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February 19, 2024

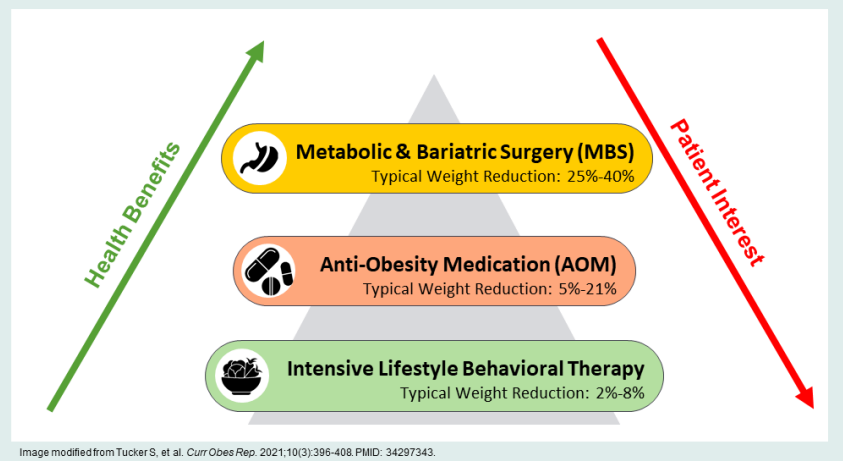
RE: **Senate Bill 594**

Dear Chair Beidle, Vice-Chair Klausmeier, and members of the committee:

As a practicing obesity medicine physician, my patients regularly say to me: “*It just doesn’t make sense – why does my health insurance cover treatments for diseases that I am likely to develop because of my weight, but excludes treatments for obesity? I know that weight loss can help me prevent these conditions from happening.*” During these conversations, I struggle to provide a logical rationale for the lack of obesity treatment coverage, as I agree it does not make sense. For over a decade, the American Medical Association has recognized obesity as a chronic disease, yet insurance coverage for obesity treatment does not reflect this reality. **Senate Bill 594** presents an opportunity for the **Maryland healthcare system to begin to “make sense” in treating obesity among recipients of the Maryland Medical Assistance Program.**

Leading medical organizations, including the American Association of Clinical Endocrinologists and American Gastroenterological Association, recommend comprehensive obesity treatment.<sup>i,ii,iii</sup> This strategy includes intensive lifestyle behavioral therapy, anti-obesity medications, and metabolic & bariatric surgery. **Senate Bill 594** proposes to **cover comprehensive obesity treatment** for recipients of the Maryland Medical Assistance Program, notably expanding coverage for anti-obesity medications.

Figure. Obesity Treatment Pyramid



Obesity treatment is a pyramid that allows physicians to tailor options based on patients’ health needs and interests (Figure). The foundation is intensive lifestyle behavioral therapy, which consists of counseling and regular follow-up. While this therapy results in 2-8% weight loss, many patients with obesity need to achieve greater amounts of weight loss to meet their health goals which is where anti-obesity medication and surgery play key roles.

Both anti-obesity medication and surgery increase the number of people who achieve and sustain a meaningful weight loss. Anti-obesity medication achieves 5-21% weight loss and surgery achieves 25-40%. These treatments tap into the complex physiologic pathways between the brain, digestive tract, and other body tissues that regulate appetite, hunger, and body weight. For many, losing weight triggers these physiologic systems to increase hunger, decrease feelings of fullness after eating, and

slow metabolism – people struggle to lose weight and maintain weight loss, as they are fighting against their physiology – it is not the case that they just need to “eat less and move more.”

**Losing weight is not a question of willpower, rather the science shows that treatment with medication or surgical tools address these biological mechanisms.** In my obesity medicine clinical practice, most patients prefer long-term treatment with medication over surgery. The management of many chronic conditions includes a foundation of lifestyle changes with the addition of medication(s) as disease severity increases – invasive procedures are reserved for the most severe cases. Comprehensive obesity treatment uses a similar strategy. Perhaps unique to obesity, its treatment often leads to the prevention of or improvement in other chronic conditions. With weight loss, patients have better blood pressure control and may be able to come off blood pressure medications – patients have better blood sugar control and may be able to come off diabetes medications – patients experience less pain and are able to be more physically active – patients have greater quality of life and improved mood and well-being.

