



**ASMBS**

American Society for Metabolic & Bariatric Surgery

**For Immediate Release**

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**NEW STUDY SHOWS PRIVATELY INSURED BARIATRIC SURGERY PATIENTS**

**LOSE SIGNIFICANTLY MORE WEIGHT THAN THOSE WITH GOVERNMENT-SUBSIDIZED INSURANCE**

**Greater Weight Loss Despite Longer Insurance-Mandated Medically Supervised Diet Program Before Surgery**

**ATLANTA, GA – NOV. 14, 2013** – Researchers found the biggest determinant of weight loss after bariatric surgery was not how long a patient was on a medically supervised diet program before surgery, but whether or not the patient had private or government-subsidized insurance.

The new research\* was presented here at the 30<sup>th</sup> annual scientific meeting of the American Society for Metabolic Surgery (ASMBS) during ObesityWeek 2013, the largest international event focused on the basic science, clinical application and prevention and treatment of obesity. The event is hosted by the ASMBS and The Obesity Society (TOS).

The retrospective study followed 300 bariatric surgery patients in Rhode Island for three years. Three months after surgery all patients had similar weight loss, but six months after surgery, those on private insurance plans lost more than 30 percent more total weight than those on government-subsidized health plans (70 pounds vs. 55 pounds), regardless of their time on pre-operative doctor supervised diet programs.

"Our study does not support pre-operative medical supervised diet programs for longer durations than three months," said Kimberly S. Maloomian, RD, LDN, at The Miriam Hospital in Providence, RI, who co-authored the study along with researchers from Alpert Medical School at Brown University. "Rather than insurers requiring diet programs that make very little difference in weight loss after surgery and increasing the amount of health care dollars spent per patient, clinicians should be allowed to use their professional judgment preoperatively, and provide individualized education to patients on a case by case basis. As we move to a non-fee for service health care model, we need to be careful about how we spend our patients' health care dollars. The pre-operative focus should be on helping to prepare patients for adherence to nutrition and activity recommendations after surgery, since it is in the post-surgical period where we can have the greatest impact on outcomes. Once the clinician feels the patient is ready, he or she should be cleared for surgery, not be required to come for more visits, which unnecessarily spends more time and money."

All the government-subsidized health plans in the study (Neighborhood Health Plan of Rhode Island, Rhody Health Partners and RItE Care; Medicare and Medicaid patients were excluded due to lack of a requirement) required patients to be on a medically supervised diet for four to six months, while private insurers required either three months or six months. Privately insured patients on the three-month diet program lost about 70 pounds after surgery, about the same weight loss experienced by privately insured patients on six-month diet plans. However, patients in government-subsidized health plans, who were all required to be on pre-operative diet plans for four to six months, lost 55.5 pounds.

In terms of excess weight loss after surgery, privately insured patients on the six month plans lost 53 percent six months after surgery; excess weight loss among privately insured patients in the three month plans was 36.9 percent and government-subsidized patients lost 37 percent.

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Prior to starting any of the pre-operative diet programs, the three groups were similar in regards to weight, body mass index (BMI), and presence of co-morbidities. Patients weighed between 284 and 299 pounds and BMIs were between 46.5 and 48.2. Weight loss from the pre-operative diet programs was minimal. The government-backed insurance patients gained a little more than a pound. Patients on the three-month programs experienced negligible weight loss and privately insured patients on the six-month plan lost less than four pounds.

The study also found the government-subsidized health plan patients were more likely to drop out of bariatric surgery programs during the pre-operative period than privately insured patients (18% vs. 14% of privately insured patients in the six month group). Privately insured patients with a three month requirement had a 6.5 percent dropout rate.

In March 2011, the ASMBS issued a position statement on prolonged preoperative diet efforts before health insurance carrier approval of bariatric surgery. The ASMBS called the requirement "inappropriate, capricious, and counter-productive given the complete absence of a reasonable level of medical evidence to support this practice. Policies such as these that delay, impede or otherwise interfere with life-saving and cost-effective treatment, as have been proven to be true for bariatric surgery to treat morbid obesity, are unacceptable without supporting evidence. Individual surgeons and programs should be free to recommend preoperative weight loss based on the specific needs and circumstances of the patient."

