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February 23, 2009

Banking, Commerce and Insurance Committee  
Room 1401, State Capitol  
Lincoln, NE 68509

Dear Chairman Pahls and the Members of the Banking, Commerce and Insurance Committee:

I am writing today to provide testimony in support of LB 326 which would require the coverage of bariatric surgery as a benefit under Nebraska's high risk insurance pool more commonly known as CHIP.

The Obesity Action Coalition (OAC), a national charitable organization made up of individuals affected by all forms of obesity, strongly supports efforts to expand the treatments of obesity. We believe that adding a bariatric surgery benefit to the CHIP program will not only improve the health of those enrolled in the plan, but will ultimately provide a financial savings to the state through lowered future health care costs. It is important to remember that the treatment of obesity is the prevention and treatment of many other expensive chronic diseases. Much of the nation's diabetes, heart disease and cancer costs can be directly attributed to the obesity epidemic and a wide variety of data suggests if we can treat obesity, we can lower these costs.

In regards to bariatric surgery specifically, I would request you review the attached OAC Fact Sheet on Why It Makes Sense to Provide Coverage of Bariatric Surgery. Studies demonstrate that bariatric surgery is safe, effective in reducing weight as well as obesity related conditions and is cost effective. In fact, several studies now show that the return on investment in the cost of a surgical procedure is now less than two years due to the dramatic reduction in obesity related illnesses.

Bariatric surgery is not for everyone. It is reserved for those who meet strict criteria set by the National Institute of Health (in general, someone who is more than 100 pounds overweight) and who have failed at less-invasive weight-loss efforts. The decision to have bariatric surgery is not an easy one. Patients who undergo such procedure usually agonize over the decision for several years before having such a procedure even when coverage is available. Surgery is not easy. As with any surgical procedure, there are risks, but for appropriate selected candidates, the benefits often outweigh the risks and the results can be truly life-changing and life-saving.

Respectfully, the OAC would request one improvement to the legislation being currently considered and that would be the addition of a third type of surgical procedure to the list of covered procedures, adjustable gastric banding. Gastric banding is often considered the least invasive form of bariatric surgery as is often recognized by its marketed names, LAP-BAND and REALIZE Band.

Insurers, employers and government agencies across the country are coming to the understanding that addressing obesity among their constituents makes sense. I would encourage you join Medicare and the vast majority of state employee programs, state Medicaid programs and major employers by providing coverage for bariatric surgery. Thank you for your consideration.

A handwritten signature in black ink, appearing to read "Joe Nadglowski, Jr.", written in a cursive style.

Sincerely,  
Joseph Nadglowski, Jr.  
President/CEO

About the OAC:

The OAC is a national non-profit organization comprised mostly of individuals who have been personally affected by obesity. In addition, our membership includes more than 1,000 healthcare providers who care for those affected. Our strong belief is that obesity, like other diseases, must be both prevented and treated. Those either currently obese, or at risk for developing obesity, and are ready to make a change in their lives, should have expanded access to both prevention and treatment avenues.



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**Fact Sheet: Why it makes sense to provide treatment for obesity through bariatric surgery**

