Written Testimony of Shawn SN
Before the Maryland General Assembly
House Health Committee
Hearing on HB0341 – Maryland Commission for Boys' and Men's Health
February 10, 2026
Position: Favorable with Amendments

Introduction

Chairperson, Vice Chairperson, and Members of the Committee,

Thank you for allowing me to testify on HB0341, which would create the Maryland Commission for Boys' and Men's Health within the Maryland Department of Health (DOH). My name is Shawn, and my expertise on this matter is shaped by validated research and firsthand experience.

For caregiving families, men's health is not just an abstraction. Whether a father remains involved with his children, a son can care for an aging parent and whether a partner can maintain a stable job and household is directly tied to men's health. This can be due to untreated depression, substance abuse disorders and uncontrolled chronic disease, which in unison strain public systems at scale.

HB0341 provides a reasonable framework to begin addressing the disparity in chronic disease, suicide, overdose death and premature mortality experienced by boys and men in Maryland. These disparities are influenced by housing instability, lack of employment security and other social determinants. A permanent advisory commission is proposed to review data, advise state policymakers on evidence-based strategies, promote gender- and culturally responsive health care services and measure and track progress toward reducing the identified disparities.

I support HB0341 on a *favorable with amendments* basis. The proposed structure for the commission is appropriate and ultimately, the success of the commission over time will be determined by how clearly it analyzes its data, how representative the membership is and whether it clearly integrates disability and caregiving into the scope of its work. I will present key areas that benefit the State through a problem-solutions manner, starting with the policy.

1. Boys' and Men's Health as a Structural Public Policy Issue

The Preamble of the bill accurately states that the increased burden of chronic disease, premature mortality and the poor health status of males in Maryland are influenced by social determinants. This perspective is important and is also consistent with the provisions of § 13-2405(b) that direct the commission to consider the diversity of the population when carrying out the duties of the commission.

There are many ways that the high rates of suicide, overdose deaths, heart disease, untreated depression and delayed preventative care among males do not simply reflect behavioral choices. Rather, they are interwoven with labor market instability, housing insecurity, justice involvement, disability and the availability of access to primary care.

In practical terms:

- Unstable housing and unemployment often lead men to discontinue routine medical care.
- Men with disabilities typically interact with multiple fragmented service systems.
- Many disabled men acting as male caregivers manage the chronic illnesses of members of their families and may postpone their own medical treatment thereby increasing their risk.
- These patterns produce secondary economic consequences in Medicaid, behavioral health services, corrections and disability systems. As such, addressing the health of boys and men has both public health and budgetary implications.
- An ongoing commission with analytic authority across sectors is a suitable way to study these intersections systematically rather than episodically.

2. Commission Membership and Representation

Second, HB0341 establishes an 18-member commission consisting of members appointed by the Governor, the President of the Senate and the Speaker of the House. The membership composition of organization representatives and at large applicants, 4 year terms, meeting attendance requirements and term limits reflect good governance.

Additionally, the holistic (i.e., “diversity”) clause in the bill is a good approach to ensure that the commission has representation that reflects the diversity of the population.

Recommendation #1 (Guidance on Representing Lived Experience):

Through amendment or through language added to the bill, please clarify that when making appointments, the appointing authorities should include:

- At least one member with lived experience as a male caregiver.
- At least one member with lived experience of serious mental illness or substance use disorder.
- At least one member with professional expertise in the social determinants of health as they affect boys and men.

This does not necessarily require that fixed seats be created. A statement of legislative intent would be adequate to indicate what type of representation is expected while providing the appointing authorities the discretion to make appointments.

3. Responsibilities and Data: Assuring Analytical Credibility

Third, section 13-2405 requires the commission to collect health data, assist in developing policies and educational materials, promote culturally and gender-responsive healthcare services and evaluate the effectiveness of laws that address the needs of boys and men. Section 13-2408 requires the commission to submit annual reports and every two years, beginning in 2028, to include measurable indicators of the progress made.

The reporting requirement is the most important component of the bill and if done properly, could result in the development of an effective strategy to improve the health of boys and men in Maryland.

