ending restrictive diets, only this time my weight climbing to over the 400 pound and my obesity related problems began to quickly worsen.

Seeing the deteriorating state I was in my Primary Care Physician Dr. Brooks then wrote a ***Letter of Medical Necessity*** to my insurance company and I saw a Bariatric surgeon in Overland Park, KS who preformed Lap Band weight loss surgeries. I sent in the letters from both doctors to Blue Cross Blue Shield for approval to resolve my increasingly dire co-morbid medical conditions.

Blue Cross Blue Shield of Kansas denied benefits despite my Doctor's Letters of Medical Necessity for the same reasoning stating that their policy's have a written exclusion for this type of procedure regardless of medical necessity. I appealed and also wrote at that time to the Governor of Kansas and Insurance Commissioner. In a letter sent to the Insurance Commissioner office, Linda Liggett of Blue Cross Blue Shield of Kansas stated that "It is the position of BCBS, based on medical studies that there are no long term outcome studies showing that any of the current obesity treatments are permanent. This was an astonishingly dishonest statement. My first though after reading this statement was; "permanent! So if I have cancer you would not treat me because the cancer could come back?" I know they don't use this argument for any other life threatening medical conditions so why are they allowed to discriminate against people who are morbidly obese.

In June of this year after my weigh climbed to an astounding 430 pounds due in part to diabetic medication which causes weight gain I suffered the devastating condition of ***Congestive Heart Failure***. My Cardiologist (Dr. Ashcom) and Diabetic Physician (Dr. Bloom) tell me that without serious weight loss my life will be significantly shortened and they both agree that Lap band surgery is the only medical option left. With a five year mortality rate for Congestive Heart Failure at 25%, and me being at the highest risk because of the weight, Dr. Bloom tried to convince Blue Cross Blue Shield of Kansas that this surgery is a matter of life and death in a letter written 8/13/07. Again Blue Cross Blue Shield of Kansas denied benefits.

I CAN NOT FOR THE LIFE OF ME UNDERSTAND HOW IS THIS POSSIBLE? I now have the following Medical Co-Morbid conditions related to my Morbid Obesity: Congestive Heart Failure, uncontrolled Type II diabetes, High Blood Pressure, Depression, Obstructive Sleep Apnea, Osteoarthritis, High Cholesterol, Acid Reflux Disease and Nocturnal Hypoxia. I take 10 different prescriptions and use a CPAP Machine for the Obstructive Sleep Apnea. I am in constant pain, I feel hopeless, scare, mad and hurt that after working and paying into health insurance since I was 18 years old now that I have a life or death illness My Health insurance company BCBS will not pay for the surgical treatment that will save my life. Treatment Dr. Bloom wanted me to point out they (meaning the Doctors who have treated me and written the Medical Necessity letters) do not financially benefit from.

My Type II Diabetic is poorly controlled. Congestive Heart Failure will continue to weaken my heart to the point that the only option will be a heart transplant in which I would not be a candidate because of my obesity. I am constantly afraid I will wind up disabled unnecessarily so for lack of a simple surgery. I under went an MRI just last week because I could not walk for three days due to agonizing hip pain. X rays taken at my doctors' office showed the arthritics in my hip joint to be bone on bone.

A Rand Corp. study published in the 2004 journal Health Affairs found the number of people age 30-49 who could not care for themselves or do other routine tasks increased by more than half from 1984 to 2000 due to the rise in obesity. I pride myself on being a productive member of society. To become disabled and a burden on the state would be devastating to me.

It is unbelievable that in 2008 insurance companies are allowed to discriminate against the obese. In the last twelve months Blue Cross Blue Shield has paid $11,200 (their cost) in medicine alone and another 12,235 (their cost) in hospital and doctor bills. That is an astonishing $23,435.00 all together. This year alone would have more than paid for the surgery and had they approved the lap band surgery when I requested it to begin with I wouldn't have had to suffer Congestive Heart Failure. Yet BCBS is more than willing to put out this amount of money year after year. This makes absolutely no since at all.

I turn to you because I need help and fast! I am desperate! I do not want to die prematurely. I want to live and see my grandkids grow up. My family is distraught and I hate to watch them

suffer because of my completely reversible health problems. A study inclosed with this testimony from the Baritric edge which is a Johnson and Johnson Company shows that after bariatric surgery a 76.8% complete resolution in type II diabetes and 86 % total found improvement or resolution, 92% Resolution of High Blood Pressure, 93% improvement in cholesterol, 90% resolution in arthritis, 85.7% resolution in sleep Apnea, and 98% resolution in Acid Reflux.

I hope you will be able to help the dilemma of the morbid obese with common sense legislation. I have included copies of my Doctor's Medical Necessity Letters and some facts about Bariatric Surgery off of the Bariatric Edge web site. If you need any other information please do not hesitate to ask. I look forward to hearing from you and I thank you for your time.

ETHICON ENDO-SURGERY, INC.
a Johnson & Johnson company
BARIATRIC EDGE℠

Type 2 Diabetes

How is it affected by bariatric surgery?
Patients who had gastric bypass surgery had lower insulin resistance. Their risk for metabolic syndrome, high blood pressure, and high amount of fats in the blood also decreased. ***In fact, a landmark study found that resolution of diabetes often occurred days following gastric bypass surgery, even before marked weight loss was achieved.***

What success have patients found through bariatric surgery?
A recent meta-analysis shows ***76.8 percent*** of gastric bypass patients found complete resolution of type 2 diabetes, and 86 percent found improvement or resolution. Many gastric bypass surgery patients with type 2 diabetes have demonstrated little or no need for continuing medication.

High Blood Pressure/Heart Disease

What success have patients found through bariatric surgery?
A recent meta-analysis showed hypertension was resolved or improved in 78.5 percent of patients. A study of 500 patients showed 92 percent resolution of hypertension.

High Cholesterol

What success have patients found through bariatric surgery?
Recent research on the impact of gastric bypass surgery found that hyperlipidemia and hypercholesterolemia were improved in more than 93 percent of patients.

Osteoarthritis

What success have patients found through bariatric surgery?
A recent study of 500 patients showed a 90 percent resolution of arthritis among surgical patients.

Depression

What success have patients found through bariatric surgery?
Patients who have had bariatric surgery report improved quality of life, social interactions, psychological well-being, employment opportunities, and economic condition. Psychological screening before surgery may help prepare you for the changes that come with surgery, and help you set realistic goals and expectations

Sleep apnea

What success have patients found through bariatric surgery?
Recent research found that obstructive sleep apnea was resolved in 85.7 percent of patients through gastric bypass surgery.

