Obesity Care

Access to Proven Therapies
Obesity in America

- Obesity is a life-threatening disease affecting 34% of adults in the U.S.
- Between 2000 and 2005, obesity increased by 24%, morbid obesity by 50%, and super obesity by 75%.
- 18% of adolescents are overweight and have a 70% chance of becoming overweight or obese adults.
- Obese individuals have a 10-50% increased risk of death compared to healthy weight individuals.
Factors contributing to obesity:
- Genetics
- Metabolism
- Environment
- Culture
- Psychological
- Illness, e.g. Hypothyroidism, PCOS

Morbid Obesity is associated with more than 30 illnesses and medical conditions.
Physiological Impact of Obesity

- Pulmonary disease
  - abnormal function
  - obstructive sleep apnea
  - hypoventilation syndrome

- Nonalcoholic fatty liver disease
  - steatosis
  - steatohepatitis
  - cirrhosis

- Gall bladder disease

- Gynecologic abnormalities
  - abnormal menses
  - Infertility
  - polycystic ovarian syndrome

- Osteoarthritis

- Skin

- Gout

- Idiopathic intracranial hypertension

- Stroke

- Cataracts

- Coronary heart disease

- Diabetes

- Dyslipidemia

- Hypertension

- Severe pancreatitis

- Cancer
  - breast, uterus, cervix
  - colon, esophagus, pancreas
  - kidney, prostate

- Phlebitis
  - venous stasis

NAASO Obesity Online
February 2006 – Centers for Medicare & Medicaid Services (CMS) established National Coverage Policy for Bariatric Surgery to help reduce the significant health risks associated with obesity, including death and disability.

February 2009 – CMS clarifies NCD for bariatric surgery, specifying Type 2 Diabetes as one of the co-morbidities CMS would consider in determining coverage of a Medicare beneficiary who is morbidly obese.
American Society for Bariatric Surgery changes name to American Society for Metabolic and Bariatric Surgery emphasizing the important role of surgery, not only for weight loss, but as primary treatment of many life-threatening diseases.

Robust volume of clinical data continue to prove Bariatric Surgery as:

- Superior treatment of Type 2 Diabetes
- Safe & Cost Effective treatment for those suffering from obesity
Utilization of laparoscopic approach

Decreased hospital length of stay

Quicker recovery time & return to work

July 2009 *New England Journal of Medicine (LABS-1 NIH Study)*
- Improved 30-day Safety Outcomes
  - 4.1% Major adverse outcome
  - 0.3% Mortality rate
# Results of Five-Year Follow-up

<table>
<thead>
<tr>
<th>TREATMENT</th>
<th>WEIGHT LOSS SUCCESS (% of Patients)</th>
</tr>
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<tbody>
<tr>
<td>Diet &amp; exercise*</td>
<td>2 – 5%</td>
</tr>
<tr>
<td>Prescription Weight Loss Medications**</td>
<td>0%</td>
</tr>
<tr>
<td>Bariatric Surgery***</td>
<td>50 – 70%</td>
</tr>
</tbody>
</table>

* Success measured as a loss of 10% of initial body weight
** Weight loss is not maintained once treatment ends
*** Success measured as a loss of 50% of excess body weight

Nonsurgical treatment for those suffering from morbid obesity produce a failure rate near 100%


Migraine 57% resolved
Pseudotumor cerebri 96% resolved
Dyslipidemia, hypercholesterolemia 63% resolved
Nonalcoholic fatty liver disease
90% improved steatosis
37% resolution of inflammation
20% resolution of fibrosis on repeat biopsy
Metabolic syndrome 80% resolved
Type 2 diabetes mellitus 83% resolved
Polycystic ovarian syndrome
78% resolution of hirsutism
100% resolution of menstrual dysfunction
Venous stasis disease 95% resolved
Depression 55% improved or resolved
Obstructive sleep apnea 74-98% resolved
Asthma 82% improved or resolved
Cardiovascular disease 82% risk reduction
Hypertension 52-92% resolved
Gastroesophageal reflux disease 72-98% resolved
Stress urinary incontinence 44-88% resolved
"Orthopedic problems" or "degenerative joint disease" 41-76% resolved
Quality of life improved in 95% of patients
Death 89% reduction in 5-year death rate

