

SB594 Testimony.pdf

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Position: FAV

STEPHEN S. HERSHEY, JR.
Legislative District 36
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MINORITY LEADER

Finance Committee
Executive Nominations Committee

Rules Committee

Joint Committee on Legislative Ethics

Legislative Policy Committee

February 20, 2024

Chair Pamela Beidle

Finance Committee

3 East Miller Senate Office Building

Re: Senate Bill 594 Maryland Medical Assistance Program – Coverage for the Treatment of Obesity

Dear Chairwoman and Members of the Committee,

Senate Bill 594 requires Medicaid to provide coverage for the treatment of obesity, including coverage for intensive behavioral therapy, bariatric surgery, and any medications approved by the Food and Drug Administration (FDA) for those patients indicated for chronic weight management with obesity.

Obesity is recognized as a disease by organizations that include the World Health Organization, the FDA, the NIH, the IRS, the American Medical Association, the American Association of Clinical Endocrinologists, and the Endocrine Society.

Obesity is caused by a range of biologic, genetic, social, behavior, and environmental factors, which may increase the risks for other chronic conditions including Type 2 diabetes, high blood pressure, infertility, stroke, and some cancers.

Obesity is linked to more than 200 comorbid conditions. Patients living with obesity are at an increased risk of developing weight-related comorbidities, such as cardiovascular diseases, hypertension, sleep apnea, depression, asthma, nonalcoholic fatty liver disease, type 2 diabetes, knee and hip osteoarthritis, gout and more.

Obesity is treatable and should be treated. Maryland Medicaid covers the cost of bariatric surgery, but currently prohibits coverage for pharmacotherapy. We should be treating not only the symptoms of obesity but also the cause.

Maryland ranks 22nd in the nation for obesity and overweight- 34.3% has obesity and nearly 70% of the state has obesity and overweight. The most impacted population are from the African American community accounting for 41.7% of the obesity population and 32.8% of the obesity population being Hispanic.

Our state needs to shift from a system of sick-care to well-care, especially within our most vulnerable population – Medicaid participants.

I urge your favorable report for Senate Bill 594.



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THE SENATE OF MARYLAND
ANNAPOLIS, MARYLAND 21401

Background Facts

Disease

- Obesity is a serious chronic disease that is recognized as such by major medical organizations, including the American Medical Association - since 2013, the American Association of Clinical Endocrinologists, the American College of Cardiology, the Endocrine Society, the American Society for Reproductive Medicine, the Society for Cardiovascular Angiography and Interventions, the American Urological Association and the American College of Surgeons.
- Obesity is linked to more than 200 comorbid conditions. Patients living with obesity are at an increased risk of developing weight-related comorbidities, such as cardiovascular diseases, hypertension, sleep apnea, depression, asthma, nonalcoholic fatty liver disease, type 2 diabetes, knee and hip osteoarthritis, gout and more. (<https://www.ama-assn.org/topics/obesity>)
- Obesity is a complex chronic disease, one in which genetics, the environment, and biology all play important factors. Roughly 77% obesity is inherited, where <25% is based on environmental factors. (<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3717174/>)
- Obesity is known to be the main risk factor for type 2 diabetes. Treating obesity could reduce the incidence of diabetes by 58%. (<https://doi.org/10.2337/ds17-0030>)
- Obesity is associated with increased risk of 13 types of cancer: Meningioma (brain cancer), Multiple Myeloma (cancer of blood cells), Thyroid, Adenocarcinoma of the esophagus, Breast (post-menopausal women), Liver, Gallbladder, Upper Stomach, Pancreas, Kidneys, Uterus, Ovaries, Colon and Rectum. (Image: <https://www.cdc.gov/cancer/obesity/index.htm>)
- From 2005 to 2014, most cancers associated with overweight and obesity increased in the United States, while cancers associated with other factors decreased. During this time, the rate of new cancers associated with overweight and obesity (except colorectal cancer) increased 7%, while the rate of new cancers not associated with overweight and obesity dropped 13%. (The rate of new cases of colorectal cancer dropped 23% during this time. Screening tests can prevent this cancer.)(<https://www.cdc.gov/cancer/obesity/index.htm>)
- Lifestyle interventions (such as Intensive Behavioral Therapy) are associated with a mean weight loss of 2-4%. (<https://diabetesjournals.org/care/article/41/7/1526/36439/Global-Diabetes-Prevention-Interventions-A>)
- Bariatric surgery is associated with a weight reduction of 16-23% (<https://pubmed.ncbi.nlm.nih.gov/23163728/>)
- Anti-obesity medications are demonstrated to reduce weight from 5-17% (various studies), filling a void between the expected efficacy of IBT and bariatric surgery.

Costs

- The Federal Employee Health Benefits Plan (FEHB) – since 2023, TRICARE – since 2017, and the Civilian Health and Medical Program of the Department of Veteran’s Affairs (VA) (CHAMPVA) – since 2020, have all taken steps to proactively require anti-obesity medication coverage.
- Obesity accounts for 47% of the total cost of chronic diseases in the U.S. (<https://milkeninstitute.org/report/americas-obesity-crisis-health-and-economic-costs-excess-weight>)
- The economic burden of comorbidities increases exponentially over time. Over 10 years, an employee with a BMI over 40 can expect to incur a total economic burden nearly three times higher than an employee with a BMI between 30-34.9. (<https://pubmed.ncbi.nlm.nih.gov/26057567/>)
- Obesity is associated with high indirect costs for employers.
 - Short-term disability: employees with obesity-related complications are nearly two times as likely to file short-term disability claims; the number of short-term disability claims can increase by 37% as BMI increases from 30 to 35 for those with diabetes, hypertension, or hyperlipidemia. (<https://pubmed.ncbi.nlm.nih.gov/24779722/>)
 - Workers’ Compensation: in a 3-year study of workers’ compensation claims, claims were 160% higher for employees with obesity compared with those who have normal weight. (<https://pubmed.ncbi.nlm.nih.gov/27608149/>)
 - Absenteeism: According to one study using 2006-2008 survey data, employees with a BMI of 40 will miss 77% more work days compared with employees with a BMI of 25. Obesity-related absenteeism can cost US employers \$12.8 billion annually. (<https://pubmed.ncbi.nlm.nih.gov/20881629/>)
 - Presenteeism/Productivity: Presenteeism isn’t the workplace has been shown to be the single largest cost driver associated with obesity, regardless of BMI. Increasing BMI is associated with impaired work productivity and indirect costs. (<https://pubmed.ncbi.nlm.nih.gov/29065062/>)
- Obesity increases the risk for severe COVID-19.
 - Persons of any age with obesity (defined by the CDC as BMI of 30+) are “at an increased risk of severe illness from COVID-19”. (<https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/people-with-medical-conditions.html>)
 - The CDC reported that 78% of COVID-19 patients requiring admission to an intensive-care unit (ICU) had at least one underlying health condition, many of which were obesity-related diseases. (https://cdc.gov/mmwr/volumes/70/wr/mm7010e4.htm?s_cid=mm7010e4_w)

Health Equity

- African American women have the highest rates of obesity among any demographic group; approximately 4 out of 5 African American women have overweight or obesity. (<https://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlid=25>)
- Non-Hispanic blacks had the highest prevalence of obesity at 49.6%, followed by Hispanics at 44.8%, and non-Hispanic whites at 42.2%. (<https://www.cdc.gov/obesity/data/adult.html>)
- Women and minorities are disproportionately impacted by cancer types associated with obesity. (<https://www.cdc.gov/media/releases/2017/p1003-vs-cancer-obesity.html>)
 - 55% of all cancers diagnosed in women and 24% of those diagnosed in men are associated with obesity.
 - Women who have obesity are two to about four times as likely to develop endometrial cancer.
 - Non-Hispanic blacks had higher incidence rates of cancer types associated with obesity compared with other racial and ethnic groups.
 - Black males and American Indian/Alaska Native males had higher incidence rates than white males.
- Obesity is impacted by socioeconomic status: overall, men and women with college degrees have lower obesity prevalence compared with those with less education. (<https://www.cdc.gov/obesity/data/adult.html>)

Mental Health

- Obesity is a highly stigmatized disease. The misconception that a person's body weight is within an individual's control and that obesity results from individual choices negatively impacts a patient's mental and physical health. (<https://doi.org/10.1016/j.eclinm.2022.101408>)
- Individuals who have obesity also struggle with issues related to their mood, self-esteem, quality of life, and body image. (<https://doi.org/10.1016/j.ecl.2016.04.016>)
- Obesity is associated with significant increases in lifetime diagnosis of major depression. (<https://doi.org/10.1001/archpsyc.63.7.824>)
- Adults suffering from obesity have a 55% higher risk of developing depression over their lifetime compared to people that did not struggle with obesity. (<https://doi.org/10.1001/archgenpsychiatry.2010.2>)

SB0594_FAV_MedChi_Medicaid – Coverage for Treatment

Uploaded by: Danna Kauffman

Position: FAV

MedChi

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TO: The Honorable Pamela Beidle, Chair
Members, Senate Finance Committee
Senator Steven S. Hershey, Jr.

FROM: Danna L. Kauffman
Pamela Metz Kasemeyer
J. Steven Wise
Andrew G. Vetter
Christine K. Krone
410-244-7000

DATE: February 20, 2024

RE: **SUPPORT** – Senate Bill 594 – *Maryland Medical Assistance Program – Coverage for the Treatment of Obesity*

The Maryland State Medical Society (MedChi), the largest physician organization in Maryland, **supports** Senate Bill 594. This bill only applies to the Medicaid program (not the commercial market) and requires comprehensive coverage for the treatment of obesity, which includes coverage for intensive behavioral therapy, bariatric surgery, and FDA-approved anti-obesity medication (i.e., medication approved by the federal FDA with an indication for chronic weight management in patients with obesity).

According to the federal Centers for Disease Control and Prevention (CDC), the obesity prevalence in the United States has increased from 30.5% (1999-2000) to 41.9% (2017 – March 2020). During the same time, the prevalence of severe obesity increased from 4.7% to 9.2%. Conditions related to obesity include heart disease, stroke, Type 2 diabetes, and certain types of cancer. These are among the leading causes of preventable, premature death. The estimated annual medical cost of obesity in the United States was nearly \$173 billion in 2019. Medical costs for adults who had obesity were \$1,861 higher than medical costs for people with healthy weight.

Improving population health is a key goal of the Maryland Total Cost of Care Model. Under the Model, Maryland is expected to progressively transform care delivery across the health care system with the objective of improving health and quality of care. Addressing diabetes is one of the key goals under population health and obesity is recognized by the State as a key risk factor in developing diabetes. As such, MedChi supports Senate Bill 594 and believes that it will continue to advance Maryland's current efforts under population health and that, in the long-term, it will result in cost savings to the State by avoiding those conditions most associated with obesity.

SB594_NationalHispanicMedicalAssoc_FAV

Uploaded by: Elena Rios

Position: FAV



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February 14, 2024

Senator Stephen Hershey
Republican Minority Leader
The Maryland Senate

Dear Honorable Senator Hershey,

We write to support coverage for FDA-approved anti-obesity medications, including those of the GLP-1 class, for patients diagnosed with obesity or overweight covered under Maryland Medicaid. According to recent research on obesity care, only .002 of people living with obesity are being treated with anti-obesity medications.

Obesity is recognized as a chronic disease, on par with hypertension and diabetes, by the American Medical Association. This year, several medical organizations, including the AMA, have updated their obesity guidelines to reflect the highly effective medical treatments that are now available to our patients. However, Medicare does not cover drugs prescribed to treat obesity, costing patients \$1,000 to \$1,300 a month, or over \$15,000 a year. Weight loss medication must be included in coverage to ensure people who suffer from obesity have access to adequate, affordable treatment.

Studies are showing that pharmacological treatment results in significant benefits in obesity-related complications including dyslipidemia, heart failure, fatty liver and hepatic steatosis, cardiovascular disease, and both prevention and remission of type two diabetes. Currently, there are about 711,000 Latinos and almost 2 million African Americans residing in Maryland. According to the CDC, Hispanic adults have the second highest age-adjusted prevalence of obesity, at 45.6%, and are therefore more likely to suffer the consequences of related health conditions. Marylanders with these conditions suffer adverse health outcomes, which disproportionately affect patients from marginalized racial, ethnic, and socioeconomic groups, including children, and are cost drivers in our health system.

The federal Office of Personnel Management now requires obesity care and treatment, inclusive of pharmacotherapy options, for all federal employees effective January 1, 2023. The most recent data from the U.S. Department of Health and Human Services Office of Minority Health, attests that Hispanic Americans were 1.2 times more likely to be obese than non-Hispanic whites, in 2018. Maryland has always been a forward-thinking innovator in health care, and it is time to bring our obesity policies up to that standard, especially for the most vulnerable population.