Acid Reflux

A 2000 study of 500 patients showed complete resolution of GERD in 98 percent of patients. While there is anti-reflux surgery, it fails more often in people with morbid obesity and only addresses one co-morbidity. Another study found that all participants who had gastric bypass surgery reported an improvement in or no symptoms of GERD.

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Kyle W. Brooks, MD
Craig R. Parman, MD

June 21, 2006

BlueCross BlueShield of Kansas
1133 S.W. Topeka Boulevard
Topeka, KS 66629-0001

RE: Justin Cessna (DOB: 08/06/1963)
ID # XSB880841821
Group # 0900701

Letter of Medical Necessity

Request for Pre-approval for Lap Band Surgery (CPT Code 43770 for ICD-9 code 278.01)

To Whom It May Concern:

Mr. Cessna has been a patient of mine for the last four years. Justin is 5'11" in height and weighs 410 lbs. with a BMI of 57.2. Justin has been extremely overweight for the past 16 years and I believe he will benefit significantly from Bariatric lap band surgery.

In addition to morbid obesity, Justin is suffering from the following co-morbid conditions: hypertension, diabetes mellitus type II, osteoarthritis, hyperlipidemia, shortness of breath, swelling and numbness in the lower extremities and many quality of life problems.

Justin is dreadfully aware the health risks associated with morbid obesity and rightly believes his very life is in grave danger. I believe he has done his absolute best in trying to control his weight. In his efforts to resolve his weight problem Justin reports having tried many methods of weight loss over the years including the use of Redux diet pills in the later part of 1996 for several months until it was pulled from the market. Justin's medical

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records revealed that he lost 40 lbs during this time but regained all the weight after having to stop the treatment. Other methods reported include: seeing a therapist for food addiction, exercise using a personal trainer, numerous over-the-counter diet pills, Slim-Fast drinks, protein shakes, low-fat diets, low-calorie diets, nutritional therapists, packaged diet meals, self-help diet books, meditation and subliminal diet tapes.

I placed Justin on the Akins diet on April 4, 2003. He did well for the first 16 months and initially lost 61 lbs. going from 383 lbs to 322 lbs. before hitting a plateau. Justin was discouraged and frustrated having never being able to get off the induction phase of the diet without gaining weight. Failing to maintain the stringent diet restrictions he regained all of the weight after 2 years and now weighs an additional 27 lbs. more than when he initially started the diet. Due to the increasing weight gain over the past year his lab work revealed that his diabetes and hyperlipidemia were uncontrolled. Lab work done on November 11, 2005 showed his Hemoglobin A_{1c} at 10.2% with total cholesterol 367 and triglycerides of 496. On February 2, 2006, his Hemoglobin A_{1c} at 10.8%. On May 23, 2006 showed his Hemoglobin A_{1c} at 10.3% with total cholesterol 329 and triglycerides of 304.

Justin is also limited in his ability to exercise due to his morbid obesity and co-morbidities but has tried to do some walking. He does have a moderately physical job where he is on his feet for about 8 to 9 hours a day.

Justin is currently on the following prescribed medications: Prandin, Actos, Tricor, Niaspan, Metformin, Zestril, Cozaar, and Byetta. Because of the rising cost of medications this surgery could potentially benefit him to be off all prescribed medications.

Family medical history includes positive for the following conditions: morbid obesity, heart disease, hypertension, diabetes, osteoarthritis, rheumatoid arthritis, hyperlipidemia, sleep apnea and degenerative joint disease on both sides of the family.

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According to the National Institutes of Health (NIH) in its 1991 Consensus Conference on "Gastrointestinal Surgery for Severe Obesity" a man with a BMI of 40 and higher is morbidly obese and at this level mortality rates increase. Patients whose BMI exceeds over 40 may be surgery candidates if they strongly desire substantial weight loss. In fact weight loss surgery is endorsed by the NIH as the only effective treatment for morbid obesity. Bariatric surgery is not cosmetic surgery. It is a major surgery performed on extremely large patients whose obesity puts them at risks for complications and possible death.

According to the BlueCross and BlueSheild Association Technology Evaluation Center Special report states *The relationship between weight loss and changes in morbidity following bariatric surgery for obesity.* September 2003 www.bcbs.com/tec/vol18/1809.html "Surgery improves health outcomes for patients with morbid obesity as compared to non-surgical treatment."

In my medical opinion this surgery is not only medically necessary but a LIFE SAVING PROCEDURE. It is extremely unlikely that Justin could ever lose significant enough weight without this surgery. I am respectfully requesting pre-authorization for Bariatric lap band surgery. I feel this is the ONLY solution for PERMANENT weight loss and elimination of future health concerns due to morbid obesity, as well serving to keep current health conditions from worsening.

Obesity has been shown to directly increase healthcare costs. In an article in the March 9, 1998 issue of the Archives of Internal Medicine, 118 members of the Kaiser Permanent Medical Care Program were studied to determine the association between body fatness and healthcare costs. The results showed that patients with BMI greater than 30 were at 2.4 times at greater risk for increased inpatient and outpatient costs than patients with BMI below 30.

It can be expected that Justin will continue to gain weight an the costs of co-morbid conditions, including the ones he already has and/or will surely acquire as time goes on, will far outweigh the costs of lab band surgery that

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I am asking for approval of this surgery. To wait any longer would put the patient as risk for increasing complications.

I trust this information will aid you in understanding the severity of Justin Cessna's case and will help in facilitation of the correct assessment. If you have any other questions or concerns, please do not hesitate to contact me.

Sincerely,

Lyle W. Brooks M.D.

1-10

Malley Surgical Weight Loss Center

5820 Lamar Ave, Ste. 200 Mission, KS 66202 (913) 492-2530 Fax # (913) 492-2576

*****PRE DETERMINATION REQUEST*****

Procedure: Adjustable Lap Band, CPT Code 43770
Band Adjustments, CPT Code 90779

August 10, 2006

BCBS of Kansas

Attention: Medical Review Department

Re: Justin Cessna
ID#:XSB880841821
Grp#: 0900701

Dear Review Board:

I am writing on behalf of the above referenced patient to seek certification and preauthorization of insurance coverage for the LAP-BAND Adjustable Gastric Banding System to treat Morbid Obesity (CPT #43770). The procedure will be performed at Menorah Hospital as a 23-hour observation procedure.

This surgical procedure is medically necessary for the reasons set forth in this letter and, after careful discussion with this patient, we have determined that the listed procedure is medically appropriate for her multiple health problems.

This patient stands 5'11" tall and weighs 411 pounds which calculates to a body mass index of 57. Under the guidelines of the National Institutes of Health, this patient suffers from "morbid obesity" (ICD-9 code 278.01).