In addition to Maloomian, study co-authors include Sivamainthan Vithiananthan, MD, Beth A. Ryder, MD, Sara E. Metro Stiles, RD, LDN, Hari Vigneswaran, BS, Kellie C. Armstrong, RN, MS, CBN, and G.D. Roye, MD, from the Alpert Medical School at Brown University.

### **About Obesity and Metabolic and Bariatric Surgery**

According to the Centers of Disease Control and Prevention (CDC), more than 78 million adults were obese in 2011–2012.<sup>1</sup> The ASMBS estimates about 24 million people have severe or morbid obesity. Individuals with a BMI greater than 30 have a 50 to 100 percent increased risk of premature death compared to healthy weight individuals as well as an increased risk of developing more than 40 obesity-related diseases and conditions including type 2 diabetes, heart disease and cancer.<sup>2,3</sup>

Metabolic/bariatric surgery has been shown to be the most effective and long lasting treatment for morbid obesity and many related conditions and results in significant weight loss. The Agency for Healthcare Research and Quality (AHRQ) reported significant improvements in the safety of metabolic/bariatric surgery due in large part to improved laparoscopic techniques.<sup>4</sup> The risk of death is about 0.1 percent<sup>5</sup> and the overall likelihood of major complications is about 4 percent.<sup>6</sup>

### **About the ASMBS**

The ASMBS is the largest organization for bariatric surgeons in the world. It is a non-profit organization that works to advance the art and science of bariatric surgery and is committed to educating medical professionals and the lay public about bariatric surgery as an option for the treatment of morbid obesity, as well as the associated risks and benefits. It encourages its members to investigate and discover new advances in bariatric surgery, while maintaining a steady exchange of experiences and ideas that may lead to improved surgical outcomes for morbidly obese patients. For more information, visit [www.asmb.org](http://www.asmb.org).

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**\*A-140-OR: Less is More: Bariatric Surgery Related Weight Loss In Publicly Insured Patients and Duration of Mandated Preoperative Diet Program --** *Kimberly S. Maloomian, RD, LDN; Sivamainthan Vithiananthan, MD; Beth A. Ryder, MD; Sara E. Metro Stiles, RD, LDN; Hari Vigneswaran, BS; Kellie C. Armstrong, RN, MS, CBN; G.D. Roye, MD; Presented November 14, 2013*

<sup>1</sup>Prevalence of Obesity Among Adults: United States, 2011–2012. (2013). Center for Disease Control and Prevention. Access October 2013 from <http://www.cdc.gov/nchs/data/databriefs/db131.htm>

<sup>2</sup>Office of the Surgeon General – U.S. Department of Health and Human Services. (2004). Overweight and obesity: health consequences. Accessed October 2013 from [http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact\\_consequences.html](http://www.surgeongeneral.gov/topics/obesity/calltoaction/fact_consequences.html)

<sup>3</sup>Kaplan, L. M. (2003). Body weight regulation and obesity. *Journal of Gastrointestinal Surgery*. 7(4) pp. 443-51. Doi:10.1016/S1091-255X(03)00047-7. Accessed October 2013.

<sup>4</sup>Encinosa, W. E., et al. (2009). Recent improvements in bariatric surgery outcomes. *Medical Care*. 47(5) pp. 531-535. Accessed October 2013 from <http://www.ncbi.nlm.nih.gov/pubmed/19318997>

<sup>5</sup>Agency for Healthcare Research and Quality (AHRQ). (2007). Statistical Brief #23. Bariatric Surgery Utilization and Outcomes in 1998 and 2004. Accessed October 2013 from <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb23.jsp>

<sup>6</sup>Flum, D. R., et al. (2009). Perioperative safety in the longitudinal assessment of bariatric surgery. *New England Journal of Medicine*. 361 pp.445-454. Accessed October 2013 from <http://content.nejm.org/cgi/content/full/361/5/445>