State of Arkansas *As Engrossed: H2/27/25 S4/1/25*
95th General Assembly **A Bill**
Regular Session, 2025 HOUSE BILL 1424

By: Representative L. Johnson
By: Senator B. Johnson

For An Act To Be Entitled

AN ACT TO MANDATE COVERAGE FOR SEVERE OBESITY TREATMENTS; AND FOR OTHER PURPOSES.

Subtitle

TO MANDATE COVERAGE FOR SEVERE OBESITY TREATMENTS.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

SECTION 1. Arkansas Code Title 20, Chapter 77, Subchapter 1, is amended to add an additional section to read as follows:

20-77-154. Treatment of severe obesity.

(a) The Arkansas Medicaid Program shall reimburse for the treatment of diseases and conditions caused by severe obesity.

(b) The coverage under subsection (a) of this section shall include coverage for:

(1) Bariatric surgery, as recognized by the American Society for Metabolic and Bariatric Surgery;

(2) Preoperative care for bariatric surgery; and

(3) Post-operative care for bariatric surgery.

(c) This section does not require the Arkansas Medicaid Program to provide coverage for injectable drugs to lower glucose levels or any other drugs prescribed for weight loss.

(d) The Department of Human Services shall apply for any federal waiver, Medicaid state plan amendments, or other authority necessary to implement this section.

SECTION 2. Arkansas Code Title 23, Chapter 79, is amended to add an additional subchapter to read as follows:

Subchapter 29 — Coverage for Treatment for Severe Obesity

23-79-2901. Definitions.

As used in this subchapter:

(1) "Body mass index" means body weight in kilograms divided by height in meters squared;

(2) "Covered person" means an individual who is entitled to receive healthcare services under the terms of a health benefit plan;

(3)(A) "Health benefit plan" means an individual, blanket, or group plan or a policy or contract for healthcare services offered, issued, renewed, delivered, or extended in this state by a healthcare insurer.

(B) "Health benefit plan" includes indemnity and managed care plans.

(C) "Health benefit plan" does not include:

(i) A plan that provides only dental benefits or eye and vision care benefits;

(ii) A disability income plan;

(iii) A credit insurance plan;

(iv) Insurance coverage issued as a supplement to liability insurance;

(v) A medical payment under an automobile or homeowners insurance plan;

(vi) A health benefit plan provided under Arkansas Constitution, Article 5, § 32, the Workers' Compensation Law, § 11-9-101 et seq., or the Public Employee Workers' Compensation Act, § 21-5-601 et seq.;

(vii) A plan that provides only indemnity for hospital confinement;

(viii) An accident-only plan;

(ix) A specified disease plan;

(x) A long-term-care-only plan; or

(xi) Nonfederal governmental plans as defined in 29 U.S.C. § 1002(32), as it existed on January 1, 2025;

(4)(A) "Healthcare insurer" means an insurance company, hospital and medical service corporation, or health maintenance organization that

issues or delivers health benefit plans in this state and is subject to:

(i) The insurance laws of this state;

(ii) Section 23-75-101 et seq., pertaining to hospital and medical service corporations; or

(iii) Section 23-76-101 et seq., pertaining to health maintenance organizations.

(B) "Healthcare insurer" does not include an entity that provides only dental benefits or eye and vision care benefits;

(5) "Healthcare provider" means a type of provider that renders healthcare services to patients for compensation including a doctor of medicine or another licensed healthcare professional acting within the professional's licensed scope of practice; and

(6) "Severe obesity" means a body mass index equal to or greater than:

(A) Forty kilograms per meter squared (40 kg/m2); or

(B)(i) Thirty-five kilograms per meter squared (35 kg/m2) along with an associated comorbidity.

(ii) An associated comorbidity under subdivision (6)(B)(i) of this section includes without limitation:

(a) Hypertension;

(b) Cardiopulmonary conditions;

(c) Sleep apnea; or

(d) Diabetes.

23-79-2902. Coverage for treatment of diseases and conditions caused by severe obesity.

(a) On and after January 1, 2026, a health benefit plan that is offered, issued, renewed, delivered, or extended in this state shall provide coverage for medically necessary expenses for the treatment of diseases and conditions caused by severe obesity.

(b) The coverage under subsection (a) of this section shall include without limitation coverage for:

(1)(A) Bariatric surgery as recognized by the American Society for Metabolic and Bariatric Surgery.