The 1991 NIH Consensus Conference convened to study bariatric surgery determined that surgical intervention is appropriate in persons with a BMI of 40 or greater. Surgery is also medically indicated for persons with a BMI of 35 or higher when serious co-morbid conditions are present or when a patient's weight interferes with normal life activities. The patient suffers from morbid obesity as well as:

Comorbitities:

Hypertension	**401.0**
Diabetes	**250.0**
Hypercholestolemia	**272.0**
GERD	**530.81**
Ankle, knee, and hip pain	**719.4**

Current medications:

Tricor
Niaspan
Prandin
Actos
Metformin
Byeta
Lisinopril
Cozaar
Rantidine

This patient has been evaluated by our surgical team and is found to be an appropriate candidate for this therapy. Surgical intervention has been demonstrated to provide the only effective therapy available for long term control of morbid obesity and its related diseases. The patient has a long term history of prior weight loss efforts that have not been successful in maintaining any significant weight loss or long term health benefits. These efforts include:

- Self Diets
- Fad diets such as Atkins and cabbage soup
- OTC medications such as Dexatrim
- Prescription medications such as Redux

BACKGROUND ON THE LAP-BAND SYSTEM AND TREATMENT RATIONALE

The LAP-BAND System is a less invasive procedure, adjustable, and reversible versus other bariatric surgeries. The LAP-BAND System is implanted laparoscopically and has the benefit of adjustability. It is a restrictive type of surgery that has been utilized quite successfully for many years. Because there is no bypass or stapling involved, the risk of serious complications is minimized and long-term results are quite impressive. The FDA approved the Pre-market Approval Application (PMA) based on demonstration of clinical safety and efficacy. The FDA has established very stringent labeling requirements for the use of this device, both from the standpoint of surgeons qualified to implant and adjust the device as well as identifying appropriate patients who may benefit from this therapy. I have undergone detailed product training in conformance with FDA labeling and my professional assessment is that this patient meets and/or exceeds all clinical indications requiring this therapy.

In addition, the American Society for Bariatric Surgery (ASBS) and Society of American Gastrointestinal Endoscopic Surgeons (SAGES) have established guidelines for the laparoscopic treatment of morbid obesity. The National Institutes of Health (NIH) published Clinical guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults document. The American College of Surgeons (ACS) has established recommendations for facilities performing bariatric surgery. The LAP-BAND System's FDA labeling for indicated use follows the guidelines set forth by these societies: severely obese patients with a BMI of at least 40 or a BMI of at least 35 with one or more severe co-morbid conditions, or those who are 100 lbs or more over their estimated ideal weight, and failure with more conservative weight reduction alternatives.

Also, the use of the LAP-BAND System adheres to these guidelines in that the patient meets the indications for surgery and understands its risks and benefits, and our bariatric center is able to provide appropriate, long term care of the patient.

Please confirm, in writing, that this procedure is authorized for reimbursement and that benefits are available. **Please include the rate at which these codes will be reimbursed at.** If you have any questions, feel free to contact us at 913-492-2530

Dr Stephen Malley
Tax ID# 134301573

Lamont Bloom, M.D. P.A.
Diabetes Medicine
406 E. Central
Wichita, KS 67202
1-316-265-0705 Phone
1-316-265-0785 Fax

August 13, 2007

BlueCross BlueShield of Kansas
1133 SW Topeka Blvd.
Topeka, KS 66629-0001

RE: Justin Cessna Member ID: XSB 880841821
Group Number: 0900701

To Whom It May Concern:

I have been treating Justin for his diabetes for approximately 9 months. His height is 5' 11" and a weight of 422 #, giving him a current **BMI of 58.9.**

He was being treated with Avandia, Metformin, Glyburide and Byetta. He was not getting the true GLP-1 effect from the Byetta, and for that reason I went off label with samples and tried Januvia in addition to the above regimen. He did get a short term GLP-1 effect on the combo of Byetta and Januvia, but this disappeared after about 4 weeks.

He then developed CHF, was hospitalized, and had a heart catheterization. At that point the Avandia was stopped, the Glyburide was stopped and he was started on insulin. As one would expect with his BMI, he is on greater than 200 units of insulin per day with substandard control of his diabetes. If we ever get the AIC down below 7.5%, I suspect his insulin dose will be in the 300-400 units per day.

I have read the excellent letters by Dr. Malley and Dr. Lyle Brooks. All that has happened in the last year was predicted by their letters.

At this juncture I have no successful way to treat his diabetes other than to attempt gastric bypass or lap banding. These modalities may not work, but an improvement in his BMI and therefore insulin sensitivity is the only option we have not tried. Justin has made multiple efforts at weight loss through other means. They have not been successful. It is not an exaggeration to say this is a matter of life and death.

If further specific information is needed to qualify him, please do not hesitate to call my office.

Sincerely,

Lamont Bloom, M. D.

1-14

Dr. James Hamilton, M.D., F .C.S.
Tallgrass Surgical Specialist
1/17/08

Senate Hearing on Bariatric (Weight Loss) Surgery

- Obesity is a disease!
  - Genetic factors
  - Cultural factors
  - Environmental factors
  - Behavioral factors
- Obesity is not:
  - A character flaw
    - Obese patients have the same psychiatric profiles as the overall population
  - A lack of willpower
    - Obese patients are frequently highly successful dieters, but lack the autoregulation to maintain weight.
- Failure to recognize obesity as a disease will lead to failure in our efforts to combat the societal epidemic of this disease.
- Diets don't work in the long term.
  - There is little data to support that dieting can sustain significant weight loss for more than 15% of patients for longer than 18 months.
  - If diets were pharmaceuticals, the FDA would not approve them because they are about as effective as the placebos in most pharmaceutical trials.
- Surgery is a safe, highly efficacious, cost effective treatment for obesity in educated, highly motivated, psychologically stable patients.
  - Bariatric Surgery reduces:
    - Cardiovascular mortality by 56%
    - Diabetes mortality by 92%
    - Cancer mortality by 60%
    - Overall mortality by 405
      - Adams, et al. U. of Utah, NEJM
  - Bariatric Surgery cures type II diabetes in 70% of patients!
  - Bariatric surgery is cost-effective
  - Bariatric surgery is now a covered benefit for qualified Medicare recipients when surgery is performed at Bariatric Centers of Excellence
- Barriers to treatment
  - Societal bias against the obese
  - Failure of government and insurance to recognize obesity as a disease
  - Lack of insurance coverage for treatment, especially for bariatric surgery
- Personal Comments
  - Laparoscopic Roux-en-Y gastric bypass in August 2005
  - Lost 80 lbs
  - No longer hypertensive, no longer have metabolic syndrome, no longer have sleep apnea (required CPAP before surgery)
  - Now climb mountains and have a new life!
  - Paid $27000.00 in cash as my insurance (BCBS of KS) does not cover weight loss surgery.