Maryland is already paying for obesity and its complications. With your support of the [Obesity Bill of Rights](#) and coverage for FDA-approved anti-obesity medications, you have an opportunity to make a real difference in these outcomes by increasing equitable access to effective treatment.

Best,

Elena Rios, MD, MSPH, MACP
President & CEO

National Hispanic Medical Association

Senate Bill 594 Written Testimony_KaceyChae.pdf

Uploaded by: Kacey Chae

Position: FAV

February 19, 2024

To Whom It May Concern:

My name is Kacey Chae. I am an Obesity Medicine physician practicing at the Johns Hopkins University Healthful Eating, Activity and Weight Program in Baltimore, Maryland. This program is a comprehensive medical weight-management clinic that serves a diverse population of patients in the greater DC/Baltimore metropolitan area as well as surrounding states. In addition, I practice primary care at the Johns Hopkins Greenspring Station General Internal Medicine Clinic, where I serve a diverse patient population in Baltimore City and County. The purpose of my testimony is to express my enthusiastic support for the Maryland Senate Bill 594, which would allow the Maryland Medical Assistance Program to provide comprehensive coverage for the treatment of obesity, including FDA-approved anti-obesity medications.

Addressing obesity in Maryland is imperative for safeguarding the health and well-being of our residents. Obesity is not merely a matter of individual health but a major threat to public health with far-reaching implications. The prevalence of obesity is alarming: 33% of Maryland adults are affected by obesity. Beyond immediate health risks—for example, heart disease, type 2 diabetes, hypertension, chronic kidney disease, and certain types of cancer—obesity is also a substantial economic burden on our healthcare system that undermines productivity and quality-of-life for individuals and families. The aggregate medical cost due to obesity among adults nationwide was \$260.6 billion in 2016.¹ These figures will likely rise: we estimate 1 in 2 adults will have obesity in the United States by 2030.² Furthermore, obesity exacerbates health disparities, disproportionately affecting marginalized and underserved communities. In Maryland, significantly more Black adults are impacted by obesity compared to the overall prevalence (42% compared to 33%).³

Obesity is a chronic disease; it is not caused by a mere lack of willpower. For many individuals struggling with obesity, lifestyle changes alone may not be sufficient to achieve and maintain meaningful weight loss. Anti-obesity medications offer an effective adjunct to diet and exercise interventions, helping to curb appetite, reduce caloric intake, and facilitate sustainable weight loss. Moreover, these medications can mitigate the risk of obesity-related complications. As a physician, I have witnessed the transforming power of anti-obesity medications on the overall health and

1 Cawley, J. Biener, A., Meyerhoefer, C., Ding, Y., Zvenyach, T., Smolarz, G., Ramasamy, A. (2021). Direct medical costs of obesity in the United States and the most populous states. *Journal of Managed Care & Specialty Pharmacy*. 27(3). <https://doi.org/10.18553/jmcp.2021.20410>

2 Ward, Z. J., Bleich, S. N., Craddock, A. L., Barrett, J. L., Giles, C. M., Flax, C., Long, M. W., & Gortmaker, S. L. (2019). Projected U.S. state-level prevalence of adult obesity and severe obesity. *The New England Journal of Medicine*, 381(25), 2440–2450. <https://doi.org/10.1056/NEJMsa1909301>

3 America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, United Health Foundation, AmericasHealthRankings.org, accessed 2024.

quality-of-life in my patients. For example, Ms. M—a patient in my weight-management clinic—achieved a 30% weight loss through lifestyle and behavior changes, which were reinforced by the use of anti-obesity medication. As a result of her weight loss, she had improvement in nearly all her health conditions. These conditions include prediabetes, polycystic ovarian syndrome, high cholesterol, sleep apnea, and fatty liver disease. We were able to significantly reduce her medication burden and healthcare costs.

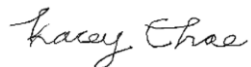
Compare the previous patient example with Mr. H. He is a patient in my primary care clinic who is suffering from the downstream effects of untreated obesity. Mr. H has high medication burden and frequent visits to specialists to manage his poorly-controlled type 2 diabetes, hypertension, and high cholesterol. These obesity-related chronic illnesses have led to heart disease, for which he is recommended for a bypass surgery. I frequently must treat patients like Mr. H who have many acute problems that are downstream of obesity. Expanding access to anti-obesity medications is an upstream solution.

The current Code of Maryland Regulations restricts the use of medications to treat obesity by the Maryland Medical Assistance Program, making these truly life-changing medications out-of-reach for our most vulnerable Maryland residents.

Through the passage of Senate Bill 594, which would expand the coverage of anti-obesity medications, particularly for the underserved population in Maryland, the Senate Bill Committee has the opportunity to enhance the effectiveness of obesity treatment strategies, empower individuals to achieve long-term weight loss goals, and address the health disparity in Maryland. It is imperative that the Senate Committee recognizes the urgency of this pressing issue and takes decisive action to implement effective strategies for preventing and treating obesity.

If I can provide further details or answer any questions, please reach out to me at kchae1@jh.edu.

Sincerely,



Kacey Chae, MD DABOM

Obesity Medicine Physician, Johns Hopkins Healthful Eating, Activity & Weight Program
General Internal Medicine Fellow, Johns Hopkins University School of Medicine

Gudzune_SB 594 Written Testimony_02-19-2024.pdf

Uploaded by: Kimberly Gudzune

Position: FAV

Division of General Internal Medicine

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Kimberly A. Gudzone, MD MPH FTOS
Associate Professor

February 19, 2024

RE: **Senate Bill 594**

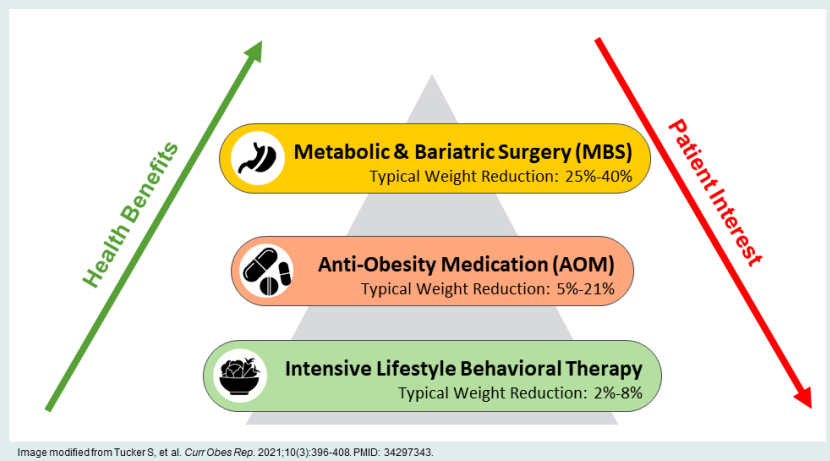
Dear Chair Beidle, Vice-Chair Klausmeier, and members of the committee:

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.^{i,ii,iii}

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.**^{iv} 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.**^v 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.**^{vi}

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.^{vii} 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.

Thank you for your consideration.



Kimberly A. Gudzone, MD MPH FTOS

Associate Professor, Medicine and Health Policy & Management
Director, Healthful Eating, Activity & Weight Program

ⁱ 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/).

ⁱⁱ Garvey WT, Mechanick JI, 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/).

ⁱⁱⁱ 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/).

^{iv} 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/).

^v 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/).

^{vi} 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/>

^{vii} 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>.

SB0594_AfPA_MD_FAV

Uploaded by: Margaret Uhler

Position: FAV



February 20, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

The Honorable Katherine Klausmeier
Vice Chair, Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

RE: Support for SB 594- Maryland Medical Assistance Program – Coverage for the Treatment of Obesity

Dear Chair Beidle, Vice Chair Klausmeier:

On behalf of the Alliance for Patient Access (AfPA), I am writing to express our strong support of SB 594, which would require Maryland to include comprehensive coverage for obesity treatment for state-sponsored health plans. As you are aware, patients with obesity now have FDA-approved pharmacologic options to treat obesity disease. However, ensuring patients can access appropriate obesity care is paramount to addressing the obesity epidemic.

Founded in 2006, AfPA is a national network of policy-minded health care providers who advocate for patient-centered care. AfPA supports health policies that reinforce clinical decision making, promote personalized care and protect the clinician-patient relationship. Motivated by these principles, AfPA members participate in clinician working groups, advocacy initiatives, stakeholder coalitions and the creation of educational materials.

The obesity epidemic in the United States is no secret. The New England Journal of Medicine predicts that 1 in 2 adults will have obesity by 2030, while 1 in 4 adults will have severe obesity. Currently, 42.7% of Maryland adults have obesity. In addition, communities of color in Maryland are disproportionately impacted by obesity with over 50% of Black adults and 43% of Hispanic adults experiencing obesity.

As you consider the overall health and well-being of Marylanders, these numbers are impossible to ignore. Obesity is not an insular disease; we know it is related to many other diseases including certain cancers, heart disease, stroke and type 2 diabetes. Furthermore, obesity is expensive. The aggregate annual medical costs due to obesity among adults in the United States is over \$260 billion. Total obesity-related government expenditures, including Medicaid and Medicare spending and federal outlays, are estimated to be \$91.6 billion per year, approximately 30% of Medicare spending.¹ Patients are also experiencing higher costs associated with obesity. Adults with obesity in the United States compared with those with lower BMIs experienced higher annual medical care costs of \$2,505.² These disparities are even more apparent for patients in lower socioeconomic areas who are more likely to have obesity and experience higher out-of-pocket costs.³

Importantly, in recent years, the FDA has approved several therapies for the treatment of obesity, meant to be used in conjunction with lifestyle changes. These treatment options have been revolutionary in ensuring patients and providers have additional tools to handle this complicated disease. Proper and effective

¹ <https://www.jmcp.org/doi/10.18553/jmcp.2021.20410>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10394178/>

³ Ibid

treatment of obesity would benefit patients through improved health outcomes, as well as the health care system in the form of savings.

Given the impact of obesity, SB 594 is an important step toward addressing this treatable disease. This legislation ensures that individual or group health plans include comprehensive coverage for the treatment of obesity. Allowing patients and providers to access the full regimen of treatment options, including behavioral therapy and anti-obesity medications, will have a positive impact on obesity patients throughout Maryland.

It is for these reasons that we believe SB 594 is crucial to solving Maryland's obesity epidemic. We respectfully request you allow this bill to advance through the legislative process, as it is imperative patients and providers have access to all available tools to treat obesity. If we can provide further details or answer any questions, please reach out to Casey McPherson at cmcpherson@allianceforpatientaccess.org or (202)951-7097.

Sincerely,

Fatima Hussein, MD
Ellicott City, Maryland

CC:

Senator Ellis
Senator Gile
Senator Hayes
Senator Hershey
Senator Kramer
Senator Lam
Senator Mautz
Senator Ready
Senator Washington

SB0594_ADA_FAV

Uploaded by: Monica Billger

Position: FAV



In Favor of: Senate Bill 594
Medical Assistance Program Obesity Coverage

Monica Billger
Director, State Government Affairs
American Diabetes Association
February 20, 2024

Chair Beidle, Vice Chair Klausmeier and Honorable Members of the Senate Finance Committee:

On behalf of the American Diabetes Association (ADA) and the almost half million Marylanders living with diabetes, and additional 1.6 million adults with prediabetes, I am writing in **support** of **Senate Bill 594** - which would provide comprehensive coverage for Marylanders in the State Medical Assistance Program who are living with obesity.

Obesity accounts for up to 53 % of new cases of diabetes each year in the United States.¹ According to the National Institutes of Health (NIH), over 85 % of people with type 2 diabetes are overweight or obese.² Moreover, obesity is the largest contributor to the chronic disease burden in the United States.³ Obesity exacerbates or causes **over 200 medical disorders** resulting in declining physical, mental and emotional health and physical mobility.⁴

The financial burden of overweight and obesity is equally compelling in supporting comprehensive treatment. In 2016, the estimated economic burden attributable to overweight and obesity in the United States was **\$480.7 billion in direct health care costs** and **\$1.24 trillion in indirect costs** due to lost productivity.⁵ For people with obesity, **per-patient-per-year health care expenditures** are an estimated **\$4,217** (adjusted to 2019 U.S. dollars [USD]) greater than in those without obesity.⁶

Moreover, the ADA is gravely concerned about the significant increase of obesity and its compounding impact on diabetes. The most expensive chronic disease in our nation, diagnosed diabetes costs an estimated **\$7 billion in Maryland** each year. ADA's 2024 Standards of Care recognize that "obesity is a chronic and progressive disease with numerous medical, physical,

¹ <https://www.ahajournals.org/doi/full/10.1161/JAHA.120.018799>

² <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4887150/>

³ Milken Institute. America's obesity crisis: the health and economic cost of excess weight. Published October 2018. Accessed October 8, 2020. <https://milkeninstitute.org/sites/default/files/reports-pdf/Mi-Americas-ObesityCrisis-WEB.pdf>

⁴ Sarma S, Sockalingam S, Dash S. Obesity as a multisystem disease: trends in obesity rates and obesity-related complications. *Diabetes Obes Metab.* 2021;23(Suppl_1):3-16. doi:10.1111/dom.14290

⁵ Milken Institute. America's obesity crisis: the health and economic cost of excess weight. Published October 2018. Accessed October 8, 2020. <https://milkeninstitute.org/sites/default/files/reports-pdf/Mi-Americas-ObesityCrisis-WEB.pdf>

⁶ Cawley, J., A. Biener, C. Meyerhoefer et al. (2021). Direct Medical Costs of Obesity in the United States and the Most Populous States. *Journal of Managed Care and Specialty Pharmacy*, 27 (3): 354-66.

and psychosocial complications, including a substantially increased risk for type 2 diabetes.”⁷ There is strong and consistent evidence that **obesity management can delay the progression from prediabetes to type 2 diabetes and is highly beneficial in treating type 2 diabetes.**⁸

Obesity also disproportionately impacts communities of color and rural communities that already face systemic inequities in life and health care. With over 40 percent of black Marylanders impacted by obesity⁹ - addressing obesity must be part of our response on health equity issues. Disparities exist not only in obesity prevalence, but also in obesity treatment outcomes focused solely on lifestyle interventions, which can be less effective for racial and ethnic minorities. These disparities are not limited to infectious diseases; racial minorities experience higher rates of chronic diseases, death, and disability compared with white Americans.