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Clinical Effectiveness

- **March 2009  American Journal of Medicine**
  - 86.6% of patients improved or resolved Type 2 Diabetes following Bariatric Surgery
  - Cuts risk of developing coronary heart disease in half

- **January 2008  Journal of the American Medical Association**
  - 73% of patients resolved Type 2 Diabetes after Gastric Band surgery

- **August 2007  New England Journal of Medicine**
  - Overall deaths were reduced by 40%
  - Deaths from diabetes were reduced by 92%
  - Deaths from heart disease were reduced by 56%
  - Deaths from cancer were reduced by 60%

- **May 2007  Journal of the American College of Surgeons**
  - Resolves obstructive sleep apnea in more than 85% of patients
Clinical Effectiveness

American Diabetes Association
Standards of Medical Care in Diabetes - 2009
Executive Summary: Standards of Medical Care in Diabetes—2009

Current Criteria for the Diagnosis of Diabetes
- Fasting plasma glucose (FPG) ≥126 mg/dL (7.0 mmol/L). Fasting is defined as no caloric intake for at least 8 h.
- Symptoms of hyperglycemia and a casual (random) plasma glucose ≥200 mg/dL (11.1 mmol/L). Casual (random) is defined as any time of day without regard to time since last meal. The classic symptoms of hyperglycemia include polyuria, polydipsia, and unexplained weight loss.
- 2-h plasma glucose ≥200 mg/dL (11.1 mmol/L) during an oral glucose tolerance test (OGTT). The test should be performed as described by the World Health Organization, using a glucose load containing the equivalent of 75 g anhydrous glucose dissolved in water.

Testing for Pre-Diabetes and Diabetes in Asymptomatic Patients
- Testing to detect pre-diabetes and type 2 diabetes in asymptomatic people should be considered in adults of any age who are overweight or obese (BMI ≥25 kg/m²) and who have one or more additional risk factors for diabetes. In those without these risk factors, testing should begin at age 45 years. (E)
- If results are normal, repeat testing should be carried out at least 3-year intervals. (E)
- To test for pre-diabetes or diabetes, an FPG test or 2-h OGTT (75 g glucose load) or both are appropriate. (B)
- A OGTT may be considered in patients with impaired fasting glucose (IFG) to better define the risk of diabetes. (E)
- In those identified with pre-diabetes, identify and, if appropriate, treat other cardiovascular disease (CVD) risk factors. (B)

Testing for Type 2 Diabetes in Children
- Test children who are overweight (BMI >85th percentile for age and sex) or obese (BMI >95th percentile for age and sex), or >120% of ideal for height) and have any two of the following risk factors:
- Family history of type 2 diabetes in first- or second-degree relative.
- Race/ethnicity of Native American, African American, Latino, Asian American, or Pacific Islander.
- Signs of insulin resistance or conditions associated with insulin resistance (acanthosis nigricans, hypertension, dyslipidemia, polycystic ovary syndrome, or small-for-gestational-age birth weight).
- Maternal history of diabetes or gestational diabetes mellitus (GDM) during the child's gestation.
- Testing should begin at age 10 years or at onset of puberty, if puberty occurs at a younger age, and be repeated every 3 years. (E)
- FPG is the preferred test. (E)

Detection and Diagnosis of GDM
- Screen for GDM using risk factor analysis and, if appropriate, use of an OGTT. (C)
- Women with GDM should be screened for diabetes 6–12 weeks postpartum and should be followed up with subsequent screening for the development of diabetes or prediabetes. (B)

Prevention/Delay of Type 2 Diabetes
- Patients with impaired glucose tolerance (IGT) or IFG should be referred to an effective ongoing, support program for weight loss of 5–10% of body weight and increasing physical activity to at least 150 min per week of moderate activity such as walking.