Beyond improvements in patient health and well-being, treating obesity may lead to decreased healthcare spending. Obesity has been estimated to **add over \$150 billion annually to healthcare spending.**<sup>iv</sup> A prior analysis estimated that **medical expenditures for the Maryland Medical Assistance Program may be reduced by 10.5% if all individuals with obesity were normal weight.**<sup>v</sup> Therefore, passage of **Senate Bill 594** would increase the likelihood that **Program recipients achieve and sustain a meaningful weight loss that may lead to cost savings.** For example, an economic modeling analysis found that **treating obesity with anti-obesity medications could generate substantial cost offsets along with positive societal impacts like reduced disability.**<sup>vi</sup>

Unfortunately, Maryland Medical Assistance Program recipients currently lack coverage for anti-obesity medications. Patients in my clinical practice must consider whether they can afford to pay for a medication out-of-pocket, which is not possible for most Program recipients. Sadly, I also have multiple patients now hoping that they develop diabetes, as this diagnosis would likely grant them access to diabetes medications that also treat obesity (e.g., liraglutide, semaglutide, tirzepatide). Ultimately, the **lack of anti-obesity medication coverage only serves to worsen health and healthcare disparities for this population.** Medicaid beneficiaries in other mid-Atlantic states, including Pennsylvania, Delaware, Virginia and New Jersey, already have coverage for anti-obesity medications.<sup>vii</sup> Senate Bill 594 may help address treatment inequities in Maryland to make available comprehensive obesity treatment.

In summary, **I respectfully request that the Committee give Senate Bill 594 a favorable report.** Please contact me with any questions about this position at [gudzune@jhu.edu](mailto:gudzune@jhu.edu).

Thank you for your consideration.



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<sup>i</sup> Apovian CM, Aronne LJ, Bessesen DH, et al. Pharmacological management of obesity: an Endocrine Society clinical practice guideline. *J Clin Endocrinol Metab.* 2015; 100(2):342-62. PMID: [25590212](https://pubmed.ncbi.nlm.nih.gov/25590212/).

<sup>ii</sup> Garvey WT, Mechanick JL, Brett EM, et al. American Association of Clinical Endocrinologists and American College of Endocrinology comprehensive clinical practice guidelines for medical care of patients with obesity. *Endocr Pract.* 2016; 22 Suppl 3:1-203. PMID: [27219496](https://pubmed.ncbi.nlm.nih.gov/27219496/).

<sup>iii</sup> Grunwald E, Shah R, Hernaez R, et al. AGA Clinical Practice Guideline on Pharmacological Interventions for Adults with Obesity. *Gastroenterology.* 2022; 163(5):1198-1225. PMID: [36273831](https://pubmed.ncbi.nlm.nih.gov/36273831/).

<sup>iv</sup> Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. Annual medical spending attributable to obesity: payer- and service-specific estimates. *Health Aff (Millwood).* 2009;28(5):w822-31. PMID: [19635784](https://pubmed.ncbi.nlm.nih.gov/19635784/).

<sup>v</sup> Trogdon JG, Finkelstein EA, Feagan CW, Cohen JW. State- and payer-specific estimates of annual medical expenditures attributable to obesity. *Obesity (Silver Spring).* 2012;20(1):214-20. PMID: [21681222](https://pubmed.ncbi.nlm.nih.gov/21681222/).

<sup>vi</sup> Sexton Ward A, Tysinger B, Nguyen PG, Goldman D, Lakdawalla D. Benefits of Medicare coverage for weight loss drugs. USC Schaeffer Center for Health Policy & Economics. (2023) Available at: <https://healthpolicy.usc.edu/research/benefits-of-medicare-coverage-for-weight-loss-drugs/>

<sup>vii</sup> Waidmann TA, Waxman E, Pancini V, Gupta P, Phillip Tabb L. Obesity Across America. Urban Health Institute. (2022) Available at: <https://www.urban.org/sites/default/files/2022-02/obesity-across-america.pdf>.