Recommendation #2 (Scope of Data Disaggregation):

Please encourage the commission to break down data by:

- Age Cohort
- Ethnicity/Race
- Geography
- Disability Status
- Insurance Category/Income Level
- In addition, the commission should analyze:
- Patterns of Preventative Care Utilization Among Boys and Men
- Trends in Suicides and Overdose Deaths Among Males with Co-Occurring Behavioral Health Conditions
- Engagement Indicators for Paternal and Male Caregiver Engagement
- System Cross Metrics Such as Incarceration Rates, Homelessness, Unemployment Rates

Unless data is broken down, aggregate trends may obscure existing disparities. Long-term this has historically led to further expenditures, therefore prevention rather than treatment is critical here.

Recommendation #3 (Expectations for Methodology):

Please express legislative intent that the commission utilize multi-year trend analyses and transparent evaluations. The State possesses a wealth of data sources, including vital statistics, Medicaid claims, and the All-Payer Claims Database. The credibility of the commission will be dependent upon the quality of its analysis, not the regulatory authority.

4. Fiscal Context and Return on Investment

Fourth, according to the Department of Legislative Services, estimated expenditures from the General Fund for FY 2027 will total $138,100. Estimated expenditures are based on 1.5 FTE

health policy analyst positions and operating expenses. Compared to overall health expenditures in Maryland, this represents a small fraction.

The relevant question is whether the analytical capacity provided by the commission can help reduce high cost system utilization such as:

- Emergency Room Use Due to Uncontrolled Chronic Disease
- Crisis-Based Interventions for Mental Illness and Substance Abuse Disorders
- Justice System Involvement Due to Untreated Mental Illness and/or Substance Abuse Disorder
- Early Disability and Dependency on Government Benefits
- Even moderate decreases in high cost system utilization would exceed the operational costs of the commission. The biennial reporting of progress indicators starting in 2028 offers a logical mechanism for assessing whether such reductions occur.

Key Caveat: Additional Funding Opportunities Through Federal and Private Sources Further Mitigate Financial Exposure.

Maryland receives millions of dollars each year from the Federal government in areas related to the Commission's Analytic Mission, as well as the Disparities identified in HB0341. The MD Department of Health was granted a federal cooperative agreement with the CDC to track and prevent overdoses with approximately $13.6 million through 2028. This funding is critical to supporting Maryland's Overdose Surveillance and Response Programs.

Additionally, MD has received large amounts of SAMHSA funding, such as a $17.7 million award for the Community Mental Health Services Block Grant for FY 2024-26, as well as ongoing funding for the State Opioid Response (SOR) project in excess of $104.5 million to provide interventions in high risk communities affected by opioids and stimulants.

Furthermore, MD receives chronic disease prevention funding ($~8.2 million) from the CDC's National Center for Chronic Disease Prevention and Health Promotion to fund long-term initiatives to reduce tobacco-related and other chronic diseases affecting men. Therefore, when these federal funding sources are combined, there is evidence of a scale of over $140 million in targeted public health resources to strengthen and coordinate if the Commission enhances Maryland's ability to analyze male specific health disparities.

5. Proposed Amendments

While HB0341 establishes a strong framework to advance the health of boys and men in Maryland, I believe several targeted amendments can strengthen the bill without expanding its scope.

Specifically, I propose:

- That the Commission's analytical scope explicitly include consideration of disability and male caregiving roles;
- Legislative Guidance to Include Representation of Individuals with Lived Experience; and
- Emphasis on Longitudinal and Disaggregated Data Analysis in Required Reporting.
- These amendments are intended to build upon the current language and enhance the effectiveness of the Commission's efforts.

Conclusion

HB0341 creates a structured advisory body to address health disparities experienced by boys and men in Maryland. It creates an analytic infrastructure and formally establishes reporting obligations without creating additional regulatory authority.

With minor amendments to assure inclusive representation and effective use of data, the Commission can assist Maryland in understanding where disparities exist, which interventions should be scaled-up and how the health of boys and men intersects with family stability and State expenditures.

For caregivers and families, the stakes are real. For the State, the stakes are both humanitarian and financial, especially in a fiscally quantifiable manner.

I have also forwarded a technical addendum, a list of key sources used, and a brief executive summary to the Maryland General Assembly, in a separate file.

I respectfully request a favorable report with the proposed amendments.

Thank you for this opportunity.

Respectfully authored and forwarded.

Shawn