Follow-up counseling appears to be important for success. (B)
- Based on potential cost savings of diabetes prevention, such counseling should be covered by third-party payers. (E)
- In addition to lifestyle counseling, metformin may be considered in those who are at very high risk for developing diabetes (combined IFG and IGT plus other risk factors such as A1C > 5%, hypertension, low HDL cholesterol, elevated triglycerides, or family history of diabetes in a first-degree relative) and who are obese and under 60 years of age. (E)
- Monitoring for the development of diabetes in those with pre-diabetes should be performed yearly. (C)

Glucose Monitoring
- Self-monitoring of blood glucose (SMBG) should be carried out three or more times daily for patients using multiple insulin injections or insulin pump therapy. (A)
- For patients using less frequent insulin injections, continuous glucose monitoring or a continuous glucose monitoring and physical activity alone, SMBG may be used as a guide to the success of therapy. (E)
- To achieve postprandial glucose targets, postprandial SMBG may be appropriate. (E)
- When prescribing SMBG, ensure that patients receive initial instruction in, and routine follow-up evaluation of, SMBG technique and their ability to use data to adjust therapy. (E)

Continuous glucose monitoring (CGM) in conjunction with intensive insulin regimen can be a useful tool to lower A1C in selected adults (aged ≥18 years) with type 1 diabetes (A)
- Although evidence for A1C lowering is less strong in children, teens, and younger adults, CGM may be helpful in these groups. Success correlates with adherence to ongoing use of the device. (C)
- CGM may be a supplemental tool to SMBG in those with hyperglycemic unawareness and frequent hypoglycemic episodes. (E)
Bariatric surgery should be considered for adults with BMI $\geq 35$ kg/m$^2$ and type 2 diabetes, especially if the diabetes is difficult to control with lifestyle and pharmacologic therapy.

Patients with type 2 diabetes who have undergone bariatric surgery need life-long lifestyle support and medical monitoring.

ADA Executive Summary, 2009
Safety of Bariatric Surgery

- **2007** *Agency for Healthcare Research and Quality (AHRQ)*
  - Risk of death from Bariatric Surgery approximately 0.1%

- **2009** *New England Journal of Medicine*
  - Risk of major complications (30 days) – 4.1%
# Major Risks of Gastric Bypass Surgery

<table>
<thead>
<tr>
<th>Early (&lt;30 days)</th>
<th>UW Health (515)</th>
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<tbody>
<tr>
<td>Leak</td>
<td>1.4% (7)</td>
</tr>
<tr>
<td>Major bleeding</td>
<td>1.9% (10)</td>
</tr>
<tr>
<td>Wound infection</td>
<td>4.2% (22)</td>
</tr>
<tr>
<td>Pulmonary embolism</td>
<td>0.2% (1)</td>
</tr>
<tr>
<td>Death</td>
<td>0.2% (1)</td>
</tr>
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</table>

*UW data as of June 30, 2009*
Cost Effectiveness

- Health care costs for the morbidly obese are 81% above those for the non-obese population and 47% above costs for the non-morbidly obese population.

- Current costs attributable to obesity are nearly entirely a result of costs generated from treating the diseases that obesity promotes.
When the ETF has looked at broadening bariatric coverage for State employees in the past, they have used PMPM data from Deloitte to reject the notion of improving coverage. The minutes from a April 15, 2008 meeting show....

"In response to questions from Mr. Beil, Mr. Kox noted that the study group had looked at gastric bypass surgery. Mr. Roverud from Deloitte Consulting indicated that costs continue to rise due to increases in utilization."

While the minutes from March 31, 2005 show....

"3) GASTRIC BYPASS: The group discussed including this benefit. The cost impact ranged from $3.66 PMPM for 80% coverage to $4.70 PMPM for 100% coverage. This change would require numerous other contract adjustments. The group concluded that providing nutritional counseling as a benefit improvement is an appropriate first step in addressing member needs. Therefore, the group does not recommend adding this benefit for calendar year 2006. It should be noted that gastric bypass surgery may be covered under the Standard Plan if it meets BCBSWI’s medical necessity criteria."
We estimate the cost of covering bariatric surgery at approximately $1.50 to $2.50 per member per month in the small group market. This data is specific to Maryland but includes data on the entire population, including those with health coverage from public sources such as Medicaid and Medicare.