        - BCBS of KS refused to write a policy at any price to cover this surgery as a benefit to our employees when we requested them to do so.
        - BCBS of KS has failed as a Medicare intermediary and as an intermediary for other BCBS plans in processing claims for bariatric surgery for those who have it as a covered benefit.
- Bariatric surgery
    - Is best performed in a comprehensive program which often includes
        - Pre-operative screening and education
        - Operative excellence with experienced surgeons who perform laparoscopic and open procedures tailored to patient needs
        - Designation as a Bariatric Center of Excellence by the SRC or the American College of Surgeons
        - Long term post operative follow-up to maintain weight loss and prevent nutritional deficits

Effectiveness of Bariatric Surgery

Health and Welfare Committee

Topeka, Kansas • January 17, 2008

Candace Ayars, Ph.D.
Interim Director of
Public Health Studies
Kansas Health Institute

Introduction

- Morbid obesity (Class III) is a major public health problem and bariatric surgery has superior outcomes compared to other interventions for this *qualified* population when performed by *experienced* surgeons.
- Medicare and Medicaid recognize obesity as a disease and provide coverage for bariatric surgery.

What is Bariatric Surgery?

- Adjustable Gastric Banding
  - "lap band"
  - Maybe performed laparascopically
  - Reversible
  - Fewer complications; faster recovery
- Roux en Y
  - "gastric bypass"
  - Performed with open abdomen
  - Requires vigilant follow-up

Qualified Population

- Class III Obesity (BMI > 40)
  - Tripled in the last 20 years
  - BMI > 50 increased five fold
- Class II Obesity (BMI > 35) with comorbid conditions
- Multiple health problems, usually taking multiple drugs
- May be as high as 10 million persons
  - ~ 100,000 Kansans
- Twice as high in women
- 15% of African American women

Surgeon Experience

- Minimum:
  - 50 laparascopic + 15 open procedures under the supervision of an experienced surgeon
- Experienced surgeon = 200 bariatric procedures
- Perform 50 surgeries per year
- Perioperative management experience beyond standard 90 days
- Working within a Center of Excellence (125 surgeries per year) that provides integrated follow-up care

Economic Impacts of Obesity

- 9.1% of annual medical costs
- Compared to normal weight individuals:
  - 36% higher medical
  - 77% higher pharmacy
  - Men: $670/year more
  - Women: $1200/year more
  - Disabled, obese: $51,023/year

Expected Economic Impacts of Bariatric Surgery

- Average surgical cost: $30-40,000 (without complications)
- Cost with complications: up to $70,000
- Recovery of costs may take several years.
- Patients require lifelong follow-up.
- 25% will regain lost weight.
- Economic impacts may be decreased by insurance coverage of drug therapy for Class I Obesity.

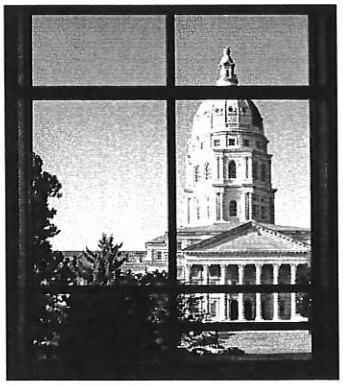
Potential Advantages

- Rapid weight loss
- Reduction of chronic diseases
- Improve patient psychology
- Increase life expectancy for the qualified population

Conclusion

Bariatric surgery should be performed in a Center of Surgical Excellence by experienced surgeons and only after rigorous screening criteria have been applied to patients.

Kansas Health Institute



Information for policy makers. Health for Kansans.

3-5

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Statement of Brad Smoot, Legislative Counsel
Blue Cross Blue Shield of Kansas
Blue Cross Blue Shield of Kansas City
Senate Public Health & Welfare Committee
January 17, 2008

Chairman Barnett and Members:

Thank you for the opportunity to appear before you at this informational hearing on insurance coverage for bariatric surgery. Blue Cross Blue Shield of Kansas provides group and individual health insurance products in 103 Kansas Counties and Blue Cross Blue Shield of Kansas City provides coverage for the Western half of Missouri and the counties of Johnson and Wyandotte in Kansas. Together these two companies serve approximately one million of your fellow Kansans.

Obesity has reached epidemic proportions in the United States, raising alarms about the health risks, diseases and corresponding health care costs associated with excessive weight. It has been a topic for much discussion at the meetings of the Kansas Health Policy Authority as the KHPA has been developing its health reform proposals.

Weight loss surgery is risky with published reports citing complications in 4 or every ten surgeries and varying reports of death rates of 1 in 50 to 1 per 100. It is a procedure that can only be performed by specially trained physicians at specially equipped hospitals. Apparently, there were more than 177,000 such surgeries in the U.S. last year including several hundred performed on children. And while there are potential benefits of the surgery for many patients, most carriers have a long history of excluding coverage for weight loss surgery.

Both Blue Cross Blue Shield plans I represent specifically exclude coverage for weight loss surgeries and I believe you will find that most other health insurers do also. We can and do provide coverage for large self funded employers (referred to as Administrative Services Only or ASO groups) who specifically request that the ordinary exclusion be deleted from their policy. This request is rare. It is my understanding that neither the Kansas state employees plan nor Medicaid/SCHIP covers the procedure.

Dr. Ralph "Scott" Weber, Medical Director for BCBSKS has joined us today to respond to the Committee's questions on our coverage for obesity surgery. Thank you.

KHPA
Kansas Health Policy Authority

Coverage of Bariatric Surgery in the State Employee Health Plan and Medicaid

Andrew Allison, PhD,
Deputy Director, Kansas Health Policy Authority

1

History

- Prior to Plan Year 2008, all treatment for obesity was excluded from coverage under the SEHP
- Medicaid reimbursed for weight-loss medications but excluded coverage for bariatric surgery
- The HCC considered coverage for bariatric surgery in 2006
- Consistent with KHPA initiatives in the area of prevention and wellness, HCC decided to cover preventive and non-invasive obesity treatments for 2008 under SEHP

2

SENATE PUBLIC HEALTH AND WELFARE
DATE: 01/17/08
ATTACHMENT: 5

HCC Review of Bariatric Surgery in 2006

- Findings:
  - Preventive, non-invasive treatment not covered at that time
  - Relatively high incidence of complications and even death
  - Morbidity and mortality vary considerably with experience of surgeon and hospital
  - No Centers of Excellence in Kansas
  - Long-term cost-effectiveness not yet demonstrated