ADA recommends comprehensive access to and coverage of person-centered obesity treatment and services to urgently address the obesity epidemic. As detailed in ADA’s 2024 Standards of Care, this includes intensive behavioral and nutritional counseling, physical activity, access to FDA approved medications for both short and long-term weight management, as well as metabolic surgery when needed and prescribed. As such, we strongly encourage your support for SB 594.

We would be pleased to provide you with additional information should you have any questions. We look forward to working with your office and being a resource on matters that impact Marylanders with diabetes.

Sincerely,

A handwritten signature in black ink, appearing to read "Monica Billger". The signature is fluid and cursive, with a long horizontal stroke at the end.

Monica Billger
mbillger@diabetes.org

⁷ American Diabetes Association: Standards of Medical Care in Diabetes 2024, Diabetes Care 47: Supp. 1, p S145, (January 2024).

⁸ American Diabetes Association: Standards of Medical Care in Diabetes 2024, Diabetes Care 47: Supp. 1, p S145, (January 2024).

⁹ <https://www.cdc.gov/obesity/data/prevalence-maps.html#overall>

SB0594 Testimony.pdf

Uploaded by: Sarah Paul

Position: FAV



Statement of Maryland Rural Health Association (MRHA)

To the Senate Finance Committee

Chair: Senator Pamela Beidle

February 19, 2024

Senate Bill 0594: Maryland Medical Assistance Program – Coverage for the Treatment of Obesity

POSITION: SUPPORT

Chair Beidle, Vice Chair Klausmeier, and members of the committee, the Maryland Rural Health Association (MRHA) is in SUPPORT of Senate Bill 0594 Maryland Medical Assistance Program – Coverage for the Treatment of Obesity

Obesity is a chronic condition that impacts millions of Americans and Marylanders alike. Today, nearly 2 out of 5 Americans are classified as obese (Centers of Disease Control and Prevention (CDC), 2022). Obesity impacts all systems of the human body and can put individuals at a higher risk for other serious conditions such as heart disease or stroke; both of which are leading causes of death for Americans (CDC, 2024). Poor diet and physical inactivity are the two largest contributors to obesity. The standard American diet consists of many foods with high levels of salt, saturated fats, and sugar. Instead of putting nutritious food in our body, many Americans consume foods that are high in calories but low in nutritional value for the sake of affordability or convenience. According to the CDC, over 25% of Americans are physically inactive (2022). With Americans consuming high calorie foods with inadequate exercise, it is no shock that so many struggle with obesity. Although diet and exercise seem to be the obvious solution, it is much easier said than done for our most vulnerable populations. For example, African Americans, low-income individuals, or rural Maryland residents are all at a much higher risk of being obese than compared to their counterparts (CDC, 2022). Healthier food options have become expensive, and those with tight budgets cannot withstand the financial burden healthy foods impose on their household. For those with demanding schedules, it is more convenient to grab food on the go or order out rather than making something of nutritional value at home. Marylanders who receive healthcare coverage under the Maryland Medical Assistance Program are likely to have low incomes, which not only makes affording healthy food difficult, but also paying for medical treatment. By extending coverage to treatment for obesity, Marylanders will be able to turn their health around by losing weight. In turn the weight loss can reduce the prevalence of high blood pressure and diabetes, and subsequently the risk for heart disease and stroke. Notification for change in coverage is extremely important for Maryland medical assistance program participants as they may go unaware of the new opportunity for obesity treatment. Due to these benefits that will directly improve the health of the residents of rural Maryland, the Maryland Rural Health Association supports SB0594: Maryland Medical Assistance Program – Coverage for the Treatment of Obesity.

*On behalf of the Maryland Rural Health Association,
Jonathan Dayton, MS, NREMT, CNE, Executive Director
jdayton@mdruralhealth.org*

Senate Bill 594 Letter_Feb 2024.pdf

Uploaded by: Selvi Rajagopal

Position: FAV

February 8, 2024

RE: Medicaid Anti-Obesity Medication Coverage

To Whom It May Concern,

I am a physician who specializes in Obesity Medicine at the Johns Hopkins University Healthful Eating, Activity and Weight Program in Baltimore, Maryland. The Healthful Eating, Activity and Weight Program is a comprehensive medical weight management clinic that serves a diverse population of patients in greater DC/Baltimore metropolitan area as well as surrounding states. The purpose of my letter is to request approval of Maryland Senate Bill 594, which would require the Maryland Medical Assistance Program to provide comprehensive coverage for the treatment of obesity, including FDA-approved anti-obesity medications.

Currently the Code of Maryland Regulations (COMAR) restricts the use of medications to treat obesity by the Maryland Medical Assistance Program. Removing coverage restrictions for anti-obesity medications would help ensure comprehensive obesity care for patients and allow Maryland to better address the obesity epidemic.

Obesity affects 33.2% of adults in the state of Maryland. Meanwhile, communities of color are disproportionately impacted; in Maryland, Black adults suffer from obesity with a 42% obesity rate.¹ As you consider the overall health and well-being of Maryland residents, these numbers are impossible to ignore.

Obesity is not an insular disease. We know it is related to a host of other diseases including certain cancers, heart disease, stroke, and type 2 diabetes. Furthermore, obesity is expensive. The aggregate medical cost due to obesity among adults nationwide was \$260.6 billion in 2016.² These figures are expected to rise as we estimate 1 in 2 adults to have obesity in the United States by 2030.³

The medical community and major public health entities recognize obesity as a chronic disease, requiring multimodal treatment and prevention efforts.⁴ In recent years, the FDA has approved several therapies for the treatment of obesity, meant to be used in conjunction with lifestyle

¹ America's Health Rankings analysis of CDC, Behavioral Risk Factor Surveillance System, United Health Foundation, AmericasHealthRankings.org, accessed 2024.

² Cawley, J. Biener, A., Meyerhoefer, C., Ding, Y., Zvenyach, T., Smolarz, G., Ramasamy, A. (2021). Direct medical costs of obesity in the United States and the most populous states. *Journal of Managed Care & Specialty Pharmacy*. 27(3). <https://doi.org/10.18553/jmcp.2021.20410>

³ Ward, Z. J., Bleich, S. N., Craddock, A. L., Barrett, J. L., Giles, C. M., Flax, C., Long, M. W., & Gortmaker, S. L. (2019). Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity. *The New England journal of medicine*, 381(25), 2440–2450. <https://doi.org/10.1056/NEJMsa1909301>

⁴ Powell-Wiley et al. (2021). Obesity and Cardiovascular Disease: A Scientific Statement from the American Heart Association. *Circulation*. 143(21):984-1010. <https://doi.org/10.1161/CIR.0000000000000973>

changes. These treatment options have been revolutionary in helping patients reverse obesity along with its myriad health complications. These truly life-changing medications have unfortunately been out of reach for our most vulnerable Maryland residents due to the COMAR restriction.

Passage of Senate Bill 594 is a critical step allowing providers to deliver the standard of care for patients with obesity in the Maryland Medical Assistance Program. Allowing patients and providers to access the full range of treatment options, including anti-obesity medications, will have a significant impact on Marylanders living with obesity.

If I can provide further details or answer any questions, please reach out to me at srajago7@jhu.edu or 713-724-9767.

Sincerely,

Selvi Rajagopal, MD MPH
Assistant Professor of Medicine
The Johns Hopkins University School of Medicine

SB594_GlobalDataStudy

Uploaded by: Senator Hershey

Position: FAV



November 2023

Obesity Economic and Labor Force Impact per Million U.S. Population

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Supported by Eli Lilly and Company

Executive Summary

Obesity presents a significant public health challenge to communities across the U.S. Recently published state-specific studies on the economic and labor force implications of obesity capture the differences across states in prevalence of obesity, demographics, economic conditions, costs for healthcare services, and state budget implications via the impact of obesity on tax revenue collections and government expenditures.¹ This report presents estimated results per million people in the U.S. using national averages. Results can be scaled to the community or state level to provide an estimate of the impact of obesity to the local economy, workforce, and budget. State's whose prevalence of obesity is higher (or lower) than the national average, or states where prices for healthcare services and average earnings are higher (or lower) than the national average, can expect obesity economic impacts to be greater (or lower) than reported for this hypothetical population of one million.

For a nationally representative sample of one million people, approximately 217,000 (22%) are under the age of 18, 172,000 (17%) are aged 65 or older, and the remaining 611,000 (61%) are adults aged 18-64 who have a high propensity to be in the workforce. This population of 611,000 is the focus of our analysis, as well as a small number of adults aged 65 or older who are in the workforce. Among the adult population aged 18-64, an estimated 197,600 (32%) are categorized as having obesity and 193,600 (32%) have overweight. These high prevalence rates not only increase the risk of additional chronic conditions, such as heart disease, type 2 diabetes, various cancers, and other health conditions, but also pose substantial implications to the economy and workforce. National studies have consistently demonstrated that obesity and its associated health conditions contribute to higher medical expenditures, reduced workforce activity and productivity, increased disability expenditures, diminished quality of life, and premature mortality.

This study estimates the economic and workforce impact of obesity for a population of a million people, as well as the impact on state tax revenue collections and costs. The analysis focuses on adults who are currently part of the workforce or would have been in the workforce if not for having obesity. Modeled healthcare cost implications are for commercially insured adults, including insured state and local government employees, and Medicaid beneficiaries.

Key findings for 2022 include:

- Obesity and overweight reduce economic activity by \$1.3 billion (or 1.7% of gross domestic product [GDP] expected for a population of one million). Over 99% of this economic loss is attributed to obesity, with less than 1% attributed to overweight.
- Obesity and overweight have a detrimental effect on the state budget of \$144.3 million (Exhibit ES-1).
 - State tax revenues are lower by \$60.8 million.
 - State costs for Medicaid, public assistance, and state government health insurance are higher by \$83.5 million.
- Contributing factors to reduced economic activity and detrimental budget implications include:

Obesity and overweight cost per million population in 2022:

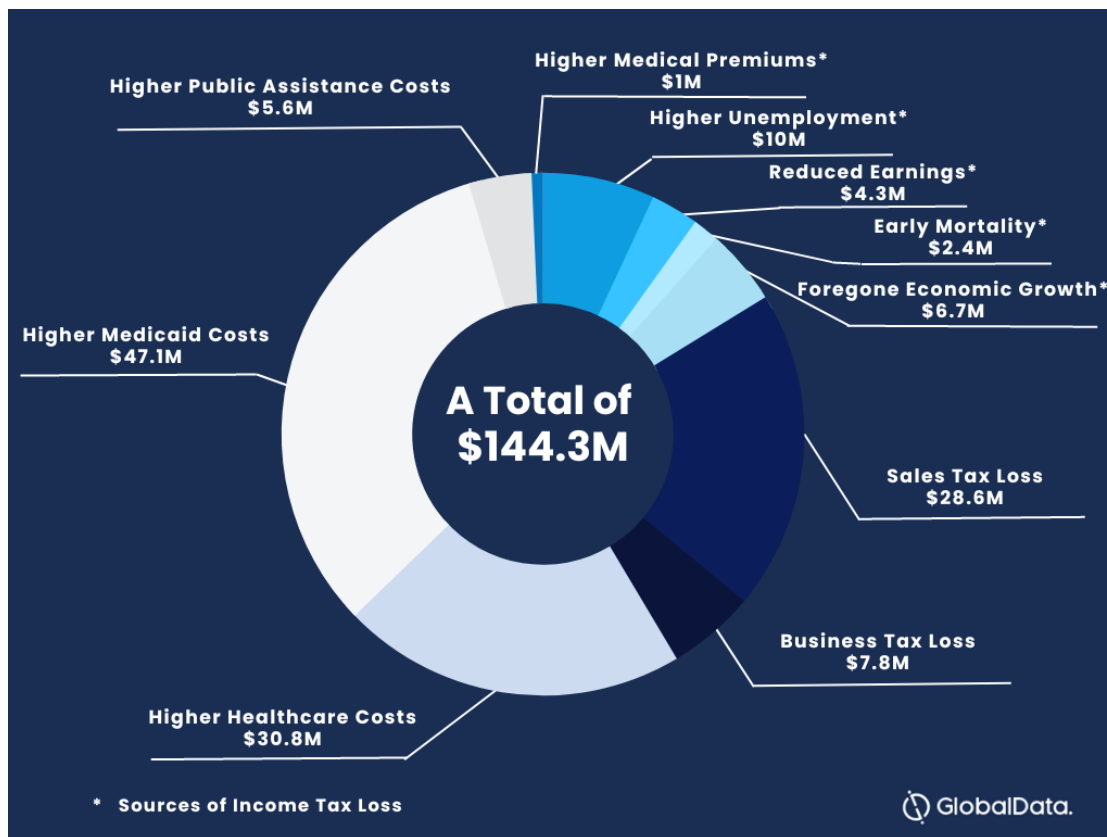
- **\$1.3 billion in reduced economic activity, or 1.7% of estimated GDP**
- **\$144.3 million impact on the state budget**
- **\$134 million in health-related absenteeism and disability costs**
- **9,500 fewer adults in the workforce**
- **9% reduced earnings for women with obesity**

Higher healthcare costs attributed to obesity and overweight total:

- **\$167 million for employers**
- **\$98 million for households with private insurance**
- **\$47.1 million in higher Medicaid costs to the state**
- **\$304 million in federal Medicare and Medicaid spending**

- Obesity raises health-related absenteeism and employer disability costs by \$134 million annually.
- 9,500 fewer adults are in the workforce due to obesity, including 7,900 additional unemployed adults and 1,600 fewer adults from premature deaths.
- Obesity reduces earnings by 9% for women (relative to women with healthy weight).
- Estimates of increased healthcare costs associated with obesity and overweight include:
 - \$167 million for employers and \$98 million for households with private insurance.
 - \$47.1 million in higher Medicaid costs to the state.
 - \$304 million in federal Medicare and Medicaid spending (which we exclude from the overall economic impact number to focus on state workforce and budget implications).
- Under the assumption that consumption/sales and business activities would be higher by the same 1.7% as GDP contribution from this population of one million, then in the absence of obesity and overweight, the state’s consumption/sales tax revenues and business tax revenues would have been higher by about \$28.6 million and \$7.8 million, respectively.
- Among the 7,900 adults without employment attributed to obesity, an additional 1,350 participate in state and local assistance programs who otherwise would not if they were employed. This estimated cost to the state government is \$5.6 million.

Exhibit ES- 1. State Budget Implications of Obesity and Overweight per Million Population: 2022



- Evidence-based approaches to treat obesity include intensive lifestyle modification programs such as the Diabetes Prevention Program², and medical interventions, such as anti-obesity medications and bariatric surgery. In our modeled scenarios, the non-Medicare adult population with obesity has improved access to treatment and achieves weight loss ranging from 5% up to 25%.
 - Under the least aggressive (5%) weight loss scenario, 19% of people with obesity would no longer meet the criteria for obesity. In the most aggressive (up to 25%) weight loss scenario, this percentage increases to 72%.
 - In the most aggressive scenario, over a 10-year period:
 - There would be a decline in incidence of type 2 diabetes onset, stroke, heart attack, coronary heart disease, and overall mortality by 43%, 31%, 29%, 24%, and 4.3%, respectively.
 - Medical costs among the modeled population would decline by \$2.9 billion, or by an average of \$14,558 per person with obesity cumulative over the 10-year period.

In addition to the quantifiable financial and employment-related impacts of obesity examined in this study, there are significant effects of obesity that are more challenging to quantify in economic terms. These effects include:

- **Reduced workforce resilience:** Obesity reduces the available labor force as some jobs have specific weight or physical fitness requirements due to safety concerns or performance expectations. Other jobs require high levels of physical exertion, and obesity can limit mobility, stamina, and overall physical performance, making it more challenging to meet the physical demands of these jobs. This can lead to decreased work efficiency, increased fatigue, and a higher risk of work-related injuries.
- **Stigma and discrimination:** People with obesity often encounter stigma, bias, and discrimination in various aspects of life, including education, employment, healthcare, and relationships.³ These negative experiences may lead to reduced self-confidence and restricted opportunities for social and professional advancement.
- **Health complications, quality of life, and early mortality:** Obesity and its related health conditions can significantly impact mobility, physical functioning, and engagement in daily activities, hobbies, and social events. This may result in pain, discomfort, and limitations in daily functioning, leading to a diminished quality of life. Additionally, obesity is associated with a higher risk of premature mortality.
- **Equity:** Many aspects of obesity disproportionately affect Black/African American, Hispanic, Native American, Alaskan Native persons, and women.⁴⁻⁶

The findings of this study emphasize the substantial economic impact of obesity on individuals, businesses, state, and local government. They underscore the urgency of addressing obesity as a critical public health issue and implementing effective prevention and treatment strategies to mitigate its negative economic impact. Prioritizing efforts to prevent and treat obesity can improve the well-being and economic resilience of individuals, foster a more equitable society, and cultivate a healthier workforce.

Recommendations

Prominent organizations have released evidence-based guidelines that provide valuable guidance for healthcare professionals and policymakers concerning the prevention and treatment of obesity.⁷⁻²⁰ Still, access to and utilization of obesity treatment remains limited. The following recommendations to state policy makers and to employers can increase access to modernized^a and evidence-based obesity care.

^a Modern healthcare leverages science, technology, health capabilities, and cost-effective solutions to enhance quality, efficiency, and delivery of care.

State policy makers

1. **Promote insurance coverage for comprehensive obesity treatment:** State policy makers can demonstrate modern care for obesity by updating health insurance for state employees to cover evidence-based obesity treatments, including intensive behavioral counseling, nutrition support, pharmacotherapy, and bariatric surgery.
2. **Expand Medicaid coverage for obesity treatment:** State policy makers can expand Medicaid coverage to include evidence-based obesity care, including intensive behavioral counseling, nutrition support, pharmacotherapy, and bariatric surgery.
3. **Invest in community-based programs and education campaigns:** State policy makers can invest in community-based programs and infrastructure that serve as an adjunct to access to obesity treatment, ensuring individuals have access to healthy, affordable food and safe, affordable opportunities for being physically active. Education campaigns can increase awareness about the causes of and health risks associated with obesity and promote evidence-based obesity treatments. Investing in community health worker (CHW) programs, for example, can be a cost-effective way to provide outreach and support to address obesity among underserved populations.^{21,22}

Employers

4. **Offer insurance coverage and wellness programs for obesity care at parity with other chronic diseases:** Employers can ensure their health insurance plans cover evidence-based obesity treatments, including intensive behavioral counseling, nutrition support, pharmacotherapy, and bariatric surgery. Employers can implement wellness programs that specifically address obesity prevention and management. These programs can include resources for healthy eating, physical activity initiatives, access to fitness facilities or classes, and weight management support.
5. **Foster a culture of support and inclusion:** Employers can create a culture of support and inclusion that recognizes and accommodates the needs of employees with obesity. This can involve implementing non-discriminatory policies, offering weight bias and stigma training, creating a supportive workplace environment that promotes healthy behaviors such as providing healthy food options, offering opportunities for physical activity, and providing reasonable workplace accommodations for individuals with obesity and related health conditions.
6. **Provide education and resources:** Employers can provide education and resources to employees to educate about the health risks associated with obesity as well as strategies for obesity care and weight management. This can include partnering with their health insurance program and other providers to encourage weight assessments as part of their annual physical, and offer health screenings, health coaching, and other support services.

In summary, for a nationally representative population of one million in 2022, obesity is associated with **\$1.3 billion in lost economic activity** and **9,500 fewer adults** in the workforce. The estimated state **budget impact of \$144.3 million** includes \$60.8 million in lost tax revenues and \$83.5 million in increased costs. The impact would likely be larger in states with higher prevalence of obesity and states with higher cost of living. These numbers understate the total economic implications of obesity as they omit higher federal spending for Medicare and Medicaid costs, as well as the costs among children with obesity. Supporting individuals to treat their obesity has the potential to generate substantial medical savings while also increasing labor force participation and productivity, thereby stimulating significant economic activity.

Background

Obesity presents a significant public health challenge to communities across the U.S. Recently published state-specific studies on the economic and labor force implications of obesity capture the differences across states in prevalence of obesity, demographics, economic conditions, prices for healthcare services, and state budget implications via the impact of obesity on tax revenue collections and government expenditures.¹ This report presents estimated results per million people in the U.S. using national averages. While not as precise as a state-specific study, results can be scaled to the community or state level to provide an estimate of the implications of obesity to the local economy, workforce, and budget. State's whose prevalence of obesity is higher (or lower) than the national average, or states where prices for healthcare services and average earnings are higher (or lower) than the national average, can expect obesity economic impacts to be greater (or lower) than reported for this hypothetical population of one million.

For a nationally representative sample of one million people, approximately 217,000 (22%) are under the age of 18, 172,000 (17%) are aged 65 or older, and the remaining 611,000 (61%) are adults aged 18-64 who have a high propensity to be in the workforce. This population of 611,000 is the focus of our analysis, as well as a small number of adults aged 65 or older who are in the workforce. Among the adult population aged 18-64, an estimated 197,600 (32%) are categorized as having obesity and 193,600 (32%) have overweight. These high prevalence rates have profound implications for the population's health, as obesity and overweight are associated with a range of serious diseases including type 2 diabetes, cardiovascular conditions, certain cancers, and numerous other health complications, resulting in increased medical costs and premature mortality.²³⁻³¹ Studies consistently demonstrate the substantial economic impact of obesity on a national scale, with estimated direct and indirect costs accounting for 2.0% to 3.3% of the country's gross domestic product (GDP).^{32,33}

These national studies underscore the substantial health, social, and economic burden imposed by obesity as well as the detrimental impact on workforce resilience. The objective of this study is to estimate the economic, workforce, and state and local budget implications of obesity within a nationally representative sample of one million people. Reported numbers can be easily scaled to provide an estimate of the implications of obesity for states without state-specific numbers. Our analysis primarily focuses on adults who are currently part of the workforce or would have been in the workforce if not for their obesity. Modeled healthcare cost implications are for commercially insured adults, including insured state and local government employees, and Medicaid beneficiaries. This report provides insight on the significant impact of obesity and provide recommendations for enhancing access to modern, evidence-based obesity care. Through these efforts, we strive to address the multifaceted challenges posed by obesity and contribute to the overall well-being of individuals, the economy, and the broader health of each state's population.

Economic and Workforce Implications of Obesity

A healthy population is vital for driving economic growth as it expands the labor force, enhances productivity, reduces absenteeism and turnover, and allows for resources otherwise spent on healthcare to be allocated to other productive sectors.^{30,34} A healthy and productive workforce creates an appealing business environment for investment, attracting companies that value access to skilled workers, increased productivity, and lower healthcare expenses.³⁵

Analysis of the National Health Interview Survey (NHIS) shows that individuals with obesity have a higher likelihood of unemployment compared to those with healthy weight or overweight, even after considering demographic factors.ⁱ (Healthy weight for adults is defined as having a body mass index [BMI] between 18.5 to <25.0; overweight is defined as BMI between 25.0 to <30.0, and obesity is defined as BMI of 30.0 or higher).³⁶ Men with obesity have 7% lower odds of

being employed compared to men with healthy weight, while women with obesity have 20% lower odds of being employed compared to women with healthy weight. For a population of one million, this translates to 7,900 fewer adults with obesity in the workforce in 2022 due to unemployment compared to a theoretic obesity-free scenario. By analyzing the 2022 Current Population Survey (CPS) data on national average earnings and considering the demographics of individuals who are unemployed due to obesity, as well as estimates that state and local income taxes average 2.1% across the nation³⁷, we found that the absence of these 7,900 individuals from the workforce led to a decrease of \$474.6 million in economic activity and a reduction of \$10 million in state and local income tax revenues.

Our analysis also reveals that women with obesity earn 9% less than women with healthy weight, aligning with published studies.³⁸⁻⁴⁰ The reasons behind this disparity are not fully understood but could be attributed to factors such as reduced working hours, lower-paid occupations due to health issues, or discrimination.⁴¹ In 2022, obesity is associated with \$206.2 million in reduced earnings and \$4.3 million in decreased state and local tax revenues.