<table>
<thead>
<tr>
<th></th>
<th>Low</th>
<th>High</th>
</tr>
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<tbody>
<tr>
<td>Utilization per 100,000 adults</td>
<td>68</td>
<td>119</td>
</tr>
<tr>
<td>Cost per surgery, including complications and pre- and post-surgery care</td>
<td>$27,500</td>
<td>$27,500</td>
</tr>
<tr>
<td>Cost per adult per month</td>
<td>$1.56</td>
<td>$2.72</td>
</tr>
<tr>
<td>Average number of members per adult</td>
<td>1.33</td>
<td>1.33</td>
</tr>
<tr>
<td>Claim cost per member per month</td>
<td>$1.17</td>
<td>$2.04</td>
</tr>
<tr>
<td>Small group market loss ratio</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Premium impact per member per month</td>
<td>$1.46</td>
<td>$2.55</td>
</tr>
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New Data

Relevant for Wisconsin?
<table>
<thead>
<tr>
<th>State</th>
<th>Population (Rank)</th>
<th>% Obese</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maryland</td>
<td>5,633,597 (#19)</td>
<td>26%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>5,627,967 (#20)</td>
<td>25.4%</td>
</tr>
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CDC, 2008
A Study on the Economic Impact of Bariatric Surgery

Pierre-Yves Creminaux, PhD; Henry Buchwald, MD, PhD; Scott A. Shikora, MD; Anindam Ghosh, PhD; Haixia Elaine Yang, PhD; and Marric Guussing, BA

The prevalence of obesity among the US adult population has increased steadily to reach one third of the US adult population. More alarming yet, the trend in morbid obesity surpasses that of nonmorbid obesity. From 2000 through 2005, the US obesity rate increased by 24%, while the rate of morbid obesity (body mass index [BMI], calculated as weight in kilograms divided by height in meters squared [kg/m²]) grew by 75%, and the rate of patients with a BMI exceeding 50 kg/m² grew by 75%. This trend in modbid obesity results in increased healthcare utilization and costs; as healthcare costs for the morbidly obese are 81% above those for the nonobese population and 47% above those for the non-morbidly obese population.4

Morbid obesity is associated with a myriad of serious comorbid conditions, including hypertension, type 2 diabetes mellitus, dyslipidemias, osteoarthritis, and gallbladder disease.5 Bariatric surgery has been demonstrated to be an effective weight-loss alternative for the morbidly obese6-9 and is associated with marked reduction of comorbidities.9-11 Other studies5,9,12 have found similar results, with reductions in morbidity, cardiovascular risk, healthcare utilization, and costs in bariatric surgery patients compared with control subject. Although most of the current literature examines health benefits associated with bariatric surgery,9,13 studies have also documented the economic improvements.14 Length-of-life increases,15-17 and reduced work loss18 associated with bariatric surgery.

Despite the extensive literature on the clinical effects of bariatric surgery, little research has been published on the economic impact of the procedures. Therefore, a renewed focus on the economic impact of the procedure is needed given the known clinical outcomes become better known and the procedure becomes more commonplace (>15,000 surgical procedures in 2005), while its economic costs or benefits remain unknown.19 The present study is unique in its use of actual patient-level data from 1068 patients who underwent the procedure. The resulting return on investment is calculated based on up to 5 years of postoperative cost data.

This study quantifies the effect of bariatric surgery on direct medical costs. We focus on the time required for third-party payers to recover the initial investment associated with bariatric surgery (i.e., the return on investment).20 Using the Ingenix private insurer claims database and a matched cohort method and focusing only on costs incurred and saved by the private insurer, we build on findings of a
## Table 2. Multivariate Regression Analysis of Total Monthly Costs of Bariatric Surgery (Dependent Variable Minus Total Monthly Costs) Estimated Using a Tobit Model