3

HCC Review of Bariatric Surgery in 2006

- KHPA Staff Recommendations for SEHP:
  - Educate consumers on available options for promoting wellness and addressing weight problems
  - Review SEHP plans for 2008 to examine possible expansion in preventive benefits
  - Review HealthQuest program to consider initiatives in the following areas:
    - Physician-supervised weight management
    - Behavior modification
    - Health eating
    - Exercise
  - SEHP and Medicaid Staff review of bariatric surgery exclusion
    - Retain exclusion of bariatric surgery

4

SEHP Changes in 2008

- Provide coverage for non-surgical treatment of obesity
- Expanded coverage for consultation with a dietitian
  - Coverage not limited to diabetics
- Added coverage for prescription weight loss medications

5

HealthQuest for 2008

- Healthy Lifestyle Programs Includes:
  - Healthy eating and weight management information
  - Health coaches to provide ongoing support
  - Teleclass: Healthy Weight
  - Online class and tools

6

Medicaid

- Continues to provide reimbursement for prescription weight-loss medications with prior authorization
- Provides for reimbursement for medical nutrition therapy for children under KanBeHealthy

7

New Developments

- Kansas now has two Centers of Excellence for bariatric surgery as designated by the American Society for Bariatric Surgery
- CMS has 3 certified centers in Kansas to provide bariatric services to Medicare beneficiaries
  - Limited geographic area
- Continued increase in insurance coverage and prevalence of bariatric surgery
- Explosion in research
  - Emerging evidence of the positive health impact for the extremely obese
  - Continued advancement in procedures and knowledge of quality indicators

8

Additional Considerations

- Estimated cost of coverage for SEHP: $13 million dollars
  - Estimate depends on pre-certification requirements
- Additional costs of coverage in Medicaid

9

Kansas Health Policy Authority Board

Health Reform Recommendations

UPDATED

January 10, 2008

PREPARED BY:

KHPA
Kansas Health Policy Authority
Coordinating health & health care for a thriving Kansas

5-6

Executive Summary

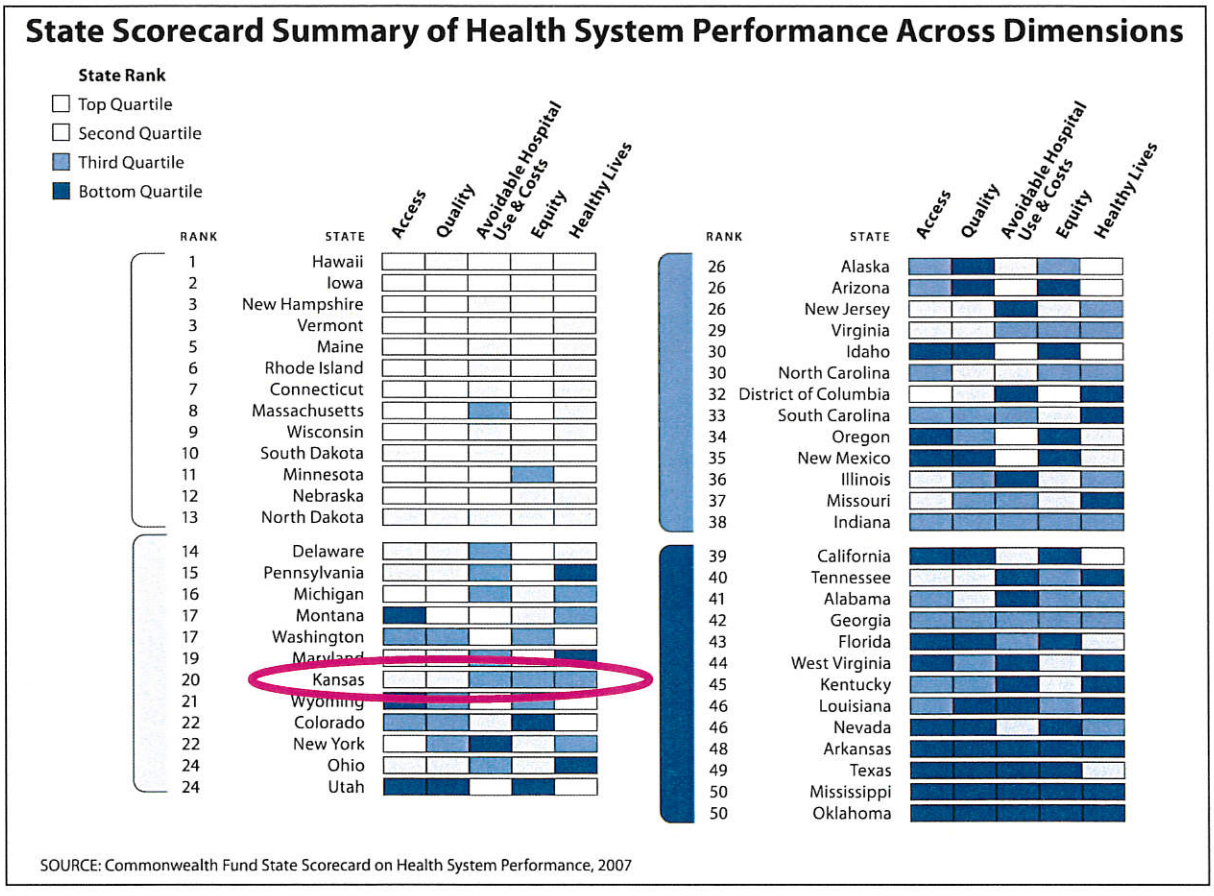
Background

The current health system in Kansas and the nation face many challenges. Health care costs continue to rise at an unsustainable rate, the health system is inefficient and fragmented, and the health status of many Kansans is at risk. From the perspective of health system performance, Kansas currently ranks 20th in the nation[1] – we can and should do better (Figure 1). The goals of the health reform recommendations described in this report are twofold: 1) to begin the *transformation* of our underlying health system in order to address the staggering rise in health care costs and chronic disease, as well as the underinvestment in the coordination of health care; and 2) to provide Kansans in need with affordable access to health insurance. Taken together, these reforms lay out a meaningful first step on the road to improve the health of Kansans, and we respectfully submit them to the Governor and Legislature for their consideration.

These health reform recommendations were requested by both the Governor and the Legislature. During the 2007 legislative session, the Kansas Legislature passed House Substitute for Senate Bill 11 (SB 11), which included a number of health reform initiatives. This Bill passed unanimously by both the House and Senate, and was signed into law by the Governor. In addition to creating a new "Premium Assistance program" to expand access to private health insurance, the Bill directed the Kansas Health Policy Authority (KHPA) to develop health reform options in collaboration with Kansas stakeholders.