Reason	Evidence/Details
Obesity is widespread, deadly and expensive	<ul style="list-style-type: none"> <li>• 34% of Americans are obese<sup>1</sup> with 4.7% morbidly obese (more than 100 pounds overweight).<sup>2</sup></li> <li>• Approximately 75% of the morbidly obese have at least one co-morbid condition (diabetes, hypertension, sleep apnea, etc.) which significantly increases the risk of premature death.<sup>3</sup></li> <li>• Life expectancy for a 20 year-old morbidly obese male is 13 years shorter than a normal weight male of the same age.<sup>4</sup></li> <li>• Annual direct medical expenditures attributable to obesity are \$75 billion.<sup>5</sup></li> </ul>
Obesity disproportionately affects minority and poor populations	<ul style="list-style-type: none"> <li>• African-Americans are disproportionately affected by obesity. Caucasians make up 75% of the U.S. population, but only 64% of the morbidly obese population. In contrast, African-Americans make up 12% of the population but 23% of the morbidly obese population.<sup>6</sup></li> <li>• Poor populations (those making less than \$20,000 annually) show a similar increase in likelihood of being morbidly obese.<sup>5</sup></li> </ul>
Bariatric surgery is a life-saving procedure as it is proven to increase life expectancy	<ul style="list-style-type: none"> <li>• Christou study compared morbidly obese patients who were treated with surgery versus those who were not. It found an 89% reduction in the risk of death throughout five years in the surgery group. <b>In other words, those who received surgery were nine times less likely to die over the next five years.</b><sup>7</sup></li> <li>• New England Journal of Medicine Study comparing 15,000 plus severely obese individuals found a 40% lower risk of death over 7 years in surgery patients for all causes. The study found a 52% lower risk of death from obesity related illnesses including a 92% lower risk of death from diabetes.<sup>8</sup></li> </ul>
Bariatric surgery resolves potentially fatal co-morbid conditions	<ul style="list-style-type: none"> <li>• A meta-analysis study including more than 22,000 patients showed the following effects of surgery on co-morbidities:             <ul style="list-style-type: none"> <li>◦ Diabetes was completely resolved in 76.8% of patients.</li> <li>◦ High cholesterol was resolved or improved in more than 70% of patients.</li> <li>◦ High blood pressure was resolved in 61.7% of patients.</li> <li>◦ Sleep apnea was resolved in 85.7% of patients.<sup>9</sup></li> </ul> </li> <li>• Other studies have shown even higher (82%) resolution of diabetes<sup>10</sup> and “profound improvement in obstructive sleep apnea.”<sup>11</sup></li> </ul>
Weight-loss post-surgery is extensive and durable	<ul style="list-style-type: none"> <li>• A long term study following patients for up to 14 years after surgery found that 89% of weight-loss was maintained.<sup>12</sup></li> </ul>
The risk-benefit tradeoff for bariatric surgery is favorable	<ul style="list-style-type: none"> <li>• The mortality rate for bariatric surgery varies by surgeon. Experienced surgeons have mortality rates ranging from .02%-.5% (averaging the rate for all types of procedures)<sup>13,14</sup>. The risks of not receiving surgery is far higher as demonstrated by the Christou study where those who did not receive surgery were almost nine times more likely to die.<sup>15</sup></li> </ul>
Coverage for bariatric surgery makes economic sense	<ul style="list-style-type: none"> <li>• Downstream savings associated with bariatric surgery are estimated to offset the costs in 2 years (laparoscopic procedure) to 4 years (open procedure).<sup>16</sup></li> <li>• Post surgery drug costs for diabetic and anti-hypertensive medications decrease dramatically. Potteiger study found a 77.3% savings.<sup>17</sup></li> </ul>

## Sources

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- <sup>4</sup> Fontaine KR, Redden DT, Wang C, Westfall AO, Allison DB. Years of life lost due to obesity. *JAMA*. 2003 Jan 8;289(2):187-93.
- <sup>5</sup> Finkelstein EA, Fiebelkorn, IC, Wang G. State-Level Estimates of Annual Medical Expenditures Attributable to Obesity. *Obesity Research* 2004 Jan;12(1):18-24.
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- <sup>7</sup> Christou NV, Sampalis JS, Liberman M. Surgery Decreases Long-Term Mortality, Morbidity, and health Care Use in Morbidly Obese Patients. *Annals of Surgery* 2004, Vol. 240, No. 3, pp. 416-424.
- <sup>8</sup> Adams TD, et al. Long-Term Mortality after Gastric Bypass Surgery. *New England Journal of Medicine* 2007;357:753-761.
- <sup>9</sup> Buchwald H, Avidor Y, Braunwald E, et al. Bariatric Surgery – A Systematic Review of the Literature and Meta-analysis. *JAMA*, 2004:292:1724-1737.
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- <sup>13</sup> Buchwald H, Avidor Y, Braunwald E, et al. Bariatric Surgery – A Systematic Review of the Literature and Meta-analysis. *JAMA*, 2004:292:1724-1737.
- <sup>14</sup> Pratt G, ASMBS Center of Excellence Course, January 2009, Surgical Review Corporation BOLD Database
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