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<tbody>
<tr>
<td><strong>Presurgery, $</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Months -6 to -2</td>
<td>148.04&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-94.99</td>
<td>274.51&lt;sup&gt;c&lt;/sup&gt;</td>
<td>312.87&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Month before surgery</td>
<td>1815.04&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1814.84&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1971.79&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1278.99&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Time of surgery</td>
<td>19,118.01&lt;sup&gt;b&lt;/sup&gt;</td>
<td>20,325.78&lt;sup&gt;b&lt;/sup&gt;</td>
<td>19,900.61&lt;sup&gt;b&lt;/sup&gt;</td>
<td>14,468.50&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Postsurgery, $</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Months 1 to 2</td>
<td>1799.76&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2170.51&lt;sup&gt;b&lt;/sup&gt;</td>
<td>1801.62&lt;sup&gt;b&lt;/sup&gt;</td>
<td>859.40&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Months 3 to 6</td>
<td>-49.4&lt;sup&gt;b&lt;/sup&gt;</td>
<td>176.50</td>
<td>-145.16</td>
<td>-161.27</td>
</tr>
<tr>
<td>Months 7 to 12</td>
<td>-272.85&lt;sup&gt;b&lt;/sup&gt;</td>
<td>13.75</td>
<td>-402.77&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-496.55&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Months 13 to 18</td>
<td>-436.67&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-20714&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-537.07&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-926.23&lt;sup&gt;b&lt;/sup&gt;</td>
</tr>
<tr>
<td>Months 19 and longer</td>
<td>-544.69&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-399.86&lt;sup&gt;b&lt;/sup&gt;</td>
<td>-590.68&lt;sup&gt;b&lt;/sup&gt;</td>
<td>—</td>
</tr>
<tr>
<td><strong>No. of observations</strong></td>
<td>221,483</td>
<td>98,963</td>
<td>108,638</td>
<td>17882</td>
</tr>
</tbody>
</table>

*The model controls for age, breast cancer, congestive heart failure, lymphedema, major depression, osteoarthritis, polycystic ovary syndrome, pseudotumor cerebri, and venous stasis or leg ulcers. For laparoscopic surgery, a likelihood ratio test showed that the coefficients for 13 to 18 months and for 19 months and longer are statistically similar, so a single coefficient is reported. For all other models, a likelihood ratio test was performed to see if grouping the data past 19 months was significantly different from continuing with 6-month increments. All P values were statistically nonsignificant.

<sup>b</sup>P < 0.01.

<sup>c</sup>P < 0.05.
Economic Impact of Bariatric Surgery

Take-away Points

The rate of bariatric surgery use has increased in the past decade to more than 170,000 surgical procedures per year in the United States.

- The initial investment for bariatric surgery is approximately $26,000 for open surgery and $17,000 for laparoscopic surgery.
- After taking into account age, sex, and comorbidities, the initial investment is returned within 4 years for patients who undergo open surgery and within 2 years for patients who undergo laparoscopic surgery.
- Even ignoring potential quality-of-life and length-of-life benefits, as well as disability and work loss, third-party payers can rely on bariatric surgery paying for itself through decreased comorbidities within 2 to 4 years.

Cremieux, et al. American Journal of Managed Care, Vol 14, No. 9
In this issue of the Journal, Crimineu and colleagues report on an analysis of the return on investment for bariatric surgery. The authors used health insurance claims data for more than 3600 patients who underwent a bariatric procedure and for a matched control group to estimate the length of time required before the procedure breaks even (return on investment period) from the insurer's perspective. The authors find that procedure-related costs are fully recovered after 53 months. For laparoscopic procedures, the estimated return on investment is reduced to 25 months. This article makes a unique contribution to the now sparse literature on the economics of bariatric surgery. However, 2 important and subtle points require further discussion.

First, the return on investment estimates are driven primarily by rising costs in the matched control group rather than by a reduction in costs from the bariatric sample. When the authors refer to "savings," they are actually referring to the difference in costs between the surgery and control groups in the post-surgery period. Consider the savings that the authors report for month 19 and beyond. There appear to be $351 per month for the overall bariatric population and $226 per month for the laparoscopic-only sample. But in Table 1 of their article, the estimated return on investment costs for 5 months before surgery were $434, or roughly $419 per month. Because the monthly savings in procedure-related post-surgery mean costs, and dramatically so for the laparoscopic sample, the return on investment estimates seem to result from substantially higher costs incurred in the control group relative to the surgery group in the pre-surgery period.

Second, because of data limitations, the authors’ return on investment estimates are based on the assumption that the differential in costs between the 2 groups (ie, the savings) is constant after month 19 for the overall sample and after month 13 for the laparoscopic sample. However, this assumption is unlikely to hold in reality and will only be answered once additional follow-up data become available. If this assumption is not met or if another control group has a different cost profile, then the return on investment could be substantially increased.