The health reform recommendations described herein are the result of deliberations of the KHPA Board, four Advisory Councils (140 members), a 22 community listening tour, and feedback from numerous stakeholder groups and other concerned citizens of Kansas – over 1,000 Kansans provided us with their

Figure 1



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

*For more information about the Study, go to http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=494551

advice and suggestions. In addition, four Kansas foundations – the United Methodist Health Ministry, the Sunflower Foundation, the REACH Foundation, and the Health Care Foundation of Greater Kansas City – funded an independent actuarial and policy analysis of various health insurance models as well as the coordination of the four Advisory Councils. The modeling was instrumental in the development of the health insurance recommendations offered by the KHPA Board, and a separate document describing these models is available through the United Methodist Health Ministry Fund (www.healthfund.org).

These health reform recommendations represent just one of the many chapters required to write the story of improved health and health care in Kansas. Ultimately, the solution for our fragmented health system requires leadership at the federal level. However, the state of Kansas should debate and embrace reform solutions that can help our citizens right now. Additional policy issues – such as health professions workforce development, and a focus on the safety and quality of care – must also be addressed in subsequent health reform proposals over the course of the coming months and years.

PRIORITIES

Kansas established three priorities for health reform:

1) ***Promoting Personal Responsibility*** – for healthy behaviors, informed use of health care services, and sharing financial responsibility for the cost of health care;
2) ***Promoting Medical Homes and Paying for Prevention*** – to improve the coordination of health care services, prevent disease before it starts, and contain the rising costs of health care; and
3) ***Providing and Protecting Affordable Health Insurance*** – to help those Kansans most in need gain access to affordable health insurance.

The combination of these health reforms helps to improve the health status of Kansans, begins to contain the rising cost of health care in our state, and improves access to affordable health insurance.

The table below outlines the reform priorities recommended by the KHPA Board on November 1, 2007. Those policy initiatives identified as high priority are marked by an asterisk.

SUMMARY OF REFORM RECOMMENDATIONS

Promoting Personal Responsibility (P1)		
Policy Option	**Population Served**	**Estimated Cost**
Improve Health Behaviors. Encourage healthy behaviors by individuals, in families, communities, schools, and workplaces. **(Policies listed under P2)**		
Informed Use of Health Services		
***P1 (1) Transparency for Consumers: Health Care Cost & Quality Transparency Project**. Collect and publicize Kansas specific health care quality and cost information measures which will be developed for use by purchasers and consumers	All Kansans with access to the Internet (or access to public libraries)	$200,000 State General Fund (SGF) for Phase II of the Transparency project
***P1 (2) Promote Health Literacy.** Provide payment incentives to Medicaid/HealthWave providers who adopt health literacy in their practice settings	Medicaid/HealthWave enrollees under care of these providers	$280,000 All Funds (AF) $140,000 SGF for pilot program with Medicaid/ HealthWave providers
Shared Financial Responsibility. Asking all Kansans to contribute to the cost of health care. ***(Policies listed under P3)***		
Estimated Costs for P1	**$480,000 AF $340,000 SGF**	

Promoting Medical Homes and Paying for Prevention (P2)		
Policy Option	**Population Served**	**Estimated Cost**
Promoting Medical Homes		
***P2 (1)Define Medical Home**. Develop statutory/regulatory definition of medical home for state-funded health programs – Medicaid, HealthWave, State Employee Health Plan (SEHP)	Beneficiaries of state-funded health care plans	Planning process should incur minimal costs to KHPA
***P2 (2) An Analysis of and Increase in Medicaid Provider Reimbursement.** Increased Medicaid/HealthWave reimbursement for primary care and prevention services	Beneficiaries and providers in Medicaid and HealthWave programs	$10 million AF; $4 million SGF
P2 (3) Implement Statewide Community Health Record (CHR). Design statewide CHR to promote efficiency, coordination, and exchange of health information for state-funded health programs (Medicaid, HealthWave, SEHP)	Beneficiaries of state-funded health care plans	$1.8 million AF; $892,460 SGF
P2 (4) Promote Insurance Card Standardization. Promote and adopt recommendations from Advanced ID Card Project for state-funded health programs	Kansans who qualify/enrolled in state-funded health care plans	$172,000 AF; $86,000 SGF
Paying for Prevention: Healthy Behaviors in Families/Communities		
***P2 (5) Increase Tobacco User Fee.** Institute an increase in the tobacco user fee $.50 per pack of cigarettes, and an increase in the tax rate of other tobacco products to 57% of wholesale price.	Total Kansas population	Provides revenues of $61.57 million. Dept of Revenue estimate 12/07
***P2 (6) Statewide Restriction on Smoking in Public Places.** Enact statewide smoking ban in public places, couples with Governor's Executive Order requiring state agencies to hold meetings in smoke-free facilities	1.4 million working adults in Kansas	No cost to the state; limited evidence of other cost implications
***P2 (7) Partner with Community Organizations.** Expand the volume of community-based health and wellness programs through partnerships between state agencies and community organizations	All residents and visitors to state of Kansas	Costs dependent upon scope of project (number of organizations)
Paying for Prevention: Healthy Behaviors in Schools		
***P2 (8) Include Commissioner of Education on KHPA Board.** Expand the KHPA Board to include an ex-officio seat for the Kansas Commissioner of Education	Kansas school children	No cost
***P2 (9) Collect Information on Health/Fitness of Kansas School Children.** Support the establishment of a state-based surveillance system to monitor trends of overweight, obesity, and fitness status on all public school-aged children in Kansas	Kansas school children K-12; for 2006-07 year, there were 465,135 enrolled K-12 students	Schools would incur some indirect costs for staff training and body mass index (BMI) measurement