Obesity leads to increased health-related absenteeism and disability costs that rise with the severity of obesity, averaging \$907 per employed adult with obesity in 2022.^{30,34,ii} Applied to the modeled workforce, this totals to \$134 million in reduced economic activity. Employers bear a portion of this burden through decreased productivity and higher disability insurance costs, while individuals experience reduced earnings.

The medical costs for adults with obesity and overweight are higher than costs for their peers with healthy body weight. Higher annual costs attributed to obesity (overweight) average \$2,435 (\$224) for private health insurance, \$3,393 (\$917) for Medicaid, and \$2,801 (\$828) for Medicare.^{29,31,ii} Taking into account the proportion of working adults with obesity, employer-sponsored insurance coverage, and the allocation of healthcare costs between employers and employees, overweight and obesity reduce pay by \$115 to \$522 per employee. Using the lower bound of this range, this equates to \$47.9 million in reduced earnings and a \$1.0 million reduction in state and local income tax revenues.

Obesity is associated with a higher risk of various medical conditions and premature death, leading to approximately 1,460 premature deaths per year for the modeled population.⁴² We estimated the demographic distribution of people whose premature death is attributed to obesity using national all-cause mortality data from 2016 to 2021 from the Centers for Disease Control and Prevention (CDC) and attributable fractions to estimate the proportion of deaths attributed to obesity by demographics of the deceased.⁴³⁻⁴⁵ Applying labor force participation rates by demographic, among the premature deaths that occurred during the prior 5 years approximately 1,600 adults would still be in the workforce. The premature deaths of these adults represent a \$113 million loss in state GDP and a \$2.4 million loss in state and local income tax receipts.

The foregone economic activity from the combined impact of reduced employment, premature mortality, lower productivity, and lower earnings means less disposable income for families and businesses. Much of this disposable income would be spent on goods and services in the state and local community, which in turn would create additional jobs and economic activity. The multiplier effect on additional economic activity is calculated based on the proportion of disposable income that people spend versus save, and the proportion of spending that households and businesses spend in the state versus purchases from out-of-state. We use the average US long term savings rate of 8.91% as an estimate of the savings rate.⁴⁶ The proportion of spending that households and business spend in-state is unknown, but conservative estimates of 80% and 40%, respectively, are used.⁴⁷ This leads to a conservative estimate of the state multiplier of 1.4, meaning that each \$100 increase in disposable income to families and businesses would create \$140 in total economic activity in the state. We estimate that the total reduction in economic activity from the combined sources above equates to \$1.3 billion, meaning that in the absence of obesity the GDP for this population of one million could have been 1.7% higher than the level of GDP (\$76.3 billion) that would be expected based on national averages in 2022.⁴⁸

Based on national averages, a population of one million generates state and local sales tax revenues of approximately \$1.7 billion and state business tax revenues of approximately \$457.3 million.⁴⁹ If GDP were 1.7% higher, then under the assumption that sales and business activities would also have been about 1.7% higher in the absence of obesity then

consumption/sales tax revenues and business tax revenues would have been higher by about \$28.6 million and \$7.8 million, respectively. In total, an estimated \$60.8 million in lost income, sales, and business tax revenues attributed to obesity and overweight equates to 1.0% of the expected \$6 billion that a population of one million would contribute to a state's 2022 budget based on national averages.

Higher healthcare costs associated with obesity and overweight increase costs to state and local governments. For adults with private insurance, overweight and obesity are associated with, respectively, \$224 and \$2,435 in higher annual medical costs.^{29,31,iii} Accounting for overweight and obesity rates, estimates that 78% of state and local government employees participate in their employer-sponsored plan, that 34% of participating employees insure a second adult, and that government employers cover approximately 71% of healthcare premiums, state and local governments pay about \$686 extra in healthcare costs attributed to overweight and obesity per participating employee. Among a population of one million, we would expect about 57,700 state and local government employees and \$30.8 million in higher healthcare costs for state and local government employees and their dependents.

Obesity and overweight also raise the cost of care for Medicaid beneficiaries. The added cost for overweight is estimated at \$917 and the added cost for obesity is \$3,393.³¹ On average, states pay 31% of Medicaid costs, with the federal government paying the remainder.⁵⁰ Estimates of overweight and obesity prevalence among a nationally representative sample of adults in Medicaid beneficiaries are 31.5% and 37.9%, respectively. For the modeled population, an additional \$152.3 million in higher Medicaid costs in 2022 is attributed to overweight and obesity, including \$47.1 million as the state's share of Medicaid spending.

Analysis of the NHIS finds that people with obesity who are unemployed have higher participation in state and local public assistance programs relative to people with obesity who are employed. As discussed earlier, obesity is associated with higher rates of being unemployed. Of the estimated 7,900 adults unemployed due to obesity, about 1,350 are participating in public assistance programs who otherwise would not if they were employed. This additional cost to the state government is estimated to be \$5.6 million.

In summary, the economic impact of obesity and overweight in a population of one million is substantial, resulting in 9,500 fewer adults in the workforce, \$1.3 billion in lost economic activity, a reduction of \$60.8 million in state tax collections, and additional state and local government costs of \$83.5 million. These estimates may be conservative, as they do not account for pediatric obesity costs and the less quantifiable impact of reduced productivity while at work (presenteeism³⁰) due to obesity-related health conditions. Moreover, the estimate of foregone economic activity does not consider the potential benefits of reduced healthcare costs and a more resilient workforce in attracting new economic investments.

While this study focuses on costs from the perspective of a state, national studies report that Medicare patients with obesity and overweight experience higher medical costs compared to patients with healthy body weight.³¹ When applied to the 172,000 Medicare beneficiaries that would be expected among a population of one million, along with increased federal costs for Medicaid, it suggests that the federal government's spending on Medicare and Medicaid among the modeled population is approximately \$304 million higher due to obesity and overweight. Furthermore, an estimated \$167 million in additional healthcare expenses by employers and \$98 million in additional healthcare spending by households could be utilized for other purposes.

In addition to the financial and work-related impacts of obesity modeled in this study, additional detrimental impacts of obesity on the population and the workforce are less quantifiable.

- Reduced workforce resilience:** People with obesity and obesity-related comorbid conditions such as type 2 diabetes experienced greater risk of COVID-19 severity, hospitalization risk, and mortality risk which had contributed to slower economic activity.^{51,52} For many occupations, obesity reduces the available labor force. Some occupations have specific weight or physical fitness requirements due to safety concerns or performance expectations. Other occupations require high levels of physical exertion, and obesity can limit mobility, stamina, and overall physical performance,

making it more challenging to meet the physical demands of these jobs. This can result in decreased work efficiency, increased fatigue, and a higher risk of work-related injuries.

- **Stigma and discrimination:** People with obesity often face stigma, bias, and discrimination in various areas of life, including education, employment, healthcare, and interpersonal relationships.³ This can result in reduced self-confidence, and limited opportunities for social and professional advancement.
- **Health complications, quality of life, and early mortality:** Obesity is associated with a higher risk of developing various health complications, including type 2 diabetes, heart disease, stroke, certain cancers, musculoskeletal conditions, and sleep apnea. These conditions can have long-term effects on health, well-being, and life expectancy, impacting both physical and emotional aspects of an individual's life. Obesity and related health conditions can limit mobility, impair physical functioning, and restrict participation in daily activities, hobbies, and social events. These conditions can further decrease quality of life by causing pain, discomfort, and limitations in daily functioning.
- **Equity:** Many aspects of obesity disproportionately affect Black/African American, Hispanic, Native American, Alaskan Native persons, and women.⁴⁻⁶ Women are disproportionately affected by the detrimental impact of obesity on labor force participation and pay. Racial and ethnic minorities experience higher rates of obesity. The detrimental financial aspects of obesity affect household income leading to greater inequities. Obesity, therefore, exacerbates current inequities.

Study findings emphasize the considerable economic consequences of obesity on individuals, businesses, and the state government, highlighting the need to address obesity as a public health concern. It is crucial to implement effective prevention and treatment strategies to mitigate the negative economic impacts. Many communities are currently facing a shortage of workers in various industries, and the projected slow population growth for the working-age population further underscores the importance of maintaining a healthy and available workforce to drive economic growth.

Potential Value of Treating Obesity

To demonstrate the value of treating obesity, we used a published computer simulation model, the Disease Prevention & Treatment Microsimulation Model (DPTMM),⁵³⁻⁵⁷ to quantify the health and economic benefits when adults with obesity reached certain weight loss goals achievable with obesity treatment.^{iv} The simulation uses a constructed population file that is representative of the non-Medicare adult population.^v Weight loss is one component of treating obesity, with weight loss contributing to improvements in blood pressure, cholesterol levels, blood sugar levels, and other health benefits.⁵⁸ Specifically, we modeled scenarios achieving and maintaining body weight loss of up to 5%, 10%, 15%, 20%, and 25% among adult residents with obesity.

Obesity is a complex and chronic disease that requires a multifaceted approach to treatment. Successful treatment of obesity typically involves a combination of intensive lifestyle interventions, behavior modifications, and medical treatments, based on the health care professional's evidence-based assessment of the patient and shared decision making on treatment goals and approach.

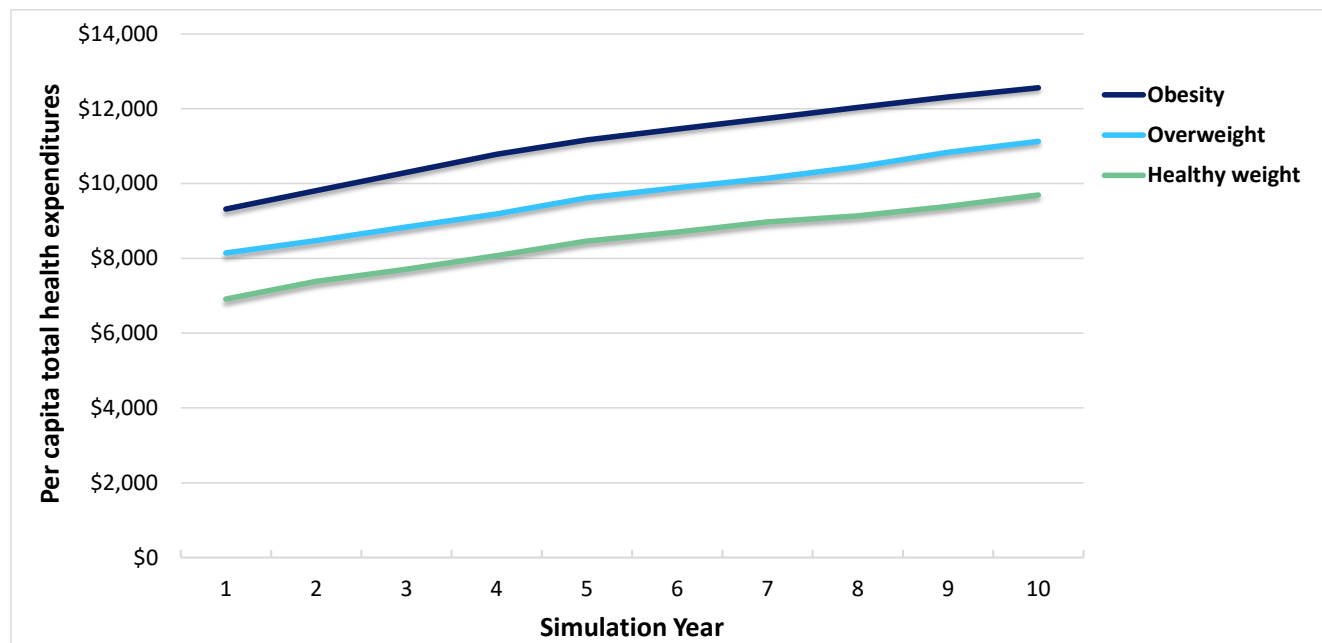
- **Lifestyle and behavioral interventions:** The cornerstone of obesity treatment is intensive lifestyle modification programs, with studies showing average weight loss up to 8% of initial body weight.^{59,60} The Diabetes Prevention Program, for example, is well established as a cost-effective intervention to achieve modest weight management.² The U.S. Preventive Services Task Force recommends that primary care clinicians screen all adults for obesity, and that all adults with obesity be offered intensive multicomponent behavioral interventions.⁶⁰ Programs that offer intensive lifestyle counseling and intervention might include a registered dietitian or other trained professional to help individuals develop a personalized nutrition and physical activity plan that meets their specific needs and goals.

Counseling often includes behavioral strategies such as goal setting, self-monitoring, and problem-solving to help individuals identify and overcome barriers to weight loss.