(B) Bariatric surgery under subdivision (b)(1)(A) of this section shall be limited to the following:

(i) Biliopancreatic bypass with duodenal switch;

(ii) Laparoscopic adjustable gastric banding;

(iii) Roux-en-Y procedure; and

(iv) Sleeve gastrectomy;

(2) Revision bariatric surgery when required to manage a complication resulting from a prior bariatric surgery type as provided in subdivision (b)(1) of this section that utilizes a different procedure from those procedures listed in subdivision (b)(1) of this section;

(3) Preoperative care, including without limitation:

(A) Psychological screening and counseling;

(B) Behavior modification counseling;

(C) Nutritional and dietary counseling;

(D) Exercise or physical therapy and counseling; and

(4) Post-operative care, including without limitation:

(A) Post-operative follow-up;

(B) Behavior modification counseling;

(C) Nutritional and dietary counseling;

(D) Exercise or physical therapy and counseling; and

(E) Psychological screening and counseling.

(c) For a covered person to qualify for coverage under this section:

(1) A healthcare provider shall issue a written order that includes a statement that:

(A) Identifies the body mass index and any associated comorbid conditions;

(B) Describes the treatment plan for diseases and conditions caused by severe obesity; and

(C) Attests that the treatment is medically necessary for the covered person according to the qualifications and treatment standards established by the American Society for Metabolic and Bariatric Surgery or the American College of Surgeons;

(2) The covered person shall attest that he or she has:

(A) Participated in a weight loss program;

(B) Received preoperative medical and mental health evaluations and clearances;

(C) Received preoperative education that addresses the risks, benefits, realistic expectations, and the need for long-term follow-up

and adherence to behavioral modifications; and

(D) Received a copy of the treatment plan that describes the preoperative needs and postoperative needs of an individual undergoing bariatric surgery;

(3) In lieu of the list of requirements in subdivision (c)(2) of this section, a covered person may attest to the completion of a multidisciplinary surgical preparation program that is also signed by the healthcare provider; and

(4) Cannot have undergone a bariatric surgery previously, unless the proposed bariatric surgery is to correct a complication that resulted from the previous bariatric surgery.

23-79-2903. Limitations.

(a) Before any treatment for diseases and conditions caused by severe obesity covered under this subchapter begins, a healthcare insurer may require a covered person to successfully complete a preoperative period of no more than three (3) months that may include counseling, nutritional education, and other covered healthcare services to assist in preparation and evaluation for treatment of diseases and conditions caused by severe obesity.

(b) The coverage for bariatric surgery shall only be for covered persons who are eighteen (18) years of age or older.

(c) A healthcare insurer may:

(1) Restrict covered healthcare services under this subchapter to those provided in facilities holding accreditation by the American College of Surgeons and the American Society for Metabolic and Bariatric Surgery's Metabolic and Bariatric Surgery Accreditation; and

(2) Require that a covered healthcare service for the treatment of diseases and conditions caused by severe obesity under this subchapter receives prior authorization from the healthcare insurer.

23-79-2904. Exclusions.

This subchapter does not require a healthcare insurer to provide coverage for injectable drugs used to lower glucose levels or any other drugs prescribed for weight loss.

23-79-2905. Rules.

(a) The Insurance Commissioner, in accordance with evidence-based industry best practices, guidelines, and screening tools as recommended by the American Society for Metabolic and Bariatric Surgery or another nationally recognized body as may be designated by the commissioner, shall evaluate and promulgate rules for additional preoperative conditions that qualify as *associated comorbidities and for coverage requirements.*

(b) If the commissioner promulgates rules under subsection (a) of this section, the rules shall include without limitation medically necessary expenses for:

(1) Bariatric surgery, revision bariatric surgery, and reoperative bariatric surgery, as recognized by the American Society for Metabolic and Bariatric Surgery;

(2) Preoperative care, including without limitation:

(A) Psychological screening and counseling;

(B) Behavior modification counseling;

(C) Nutritional and dietary counseling;

(D) Exercise or physical therapy evaluations, counseling, and treatment; and

(3) Post-operative care, including without limitation:

(A) Postoperative follow-up;

(B) Behavior modification counseling;

(C) Nutritional and dietary counseling;

(D) Exercise or physical therapy evaluations, counseling, and treatment; and

(E) Psychological screening and counseling.

/s/L. Johnson

APPROVED: 4/16/25