Promoting Medical Homes and Paying for Prevention (P2) (continued)		
Policy Option	**Population Served**	**Estimated Cost**
Paying for Prevention: Healthy Behaviors in Schools		
***P2 (10) Promote Healthy Food Choices in Schools.** Adopt policies that encourage Kansas school children to select healthy food choices by competitively pricing and marketing these foods and restricting access to foods with little or no nutritional value	Kansas school children K-12; for 2006-07 year, there were 465,135 enrolled K-12 students	Depending on pricing policies, implementation of this initiative may reduce or increase the revenue generated
***P2 (11) Increase Physical Fitness and School Health Programs**. Strengthen physical education (PE) requirements and expand Coordinated School Health (CSH) programs	465,135 enrolled K-12 students	$8,500 per participating school. KDHE has requested $1.8 million SGF for the CSH program for participation of 100 districts
Paying for Prevention: Healthy Behaviors in Workplace		
***P2 (12) Wellness Grant Program for Small Business.** Develop a community grant program to provide technical assistance and start-up funds to small businesses to assist them in the development of workplace wellness programs	Kansas employees of small firms	$100,000 SGF for pilot project
***P2 (13) Healthier Food Options for State Employees.** Expand healthy food choices in state agency cafeterias and vending machines	Approximately 45,000 state employees	Costs depend on contract negotiations and pricing policies
Paying for Prevention: Additional Prevention Options		
***P2 (14) Provide Dental Care for Pregnant Women.** Include coverage of dental health services for pregnant women in the Kansas Medicaid program	6,600 Pregnant women enrolled in Medicaid	$1.3 million AF; $524,000 SGF
***P2 (15) Improve Tobacco Cessation within Medicaid.** Improve access to Tobacco Cessation programs in the KS Medicaid program to reduce tobacco use, improve health outcomes, and decrease health care costs	Approximately 84,000 Medicaid beneficiaries who smoke	$500,000 AF; $200,000 SGF for an annual cost
***P2 (16) Expand Cancer Screenings.** Increase screenings for breast, cervical, prostate, and colon cancer through expansion of the Early Detection Works (EDW) program	7,500 women (for Breast/Cervical screenings); 6,100 men (for prostate cancer screening); and 12,000 Kansans (for colorectal cancer screenings)	KDHE has requested $6.7 million SGF for cost of expansion of all three cancer screenings
Estimated Costs for P2	**$22.4 million AF $14.3 million SGF**	

Providing and Protecting Affordable Health Insurance (P3)		
Policy Option	**Population Served**	**Estimated Cost**
P3 (1) Access to Care for Kansas Children and Young Adults		
• Aggressive targeting and enrollment of children eligible for Medicaid and HealthWave • Include specific targets and timelines for improved enrollment. Inability to meet targets will "trigger" additional action by the KHPA, to include the consideration of mandating that all children in Kansas have health insurance • Allow parents to keep young adults (through age 25 years) on their family insurance plan • Develop Young Adult policies with limited benefit package and lower premiums	Estimated 20,000 Medicaid/HealthWave eligible Estimated 15,000 young adults	$22 million AF $14 million SGF
P3 (2) Expanding Insurance for Low-Income Kansans*		
• Expansion population for the Premium Assistance program ♦ Adults (without children) earning up to $10,210 annually[100% federal poverty level (FPL)]	Estimated 39,000 low income Kansas adults	$119 million AF $ 56 million SGF
P3 (3) Affordable Coverage for Small Businesses		
• Encourage Section 125 plans (develop Section 125 "toolkits") and education campaign for tax-preferred health insurance premiums • Develop a "voluntary health insurance clearinghouse" to provide on-line information about health insurance and Section 125 plans for small businesses and their employees • Add sole proprietors and reinsurance to the very small group market (VSG: one to ten employees). Stabilize and lower health insurance rates for the smallest (and newest) businesses: obtain grant funding for further analysis • Pilot projects – support grant program in the Department of Commerce for small business health insurance innovations	Estimated 12,000 small business owners and their employees (***Note: At the person level, the uncompensated care costs for the previously uninsured are reduced due to this change, hence the reduction in All Funds shown above. Practically, however, at the program level, the State of Kansas will not change the State's Disproportionate Share Hospital reimbursement methodology.)	-$5 million AF*** $1 million SGF
Estimated Costs for P3 Cost of all 3 policy options is:		**$136 million AF** **$ 71 million SGF**
Total Costs		**$158.9 million AF**** **$ 85.7 million SGF** ****(includes federal matching dollars)**

Two additional components of health reform, separate from the policies listed here, are being submitted to the Governor and Legislature as part of the KHPA budget. Funding for each is essential as the "building blocks" of health reform: 1) **Premium Assistance. As designed in SB 11, this request asks for a $5.037 million enhancement ($12.075 AF) for the Premium Assistance program in FY2009; these funds will provide private health insurance to parents of children eligible for Medicaid who earn less than 50% of the FPL (approximately $10,000 for a family of four); and 2) **Web-Based Enrollment System**. The KHPA budget asks for a $4 million enhancement for FY2009 ($8 million AF) to implement a new electronic eligibility system that can support premium assistance, enhanced outreach, and program participation through web-based enrollment.

St. Francis Health Center
Sisters of Charity of Leavenworth Health System

Office of the President/CEO

January 17, 2008

Senator James Barnett, Chairman
Senate Public Health and Welfare Committee
State Capitol Building
Topeka, Kansas 66612

Dear Senator Barnett:

St. Francis Health Center and Tallgrass Surgical Specialists have been working diligently over the past two-plus years to establish a Center of Excellence for Bariatric Surgery. Our efforts were rewarded this past April, when St. Francis Health Center and Tallgrass Surgical Specialists were approved by the American Society of Metabolic and Bariatric Surgery (ASMBS) to be recognized as an ASMBS Center of Excellence.

St. Francis Health Center's support of bariatric surgery is based on the outcomes research that has been conducted on the beneficial results of this surgery. This research, coupled with the current knowledge that obesity is a pathway to multiple chronic illnesses, and premature death, brings us to our position of support for bariatric surgery. Annual costs of medical care are 37% higher for obese patients than for those of normal weight. Obese individuals spend 77% more on medications than do people of normal weight.[1] Clearly an increase in the patient's quality of life with the added benefit of lower overall health care costs, are compelling reasons to support the inclusion of bariatric surgery in any array of covered health care services.

SENATE PUBLIC HEALTH AND WELFARE
DATE: 01/17/08
ATTACHMENT 6

Submitted by: Cynthia Smith, authored by: Michael Schrader, President/CEO, St Francis Hospital Topeka KS ASMBS Center of Excellence

[1] Finkelstein, EA, Fiebelkorn IC, Wang G. National Medical spending attributable to overweight and obesity: How much, and who's paying? Health Affairs Web Exclusive. 2003; W3:219-226.

St. Francis Health Center supports an open dialogue concerning the efficacy of bariatric surgery; the cost benefit to the patient and the community; and most importantly, the increased quality of life and productivity experienced by the recipients.

Sincerely,

Michael E. Schrader
President/CEO

From: <istamm@cox.net>
To: Jim Barnett <senatorjb@sbcglobal.net>
CC: <Vickie.Schmidt@senate.ks.us>, <wagle@senate.state.ks.us>
Date: 1/18/2008 7:04 AM
Subject: Bariatric Surgery
Attachments: Study Shows Residential Obesity Treatment Leads to WeightLoss.doc

Senator Barnett,

Jim,

It was good talking with you yesterday. To recap my comments about bariatric surgery and to add some additional information:

1) The national center of excellence for the treatment of obesity is Duke University Medical Center in Durham, NC. Duke makes use of surgical and non-surgical treatments. Their studies reveal a 40-50% long-term success rate – still better that the 15% long-term outcome for weight loss widely quoted.