- **Medical treatments:** Medical treatments may be necessary for individuals with obesity who may not achieve sufficient weight loss through intensive lifestyle interventions and behavior modifications alone. Medical treatments may be part of initial therapy based on the health care professional’s assessment. These treatments include prescription anti-obesity medications and bariatric surgery.
 - **Prescription anti-obesity medications** should only be used under the supervision of a healthcare provider and in combination with lifestyle interventions. Studies indicate that patients who combine anti-obesity medications with lifestyle interventions achieve weight loss that is 3% to 12% higher compared to patients not using such medications.⁶¹ Recent clinical trials have reported average weight loss of 15% to 20%, or even higher in many patients.^{62–65}
 - **Bariatric surgery** may be recommended for individuals with obesity who may not achieve sufficient weight loss with lifestyle interventions and medical treatments or who meet surgical care guidelines.¹⁹ It can help individuals achieve significant weight loss and improve overall health. However, it is a major surgical procedure that carries risks and requires lifelong follow-up care. Different types of bariatric procedures have been associated with an average weight loss of 25% or higher.^{66,67}

Managing obesity can result in substantial long-term economic savings. Our analysis estimates that among the non-Medicare population, adults with obesity are estimated to have on average nearly \$2,700 in excess medical costs annually compared to similar adults with healthy weight over the next decade (Exhibit 1). This estimate is similar to published estimates of \$2,435 higher costs for adults with private health insurance and \$3,393 higher costs for adults on Medicaid.²⁹ The gap in medical spending due to obesity is projected to widen as individuals age, highlighting the long-term consequences of obesity.

Exhibit 1. Estimated Economic Burden of Obesity and Overweight per Person-year



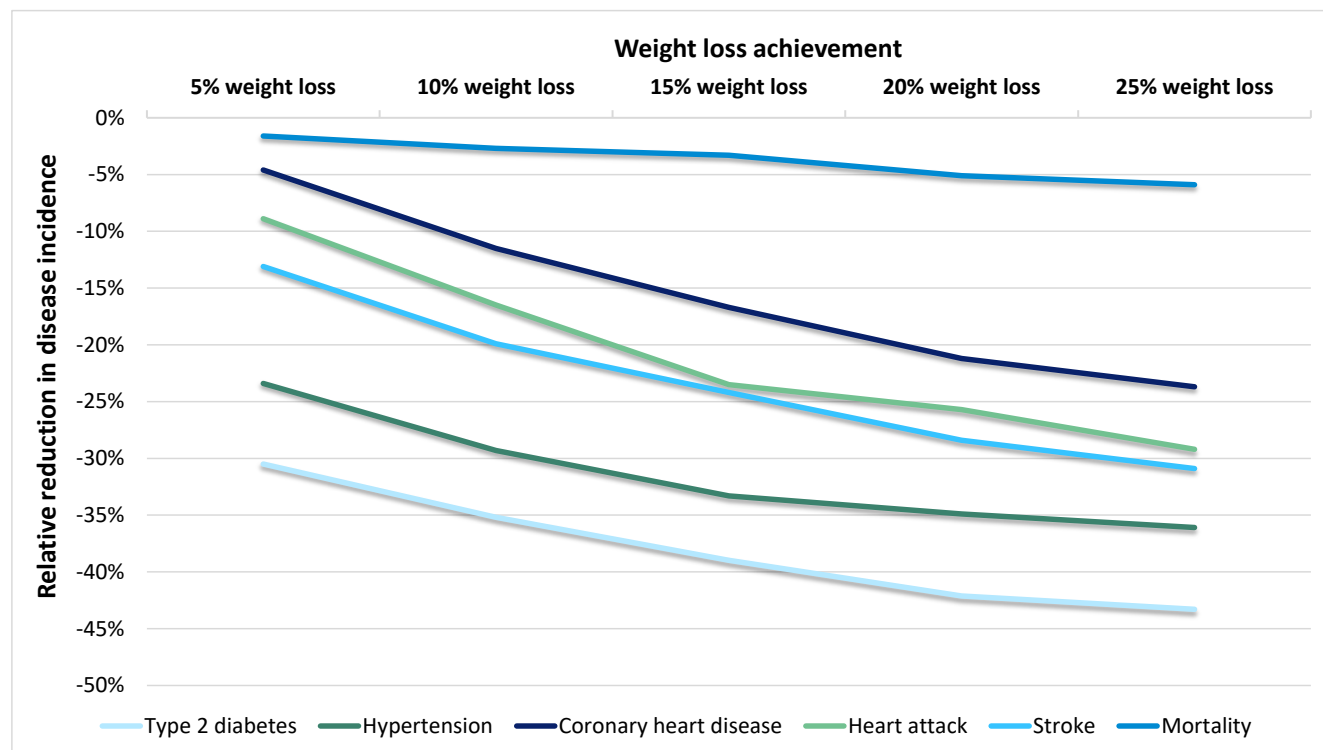
Source: GlobalData Plc.

Significant health benefits can be achieved for adults with obesity by maintaining just a 5% loss of body weight. Over the next 10 years, this modest weight loss could result in a 31% lower incidence of type 2 diabetes, 13% fewer strokes, 9% fewer heart attacks, and a 1.6% reduction in overall mortality among the population with obesity (Exhibit 2). The potential improvements become even more substantial for those who can sustain greater weight loss. For this modeled cohort, sustaining 25% weight loss could potentially reduce the onset of type 2 diabetes by 43%, incidence of stroke by 31%, incidence of heart attack by 29%, incidence of heart disease by 24%, and overall mortality by 5.9%.

These clinical improvements also translate into significant cost savings in healthcare expenditures. Among those who successfully achieve a 5% weight loss in the first year, an average savings of \$314 can be expected. If this weight loss is maintained over the following decade, the cumulative medical cost savings per person could reach \$5,914 (Exhibit 3). Particularly for individuals with a BMI greater than 40 kg/m², sustaining a higher weight loss can lead to estimated savings of \$17,056 in medical costs over the next 10 years (Exhibit 4). For the modeled population with obesity, maintaining a 5% reduction in weight could save \$1.2 billion in medical costs over the next decade. Potential savings rise to \$2.9 billion under the scenario maintaining up to 25% reduction in weight—though many people with obesity will not require the full 25% weight loss to move out of the obesity range (Exhibit 5).

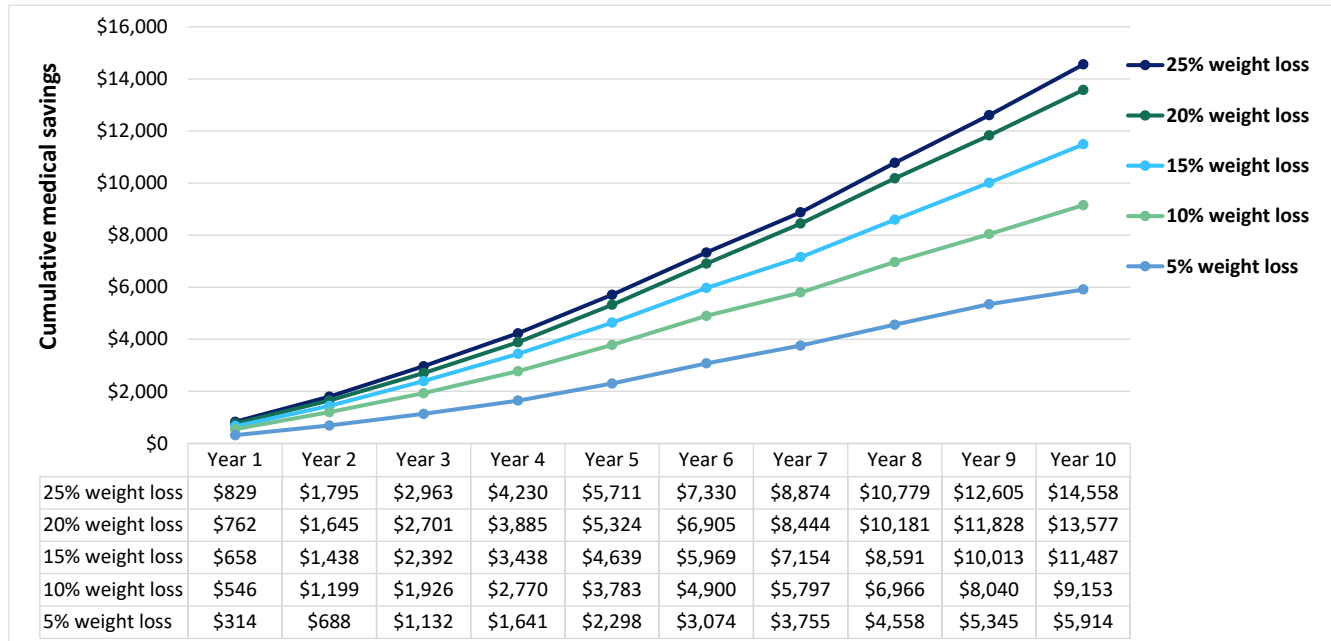
These model results emphasize the importance and substantial benefits of long-term obesity management, particularly for individuals with higher initial BMI. By investing in sustained interventions and support systems, healthcare systems can potentially alleviate the burden of obesity-related healthcare costs over time. Preventing complications associated with obesity, such as type 2 diabetes, cardiovascular diseases, and musculoskeletal disorders, can result in significant savings in medical expenses, hospitalizations, and long-term care. Moreover, a focus on long-term obesity management promotes productivity, reduces absenteeism, and positively impacts workplaces and economies by enabling individuals to lead healthier and more active lives.

Exhibit 2. Estimated Clinical Benefits of Weight Loss Among Individuals with Obesity



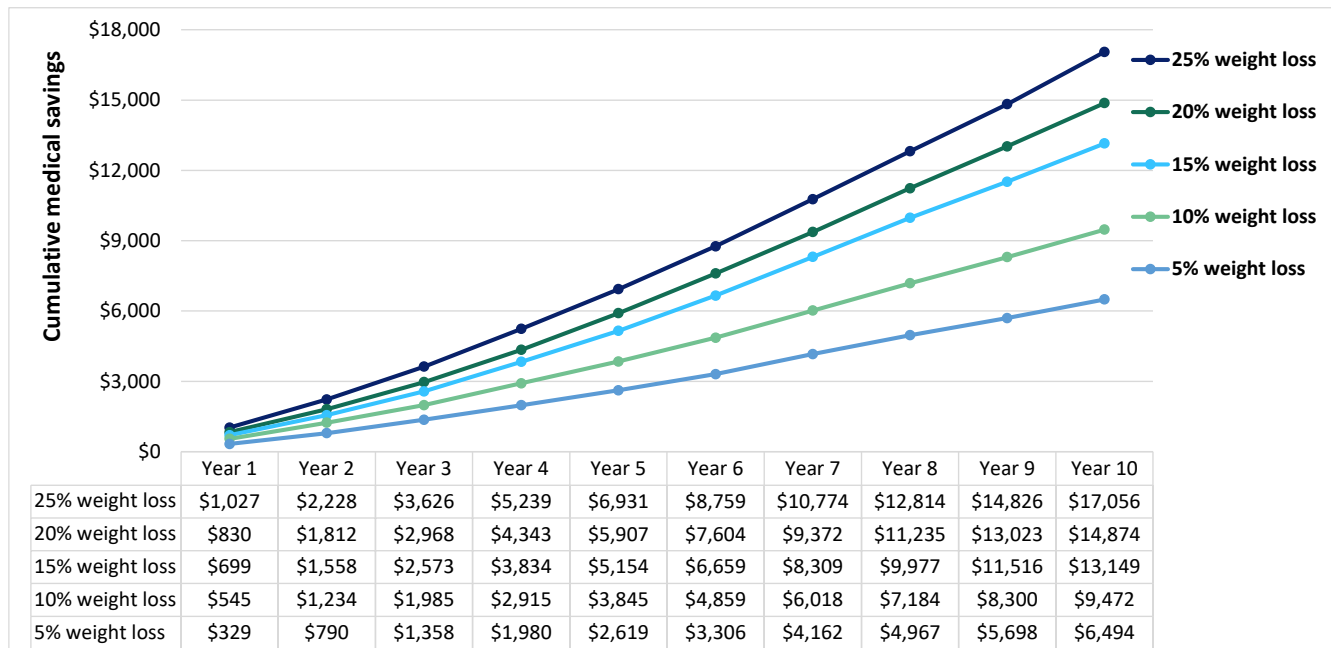
Source: GlobalData Plc.