To further highlight these points, the Figure here (based on claims data from Medstat’s proprietary MarketScan database; Thomson Reuters, Ann Arbor, Michigan) provides a graphical depiction of the cost implications of bariatric surgery. The Figure shows insurance payments before and after gastric bypass surgery (payments for the month of surgery are removed because they make it difficult to see the trend). In the roughly 54 months after the procedure takes place it can be seen that the costs of the post-surgery period seem to be no less than those in the pre-surgery period. Although gastric bypass has been shown to reduce weight and to improve comorbidities, there are several reasons why costs are not reduced. First, we found that a few individuals experienced adverse events that required lengthy and expensive re-admissions (EAF and U.S. unpublished data, 2008). Second, other individuals had high costs because the procedure was so successful. In several cases, individuals lost so much weight that they required subsequent surgical procedures to have excess skin removed. There was evidence of hip and knee replacements that likely resulted from formerly obese individuals developing OA and realizing that the damage to their skeleton that could only be fixed through additional surgical procedures, operations that would not have been required if not for the successful weight loss achieved from the procedure. The Figure also reveals substantial variation in the monthly cost estimates, suggesting that the assumption of constant savings after month 19 (or month 13) is unlikely to hold in reality. It would be interesting to see if the Figure of the data by Crimineu et al showing monthly costs for the surgery and control samples to confirm that rising costs in the control sample are generating their return on investment estimates.

As a parting note, we would like to add some caution for insurers and other payers. If coverage decisions are predicated on achieving returns on investment as short as those presented by Crimineu et al—and an internist on post analysis produces results that are not as favorable because a within
“Bariatric procedures should not be held to a different standard than other medical or surgical interventions, regardless of what the return on investment might actually be. For example, no one asks to see a positive return on investment for treatment of cancer, heart disease, or diabetes mellitus, yet treatments for these conditions are covered in almost every health plan.”

Finkelstein & Brown
“When the results of statistical analysis are used for policy determination, the consequences for patient care may be substantial.”
It's Your Choice: Reference Guide
Group Health Insurance Information
State of Wisconsin Employees
Retired State of Wisconsin Employees (Annuities)
Members with Continuation Coverage (Continuants)
UW Graduate Assistants
IV. EXCLUSIONS AND LIMITATIONS

A. EXCLUSIONS

The following is a list of services, treatments, equipment, or supplies that are excluded (meaning no benefits are payable under the Plan Benefits), or have some limitations on the benefit provided. All exclusions listed below apply to benefits offered by Health Plan and the PBM. To make the comprehensive list of exclusions easier to reference, exclusions are listed by the category in which they would typically be applied. The exclusions do not apply solely to the category in which they are listed except that subsection 11 applies only to the pharmacy benefit administered by the PBM. Some of the listed exclusions may be Medically Necessary, but still are not covered under the plan, while others may be examples of services which are not Medically Necessary or not medical in nature, as determined by the Health Plan and/or PBM.

1. Surgical Services
   a. Procedures, services, and supplies related to sex transformation surgery and sex hormones related to such treatments.
   b. Treatment, services, and supplies for cosmetic or beautifying purposes, except when associated with a covered service to correct congenital bodily defects or conditions or when associated with covered reconstructive surgery due to an illness or accidental injury (including subsequent removal of a prosthetic device that was related to such reconstructive surgery). Psychological reasons do not represent a medical/surgical necessity.
   c. Any surgical treatment or hospitalization for the treatment of obesity, including morbid obesity or as treatment for the Comorbidities of obesity, for example, gastroesophageal reflux disease. This includes, but is not limited to, stomach-limiting and bypass procedures.
   d. Keratorefractive eye surgery, including but not limited to, photorefractive keratectomy, or laser surgeries for the correction of vision.

2. Medical Services
   a. Examination and any other services (for example, blood tests) for informational purposes requested by third parties. Examples are physical exams for employment, licensing, insurance, marriage, adoption, participation

• Sex Transformation Surgery
• “Beautifying” Surgery
• Refractive Eye Surgery
• Obesity Surgery
Considerations

- Long Term Multidisciplinary Follow-up
  - Including those that have already had surgery

- New Technologies & Procedures
  - Sleeve Gastrectomy
  - Endoluminal Techniques
  - Revisional Procedures