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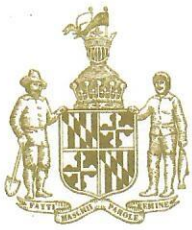
MINORITY LEADER

Finance Committee
Executive Nominations Committee
Rules Committee

Joint Committee on Legislative Ethics
Legislative Policy Committee



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Chairwoman Pamela Beidle
Finance Committee
2 East Miller Senate Office Building
Annapolis, MD 21401

Re: Senate Bill 496 Maryland Medical Assistance Program- Coverage for the Treatment of Obesity

Chair and members of the Committee,
Thank you for the opportunity to present Senate Bill 496. Obesity is a chronic, complex medical disease—and it is one of the primary drivers of healthcare costs in Maryland and across the country. It is intricately linked to some of the most expensive and debilitating conditions we treat every day in our Medicaid program:

- Type 2 diabetes
- heart disease
- stroke
- high blood pressure
- sleep apnea
- joint disease
- Fatty Liver Disease
- kidney disease, and certain cancers

These are not abstract risks—they are the conditions that lead to hospitalizations, disability, long-term care, and premature death.

SB 496 takes a practical and forward-looking approach. The bill authorizes the Maryland Medical Assistance Program to provide comprehensive coverage for the treatment of obesity, including behavioral therapy, bariatric surgery, and FDA-approved medications for chronic weight management. And if the Department chooses to offer that coverage, it simply requires that Medicaid recipients to be notified.

Let me be clear about what this bill **does not** do. This is not a mandate. It does not force the Department to cover any specific treatment. It does not override utilization management, medical necessity criteria, or clinical guidelines. And importantly, there is no fiscal note attached to this bill.

What it ***does*** **do** is send a strong and intentional signal from the General Assembly: that Maryland should treat obesity like the serious, chronic disease it is—and give our Medicaid program the flexibility to modernize care accordingly.

Right now, our system is often upside down. In practice, many Medicaid patients can only access anti-obesity medications after they have already had a heart attack or a stroke. In other words, we are paying for the ambulance ride, the ICU stay, the cardiac rehab, and the lifelong complications—but not for the treatment that could have helped prevent those outcomes in the first place. That makes no sense clinically, and it makes no sense fiscally.

From a budget perspective, this bill is about cost avoidance, not cost explosion. The most expensive care in our system is not preventive care—it is late-stage, crisis-driven care for advanced disease. Hospitalizations for heart attacks, strokes, kidney failure, amputations from diabetes, joint replacements, and long-term disability are what drive Medicaid spending. If we can reduce even a fraction of those outcomes by treating obesity earlier and more effectively, the savings to the system can be substantial.

We are also seeing significant changes in the market. As the news has reported, the prices of anti-obesity medications are coming down, and competition and broader use are continuing to push costs in a more sustainable direction. At the same time, clinical evidence continues to grow showing that these treatments can reduce not just weight, but the risk of diabetes, cardiovascular disease, and other costly complications.

This bill is supported by a broad and credible group of stakeholders. Obesity medicine specialists, primary care physicians, endocrinologists, and cardiologists increasingly view obesity as a disease that must be treated early and consistently—just like hypertension or diabetes. Patient advocates are also staunch supporters, because they see every day how untreated obesity leads to worsening health, reduced quality of life, and barriers to work and independence.

The message from clinicians and patients is consistent: treating obesity earlier is not about cosmetics or quick fixes—it is about preventing diabetes, preventing heart disease, preventing strokes, preventing joint degeneration, and preventing lifelong disability.

SB 496 respects the role of the Department of Health. It preserves flexibility. It does not mandate spending. But it does say, clearly and responsibly, that Maryland should move away from a system that only pays after people get seriously sick—and toward one that prevents disease, improves outcomes, and uses taxpayer dollars more wisely over the long term.

In short, this is a patient-centered, fiscally responsible, and medically sound step forward for Maryland's Medicaid program.

I respectfully ask for a favorable report of Senate Bill 496.