Exhibit 3. Estimated Cumulative Medical Savings Due to Weight Loss Among Individuals with Obesity



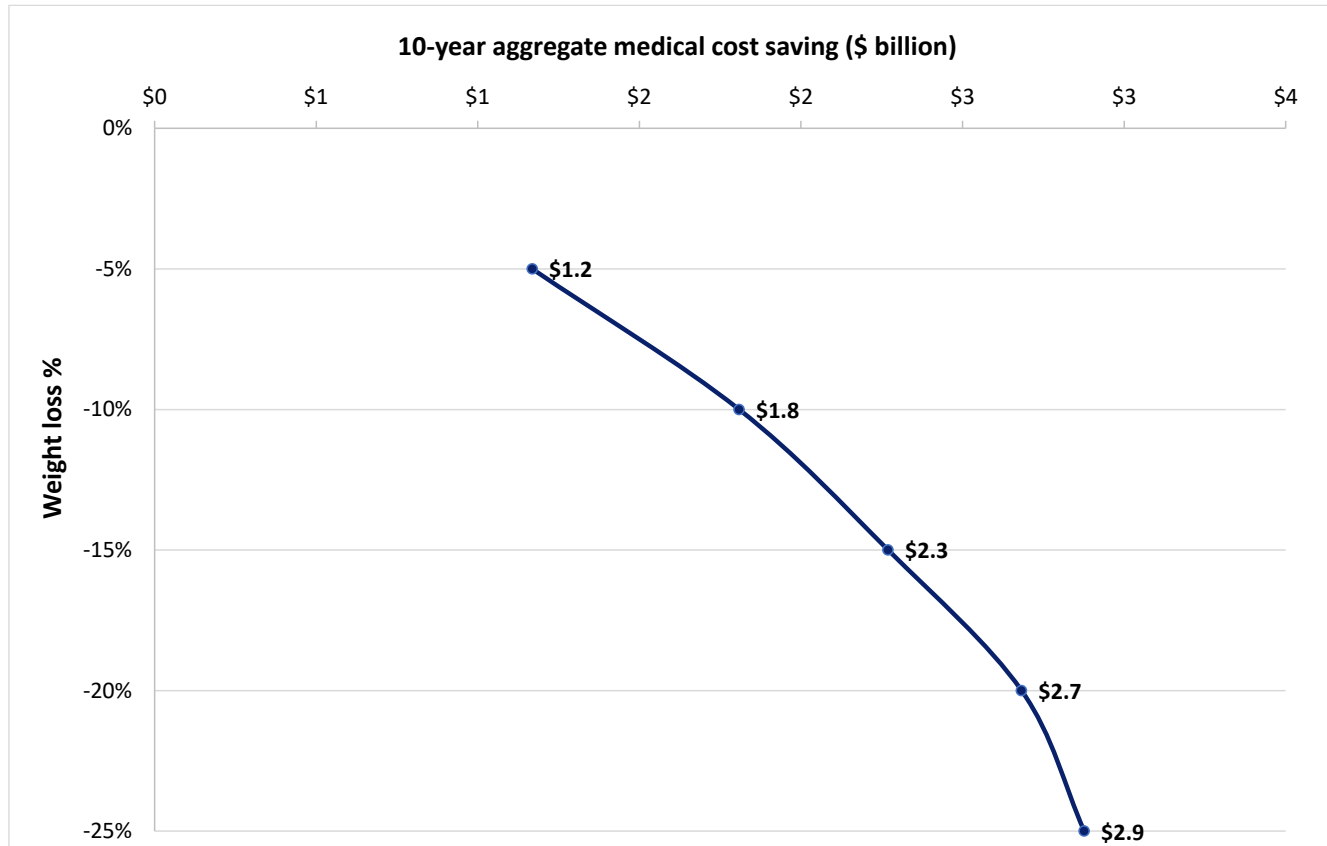
Source: GlobalData Plc.

Exhibit 4. Estimated Cumulative Medical Savings Due to Weight Loss Among Individuals with Class III Obesity



Source: GlobalData Plc.

Exhibit 5. Estimated Statewide 10-year Medical Cost Savings by Weight Loss Scenario



Source: GlobalData Plc.

Note: This chart shows the estimated cumulative savings over 10 years if within a population of one million the adults under age 65 with obesity could achieve body weight loss of 5%, 10%, 15%, 20%, or 25%.

Recommendations to Improve Access to Obesity Treatment

A multitude of state, national, and international organizations have released evidence-based guidelines concerning the prevention and treatment of obesity. These recommendations serve as valuable guidance for healthcare professionals and policymakers in tackling this significant public health concern.

- **The National Institutes of Health (NIH)** has developed guidelines for the management of overweight and obesity in adults, including recommendations for lifestyle interventions, pharmacotherapy, and bariatric surgery.⁷
- **The Centers for Disease Control and Prevention (CDC)** has developed a framework for obesity prevention and control that includes recommendations for community-based interventions and clinical management of obesity.⁸

- **The American Medical Association (AMA)** and other medical associations such as the **American Gastroenterological Association (AGA)** and the **Endocrine Society** have issued recommendations for the prevention and treatment of obesity, including the need for healthcare professionals to provide patients with evidence-based weight management strategies^{9,10} and providing insurance coverage parity for emerging obesity treatment options.¹¹
- **The American Heart Association (AHA)** has issued guidelines for the treatment of obesity in adults, including recommendations for diet, physical activity, and behavioral therapy.^{12,13}
- **The American Diabetes Association (ADA)** has issued guidelines for the prevention and treatment of obesity in the context of preventing and treating diabetes.¹⁴
- **The Obesity Society** has issued position statements on the management of obesity, including recommendations for increasing access to obesity treatment, addressing weight bias and stigma, and promoting research into the causes and treatment of obesity.^{15,16}
- **The Obesity Action Coalition** has issued policy statements to advocate for improved access to obesity treatment and address weight bias.¹⁷
- **Obesity Medicine Association: Leaders in Obesity Medicine** includes healthcare professionals committed to a comprehensive, evidence-based approach for addressing obesity.¹⁸
- **The American Society for Metabolic and Bariatric Surgery (ASMBS)** and the **International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO)** have published new guidelines for weight-loss surgery.¹⁹
- **The World Health Organization** has developed guidelines for the management of overweight and obesity in adults, including recommendations for lifestyle interventions, pharmacotherapy, and bariatric surgery.²⁰

Still, access to and utilization of obesity treatment remains limited.⁶⁸ The following recommendations to state policy makers and to employers can increase access to modernized^b and evidence-based obesity care.

State policy makers

1. **Promote insurance coverage for comprehensive obesity treatment:** State policy makers can demonstrate modern care for obesity by updating health insurance for state employees to cover evidence-based obesity treatments, including intensive behavioral counseling, nutrition support, pharmacotherapy, and bariatric surgery.
2. **Expand Medicaid coverage for obesity treatment:** State policy makers can expand Medicaid coverage to include evidence-based obesity care, including intensive behavioral counseling, nutrition support, pharmacotherapy, and bariatric surgery.
3. **Invest in community-based programs and education campaigns:** State policy makers can invest in community-based programs and infrastructure that serve as an adjunct to access to obesity treatment, ensuring individuals have access to healthy, affordable food and safe, affordable opportunities for being physically active. Education campaigns can increase awareness about the causes of and health risks associated with obesity and promote evidence-based obesity

Numerous state, national, and international organizations have released evidence-based guidelines concerning the prevention and treatment of obesity. These recommendations serve as valuable guidance for healthcare professionals and policymakers in undertaking this significant public health concern...Still, access to and utilization of obesity treatment remains limited.

^b Modern healthcare leverages science, technology, health capabilities, and cost-effective solutions to enhance quality, efficiency, and delivery of care.

treatments. Investing in community health worker (CHW) programs, for example, can be a cost-effective way to provide outreach and support to address obesity among underserved populations.^{21,22}

Employers

4. **Offer insurance coverage and wellness programs for obesity care at parity with other chronic diseases:** Employers can ensure their health insurance plans cover evidence-based obesity treatments, including intensive behavioral counseling, nutrition support, pharmacotherapy, and bariatric surgery. Employers can implement wellness programs that specifically address obesity prevention and management. These programs can include resources for healthy eating, physical activity initiatives, access to fitness facilities or classes, and weight management support.
5. **Foster a culture of support and inclusion:** Employers can create a culture of support and inclusion that recognizes and accommodates the needs of employees with obesity. This can involve implementing non-discriminatory policies, offering weight bias and stigma training, creating a supportive workplace environment that promotes healthy behaviors such as providing healthy food options, offering opportunities for physical activity, and providing reasonable workplace accommodations for individuals with obesity and related health conditions.
6. **Provide education and resources:** Employers can provide education and resources to employees to educate about the health risks associated with obesity as well as strategies for obesity care and weight management. This can include partnering with their health insurance program and other providers to encourage weight assessments as part of their annual physical, and offer health screenings, health coaching, and other support services.

State policy makers and employers play a crucial role in addressing obesity by implementing effective policies and programs that prioritize access to evidence-based treatment plans and resources. Taking a comprehensive approach to obesity prevention and treatment is key to improving population health, reducing healthcare costs linked to obesity-related conditions, improving workforce participation and productivity, and helping to reduce disparities. By working together, these stakeholders can make a significant impact in addressing the obesity epidemic and fostering a healthier future for their communities and their state's workforce.

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Technical Notes

ⁱ We conducted logistic regression analyses using data from the National Health Interview Survey (NHIS) for the years 2017-2021 to estimate the relationship between employment status and obesity status. Separate regressions were performed for men and women. The dependent variable in the regression models was employment during the prior week, while the explanatory variables included body weight status categorized as healthy weight, overweight, or obesity. Age group was included as a predictor variable, with categories defined as 18-34, 35-44, 45-54, 55-64, and 65-75 years. Additionally, race/ethnicity (classified as Hispanic, non-Hispanic white, black, or other) was included as a predictor variable. Smoking status was included as a control variable to account for its potential influence. The NHIS survey year was incorporated to control for temporal variations. These regressions did not account for other potential factors that might be associated with obesity, such as education level.

ⁱⁱ We converted medical cost estimates and indirect economic cost estimates to 2022 dollars using, respectively, the medical component of the Consumer Price Index (CPI) and the overall CPI.

ⁱⁱⁱ See note ii.

^{iv} The Disease Prevention & Treatment Microsimulation Model (DPTMM) is a Markov-based microsimulation model utilized to estimate both clinical and economic outcomes for populations affected by obesity. This model predicts the annual occurrence of diseases and corresponding healthcare expenditures based on factors such as age, sex, race, Hispanic ethnicity, and biometric measurements including BMI, blood glucose level, blood pressure levels, total cholesterol level, and high-density cholesterol level. Additional risk factors modeled include smoking status and the presence of obesity-related comorbidities such as type 2 diabetes, hypertension, ischemic heart disease, congestive heart failure, history of stroke, history of myocardial infarction, and chronic kidney disease, among others.

To project the potential clinical and economic benefits of weight loss, evidence-based scenarios were simulated using the model. The first scenario, known as the usual care scenario, incorporates each individual's annual changes in BMI following the natural aging process, derived from the analysis of public survey data and published references. The counterfactual scenarios, the weight loss scenarios, incorporate actual and simulated changes in body weight and other biometric measurements during the first year, which are then maintained from the second year through the tenth year. The simulation model employs prediction equations that utilize these biometric changes as inputs to project the onset of modeled complications and the corresponding changes in direct medical costs over the next decade. By comparing the simulated health and economic outcomes between scenarios, the potential benefits of weight loss can be assessed.

^v A population sample file was created by combining state-level data from the Behavioral Risk Factor Surveillance System (BRFSS) from 2020-2021 with additional biometric and other information from matched individuals in the National Health and Nutrition Examination Survey (NHANES) from 2014-2020. The matching process was based on a 1:1 match using propensity scores derived from risk factors such as age group, gender, race/ethnicity, insurance type, and body weight category. Each merged record in the sample file includes comprehensive data on demographics, biometric parameters, smoking status, and a history of various disease conditions. This combined dataset allows for a more comprehensive analysis and understanding of the population under study.

Contact Us

If you have any more questions regarding our research, please contact us:

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SB594_GlobalDataStudy_Factsheet

Uploaded by: Senator Hershey

Position: FAV

Obesity Economic and Labor Force Impact **per Million U.S. Population**



REDUCED ECONOMIC ACTIVITY BY **\$1.3B**

65% of adults have obesity or overweight



>\$300M in higher healthcare, absenteeism, and disability costs to employers



\$144.3M detrimental state budget impact



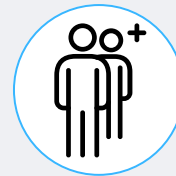
COST OF OBESITY ON POPULATION



Reduced Labor Force Participation
9,500 fewer adults with obesity working



Reduced Earnings for Employed Women
Women with obesity earn 9% less than women with healthy weight



Obesity-Attributed Early Mortality
1,460 premature deaths occur annually



Higher Medical Costs
\$98M spending by households

COST OF OBESITY ON EMPLOYERS

HIGHER MEDICAL COSTS



\$167M in higher healthcare costs to employers



\$134M in health-related lost workdays and disability



1.7% reduction in Gross Domestic Product (GDP)

5%-25% weight loss among adults age <65 over 10 years has potential to **save \$1.2B-\$2.9B** in medical costs

COST OF OBESITY ON STATE & LOCAL GOVERNMENT

\$60.8M reduced tax revenues from lost economic activity

Medicaid	\$47.1M higher Medicaid spending
Healthcare Coverage	\$30.8M for employee healthcare coverage
Public Assistance Program	\$5.6M in public assistance program costs
TOTAL	\$83.5M increased spending

For more information: Consulting@globaldata.com

Read full report: <https://www.globaldata.com/health-economics/US/perMillion/Obesity-Impact-Per-Million-Population.pdf>

SB594_NationalBlackNursesAssoc_FAV

Uploaded by: Tonya Jackson

Position: FAV



National Black Nurses Association, Inc.
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February 13, 2024

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Executive Director

Tonya Jackson

As the Executive Director for the National Black Nurses Association, and on behalf of our esteemed President Dr. Sheldon D. Fields, Board of Directors, and our Health Policy committee the National Black Nurses Association would like to thank you for your dedication to the State of Maryland.