Because of the Duke program – two other weight loss programs have emerged in the Durham area. Durham has become a Mecca for weight loss – and the restaurants and malls are used to assisting people who are obsese. It is a little like the way Topeka became a haven for those with mental illness. (My knowledge of this is from the Duke web-site and a CBS 60 minutes segment several years ago – I have not visited Duke or Durham). I do suggest to my own patients who contact me with weight-loss issues that they go to the Duke web-site and consider seeking treatment at Duke.

2) When I treated patients at the Menninger Clinic in Topeka (1972-1995) – Menninger had an eating disorder unit – 80-90% of the patients suffered with anorexia nervosa or bulimia – but some entered the hospital with obesity. In those days patients could remain in the hospital 30 days to eighteen months. Insurance would pay for this treatment.

Obesity can be treated with an intermediate/ longer term hospital stay in an eating disorders unit. Howevr, today most insurance companies including Blue Cross Blue Shield of Kansas will not pay for more than 3-5 days in a psychiatric hospital even if the patient's insurance contract allows for 45 days of psychiatric hospital care.

3) The gold standard for medical research is the double blind randomized study. Blue Cross Blue Shield of Kansas is correct in raising questions about the long-term sequelae of bariatric surgery. At the same time, many procedures in medicine without such long-term outcome data. For decades there was no randomized double blind study to assist cardiologists in determining whether a patient with blockage of an artery was better off having a stent placed in the artery or having open-heart by-pass surgery. The Federal Drug Administration approves medications based on drug studies that test the drug for only several months. The FDA sometimes approves a drug for use in the middle of a clinical trial if it shows promise and the potential to save lives.

When I had seed implants to treat my prostate cancer in 2002– the radiation oncologist showed me the research data that seed implants were effective ten years out – but he also acknowledged that the 15 and 20 year outcome data did not yet exist. He was upfront and candid in stating that he did not know the long-term effect of radiation on the body – he thought any negative effects would be negligible. Anyways – Blue Cross Blue Shield of Kansas paid for the procedure – it was my choice whether to undergo seed implants or to choose a different procedure to treat my prostate cancer.

I do want to be clear that I think there is enough medical and financial data to suggest that insurance companies should pay for bariatric surgery for patients such as the man who testified before the committee yesterday.

I am attaching a note from the Duke University Medical Center website about their residential program for

treating obesity.

I hope this note and information are of help. Feel free to share this e-mail with other members of the Senate committee.

Best regards,

Ira

--
Ira Stamm, Ph.D., ABPP
3600 SW Burlingame Road #1A
Topeka, KS 66611
913 706-8831

e-mail address:
istamm@cox.net

Study Shows Residential **Obesity Treatment** Leads to Weight Loss

DURHAM, N.C. – Residential, immersion-style obesity treatment programs can help people achieve medically significant weight loss and improve their quality of life, according to new research from Duke University Medical Center.

The Duke study found that patients who stay about 24 days, on average, at a 4-week treatment program focusing on lifestyle change, physical activity and healthful eating lose almost five percent of their total body weight. In such programs, patients immerse themselves in a weight-loss program by staying at a treatment facility for an extended period while participating in a 'day-treatment' approach to lifestyle change.

One year later, the same patients reported an average total weight loss of 10.1 percent. More than 80 percent reported quality of life improvements including improved stamina and self-confidence, better mobility and ability to bend, and improved confidence in their ability to follow a healthy lifestyle.

The results were presented October 16, 2005, at the annual meeting of The North American Association for the Study of Obesity in Vancouver, B.C. The Duke Diet & Fitness Center, a residential treatment center for obesity, funded the study.

"We know this treatment approach offers benefits to patients, but there is a paucity of research on both the short and long-term outcomes of such programs," said clinical psychologist Martin Binks, Ph.D., lead author and director of behavioral health at the Duke Diet & Fitness Center.

Binks noted that the results of the study are comparable to those seen in other behavioral weight loss programs and thus offer support for this intervention as a viable option for patients.

"It's important we provide evidence of the efficacy and health benefits of the immersion style of weight loss management in the hopes that some day, with the cooperation of insurers, it will become available to larger numbers of those in need of significant, medically managed weight loss."

The study tracked 182 patients who enrolled in a four-week treatment program at the Duke Diet & Fitness Center. In addition to following a reduced calorie diet, participants attended classes on health, nutrition, fitness and behavioral health. They also had regular visits with a physician, nutritionist, exercise physiologist and

psychologist or clinical social worker. Typically, the calorie levels ranged between 1,000 to 1,500 calories per day, and patients chose between three diet plans: high-carbohydrate (55 percent of calories from carbs), moderate-carbohydrate (35 percent of calories from carbs) and low-carbohydrate (15-25 percent of calories from carbs).

The mean age was about 51 years old, and the mean body mass index for women varied between 37.7 to 39.5 for the women and 41.5 to 49.4 for the men. BMI is a measurement of body fat based on height and weight, and obesity is defined as a BMI of 30 or greater. Severe obesity is indicated by a BMI greater than or equal to 40.

The one year telephone follow-up survey queried patients about their total weight loss and ten quality of life improvements. Fifty-nine percent of participants completed follow-up survey. There were no significant differences in weight loss among the different diet groups. Of those who responded, 74 percent lost more than five percent of their body weight and 51 percent lost more than 10 percent of their body weight.

"I hope this will motivate health care practitioners to rethink the common attitude that severely overweight people cannot accomplish meaningful weight loss without surgery," said Howard Eisenson, M.D., study co-author and director of the Duke Diet & Fitness Center.

Eisenson notes that men and women who lose 10 percent or more of their total body weight can see medically significant improvements in their health. "We do know that 10 percent weight loss typically leads to improvements in diabetic control, and reduces the risk of progression from prediabetes to diabetes. It also helps reduce blood pressure and cholesterol levels," Eisenson said.

More than 80 percent of people reported quality of life improvements in the following areas: ability to bend; mobility; smaller clothing size; improved overall quality of life; confidence in ability to follow a healthy lifestyle; improved stamina; increased activity level since beginning treatment; and, if it was an issue, better blood sugar and blood pressure control. Self-consciousness about weight improved for 68 percent of participants.

"These quality of life improvements are very important," Binks said. "Focusing on these quality of life goals and enjoying each and every area of improvement – not just weight – may help people succeed in following a healthy lifestyle over the long

term."

Co-authors include Truls Ostbye, M.D., Ph.D., Ron Sha, M.D., Ph.D., Ronette Kolotkin, Ph.D., Elisabetta Politi, R.D., and Eric Westman, M.D., all of Duke University Medical Center.