The National Black Nurses Association (NBNA) is a distinguished organization dedicated to advancing the health and well-being of the Black community through leadership, advocacy, and professional development. As the premier professional organization for Black nurses, the NBNA represent thousands of nurses across the nation who are committed to providing culturally competent care, promoting health equity, and addressing healthcare disparities.

We, at the National Black Nurses Association, are writing to lend our support for the coverage of FDA-approved anti-obesity medications, including those of the GLP-1 class, for patients diagnosed with obesity or overweight who are covered under Maryland Medicaid. As an organization dedicated to promoting the health and well-being of the Black community, we recognize the importance of addressing obesity as a chronic disease.

Obesity has long been acknowledged as a significant health concern, with detrimental effects on individuals and communities. It is imperative that we acknowledge and treat obesity on par with other chronic conditions such as hypertension and diabetes. The American Medical Association and numerous primary care and specialty societies have already recognized obesity as a chronic disease for over a decade.

This year, we have witnessed several medical organizations, including the AMA, update their obesity guidelines and practices to reflect the availability of highly effective medical treatments. These treatments have the potential to significantly benefit patients by reducing obesity-related complications and improving overall health outcomes.

Studies have shown that pharmacological treatment can lead to notable improvements in obesity-related complications, including dyslipidemia, heart failure, fatty liver and hepatic steatosis, cardiovascular disease, and the prevention and remission of type 2 diabetes. These conditions have a disproportionate impact on minoritized and marginalized racial, ethnic, and socioeconomic groups in Maryland, including children. Addressing obesity and its complications is essential in reducing the disparities in health outcomes within our communities.

Furthermore, it is worth noting that the federal Office of Personnel Management has taken a proactive approach by requiring obesity care and treatment, including pharmacotherapy options, for all federal employees starting January 1, 2023. As a state known for its forward-thinking and innovative healthcare policies, it is time for Maryland to align its obesity policies.



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with this national standard, especially for the most vulnerable populations. Maryland is already shouldering the financial burden of obesity and its complications. By expanding access to effective treatments, we have a unique opportunity to make a tangible difference in improving health outcomes for individuals affected by obesity. With your support, we can advance the well-being of Marylanders and contribute to a healthier future for all.

Kind regards,

Tonya Jackson MSHA, BSN RN

Tonya Jackson

Executive Director

National Black Nurses Association

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02162024 OAC Supports Access to Obesity Care for M

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02/19/2024

Maryland Senate Finance Committee
3 East
Miller Senate Office Building
Annapolis, Maryland 21401

RE: Support for Maryland Medical Assistance Program – Coverage for the Treatment of Obesity

Dear Chair Biedle, Vice Chair Klausmeier and Members of the Senate Finance Committee

The Obesity Action Coalition (OAC) appreciates the opportunity to state support for the passage of Senate Bill 0594/House Bill 0986 to amend Maryland Medical Assistance Program – Coverage for the Treatment of Obesity.

The OAC is a national non-profit organization dedicated to giving a voice to individuals affected by the disease of obesity. We are pleased to express our strong support for passage of SB 0594 and HB 0986, which would establish coverage for intensive behavioral therapy, bariatric surgery, and FDA-approved anti-obesity medications under Maryland Medicaid.

The OAC proudly serves 2,246 members living in Maryland and backed by more than 85,000 members across the United States. We applaud this legislation, as it improves access to obesity care and updates state policies into alignment with advances in science and clinical standards. Throughout the past decades, the prevalence of obesity has skyrocketed across our country and in Maryland – with 33 percent of adults and more than 20 percent of children (ages 10- 17) in the state currently affected by obesity.

Despite these facts, many policymakers continue to view obesity as a lifestyle choice or personal failing. Others acknowledge that obesity is a chronic and complex disease, but they believe that all that's needed is more robust prevention. These perceptions and attitudes, coupled with bias and stigma, have resulted in health insurance plans taking vastly different approaches in determining what and how obesity treatment services are covered for their members. It's time for health plans (public and private) to adopt a comprehensive benefit approach toward treating obesity.

There are multiple evidence-based treatments for people with obesity that mitigate the impacts of the disease and improve health outcomes. Unfortunately, the present landscape of obesity treatment coverage remains piecemeal and laden with arbitrary hurdles to receive comprehensive care. We applaud Maryland for moving to eliminate barriers to care – both for the long term and immediate health of those affected by obesity.

Since 2013, when the American Medical Association adopted formal policy declaring obesity as a complex and chronic disease and supporting patient access to the full continuum of evidence based obesity care, numerous

federal and state policy organizations have echoed the AMA's position. These include the National Council of Insurance Legislators, National Lieutenant Governors Association, National Hispanic Caucus of State Legislators, and the National Black Caucus of State Legislators, and the Federal Office of Personnel Management.

Further, the American Academy of Pediatrics (AAP) released their evidence-based recommendations on medical care for those age 2 and older as part of its new "Clinical Practice Guideline (CPG) for the Evaluation and Treatment of Children and Adolescents with Obesity." The AAP guidelines contain key action statements, which represent evidence-based recommendations for evaluating and treating children with overweight and obesity and related health concerns. These recommendations include motivational interviewing, intensive health behavior and lifestyle treatment, pharmacotherapy and metabolic and bariatric surgery. The approach considers the child's health status, family system, community context, and resources. The comprehensive evidence-based recommendations included in the CPG reflect just how far the understanding and care of childhood obesity has come and Maryland should be applauded for its forward thinking on obesity care – especially for those most in need.

Obesity is a complex chronic disease that extends beyond individual lifestyle choices to encompass a broader landscape of social determinants and systemic factors, contributing significantly to health inequities. Disparities in obesity rates are often closely intertwined with socioeconomic status, geographic location, and access to resources. Individuals in marginalized communities may face barriers to affordable and nutritious food options, safe spaces for physical activity, and unequal access to qualified providers of quality healthcare. These structural inequities exacerbate the prevalence of obesity among vulnerable populations, leading to a cycle of poor health outcomes. Tackling obesity requires a comprehensive approach.

Our country must acknowledge obesity for the chronic disease that it is and take steps to treat it in the same serious fashion as other chronic disease states such as diabetes and hypertension. We urge the Maryland legislature to support HB 0986 & SB 0594 and stand up for coverage of all medically necessary obesity treatment avenues – including FDA-approved anti-obesity medications.

As a voice for people living with obesity, OAC looks forward to working with the state of Maryland to ensure Medicaid recipients access to comprehensive obesity care for this complex and chronic disease. We would be happy to meet and share further information and perspectives of people living with obesity. Should you have questions or need additional information, please reach out to our Policy Advisor, Chris Gallagher at chris@potomaccurrents.com. Thank you.

Sincerely,

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

Joseph Nadglowski, Jr.
OAC President and CEO

10 - SB 594 - FIN - MDH - LOI.pdf

Uploaded by: Jason Caplan

Position: INFO



DEPARTMENT OF HEALTH

Wes Moore, Governor · Aruna Miller, Lt. Governor · Laura Herrera Scott, M.D., M.P.H., Secretary

February 20, 2024

The Honorable Pamela Beidle
Chair, Senate Finance Committee
3 East Miller Senate Office Building
Annapolis, Maryland 21401-1991

RE: Senate Bill 594 – Maryland Medical Assistance Program – Coverage for the Treatment of Obesity – Letter of Information

Dear Chair Beidle and Committee members:

The Maryland Department of Health (MDH) respectfully submits this letter of information for Senate Bill (SB) 594 – *Maryland Medical Assistance Program – Coverage for the Treatment of Obesity*. SB 594 requires Maryland Medicaid to provide comprehensive coverage for the treatment of obesity, including intensive behavioral therapy, bariatric surgery, and anti-obesity medication approved by the US Food and Drug Administration (FDA), and to provide notice to Medicaid participants of the coverage requirements. SB 594 prohibits Medicaid from imposing coverage criteria that are more restrictive than the FDA-approved drug’s indications for treatment. In addition, utilization management determinations must be made in the same manner as determinations made for the treatment of any other illness, condition, or disorder covered by the program.

MDH estimates that the cost of drug coverage will exceed \$1.1 billion total funds (\$671.1 million general funds, \$433.9 million federal funds) annually. Additional staffing and contractual resources will also be required. Over the next five fiscal years, the total fiscal impact of the bill is projected to exceed \$4.6 billion (\$2.8 billion federal funds, \$1.8 billion state general funds).

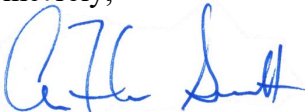
Medicaid estimates that 1 in 3 adults and 1 in 6 children are considered obese.¹ Based on enrollment in December 2023, an estimated 309,000 adults under age 65 and 37,000 children ages 12 through 17 in the Maryland Medicaid program are impacted. The Department estimates that up to 20%, or 69,195, of these participants will be prescribed an anti-obesity drug. There are several different anti-obesity drugs available on the market ranging in price from \$900 to \$16,764 per person per year. Medicaid assumes an average drug cost of \$15,504 per person per year based on market share and expected utilization. Annually, new drug costs will exceed \$1.1 billion total funds. While some obesity related costs may decrease over time if these new drugs are covered, it is difficult to estimate those savings at this time.

¹ <https://www.cdc.gov/obesity/data/prevalence-maps.html>; <https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/reducing-obesity/index.html>

The Maryland Medicaid Program covers bariatric surgery for participants who meet certain clinical criteria. Intensive behavioral therapy is also covered under existing benefits. Additionally, managed care organizations (MCOs) also offer the HealthChoice Diabetes Prevention Program (DPP). DPP is an evidenced-based program to prevent or delay the onset of type 2 diabetes and is covered for all HealthChoice participants. The program teaches lifestyle changes related to healthy eating and physical activity. MDH notes that the bill's restrictions on coverage criteria may have a chilling effect on participants' interest in undertaking other lifestyle changes, such as DPP, prior to starting an anti-obesity medication. This may also create challenges in maintaining a healthy weight for participants who eventually discontinue medication.

If you would like to discuss this further, please do not hesitate to contact Sarah Case-Herron, Director of Governmental Affairs at sarah.case-herron@maryland.gov or (410) 260-3190.

Sincerely,



Laura Herrera Scott, M.D., M.P.H.
Secretary

SB 594 Written Statement 2.20.24.pdf

Uploaded by: Laura Vykol-Gray

Position: INFO



Maryland

DEPARTMENT OF BUDGET
AND MANAGEMENT

WES MOORE
Governor

ARUNA MILLER
Lieutenant Governor

HELENE GRADY
Secretary

MARC L. NICOLE
Deputy Secretary

SENATE BILL 594 Maryland Medical Assistance Program - Coverage for the Treatment of Obesity

STATEMENT OF INFORMATION

DATE: February 20, 2024

COMMITTEE: Finance

SUMMARY OF BILL: Senate Bill 594 would require the Maryland Medical Assistance Program to provide comprehensive coverage for the treatment of obesity beginning on July 1, 2025. Treatment would include intensive behavioral therapy, bariatric surgery, and anti-obesity medication approved by the U.S. Food and Drug Administration.

EXPLANATION: The Maryland Department of Health (MDH) does not expect additional fiscal impacts attributable to bariatric surgery for participants who meet clinical criteria, nor for intensive behavioral therapy. However, MDH anticipates a significant fiscal impact for the provision of chronic weight management medications. MDH estimates costs amounting upwards of \$1.1 billion total funds per year (\$671 million in federal funds, \$434 million in general funds) for the provision of anti-obesity medication to Medicaid participants.

The Department of Budget and Management (DBM) is charged with submitting a balanced budget to the General Assembly annually and will be working with the General Assembly to achieve structural balance over the long-term. In light of current projected general fund deficits in fiscal 2026 forward, the Department urges caution in passing legislation with significant new general fund spending. State government must be intentional, disciplined, and strategic with its allocation of State funding to ensure maximum impact toward priority outcomes. It would be challenging for the State to manage a significant increase in spending given the forecasted out-year deficits for the General Fund.

**For additional information, contact Laura Vykol-Gray at
(410) 260-6371 or laura.vykol@maryland.gov**

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<http://dbm.maryland.gov>