

Treating Obesity in Medicaid: A High-Value Investment

A new study in *Diabetes, Obesity, and Cardiometabolic CARE (2026)* evaluates the five-year clinical and economic impact of expanding obesity treatment among Medicaid adults.

Evaluating intensive lifestyle management (ILM), obesity medications (OMs), and metabolic/bariatric surgery (MBS), findings demonstrate that obesity treatment is not just clinically effective, but a strong economic investment.

Scope of the Challenge



or **45%** of all adult Medicaid beneficiaries, have obesity.



are at coverage risk without a diabetes or cardiovascular disease diagnosis.



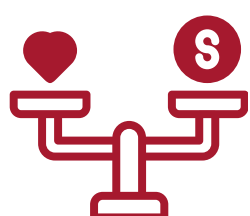
is the annual increased Medicaid spending linked to obesity: **\$3,800 per person.**

KEY FINDINGS: 2025-2029



REDUCED DISEASE INCIDENCE

- Over five years, treatment saw a **45–48%** reduction in new type 2 diabetes cases and up to a **45%** reduction in hypertension.
- 10-year projections found treatment achieving **50%** diabetes prevention and **47%** hypertension reduction.



COSTS & SAVINGS

At a cost of \$5.4B nationally, or \$2.3B for states, obesity treatment produces:

- \$997M** in direct medical cost savings.
- \$847M** in productivity gains.
- \$7B** in quality-of-life improvements.
- \$11.8B** in mortality reduction value.



RETURN ON INVESTMENT

An estimated 2M people could be treated, generating a return of:

- \$3.81 per \$1** invested nationally.
- \$8.57 per \$1** for states.
- A national 5-year value of **\$15B.**
- A state 5-year value of **\$17.5B.**

State Benefits

Reduced State Spending



- Coverage expansion reduces costs tied to obesity-related complications.
- \$429M** seen in direct state Medicaid medical savings over five years.

Economic Participation



- Strengthens workforce participation and return-to-work.
- Reduces absenteeism and disability-related limitations.

Budget Stability



- Reduces volatility from preventable high-cost claims.
- Improves long-term actuarial predictability.

Improved Population Health



- Reduced type 2 diabetes, hypertension, and cardiovascular disease rates.
- Healthier Medicaid populations lower long-term disease burden for states.

Clinical Impact

On average, sustained treatment was found to extend life expectancy by **8-15 days per year** of treatment, producing more than **55,000 additional life-years** across treated beneficiaries over the 5 years, through:

Screening & Prevention
Life Counseling & Intervention
Obesity Medications
Metabolic Bariatric Surgery



- ✓ **Sustained** weight management
- ✓ **Reduced** A1C, blood pressure & inflammatory markers
- ✓ **Improved** lipid profiles
- ✓ **Heightened** quality of life & functional capacity



March 17, 2026

Minnesota House of Representatives
House Committee on Health Finance and Policy

Re: MN HF 4142 - Medical assistance coverage of prescription drugs solely for weight loss prohibited.

On behalf of the Diabetes Patient Advocacy Coalition (DPAC), I write to oppose HF 4142, which would restrict the Medicaid drug formulary managed by the Minnesota Department of Human Services by prohibiting coverage of prescription drugs used solely for weight loss. DPAC is an alliance of people with diabetes, caregivers, patient advocates, health professionals, and others working together to support public policy initiatives to improve the lives of Americans living with and at risk for diabetes and its complications. As an organization run by and for people with diabetes, DPAC seeks to ensure quality of and access to care, medications and devices for our community.

The diabetes community cares deeply about maintaining and expanding coverage of anti-obesity medications (AOMs), because access to effective obesity therapies is crucial to effectively prevent and manage diabetes. The use of weight loss drugs reduced the risk of developing Type 2 diabetes by 94% in obese or overweight adults with pre-diabetes compared to a placebo, according to initial results from a long-term study.¹ The American Diabetes Association in their standards of care, cite extensive evidence that obesity management can delay the progression from prediabetes to Type 2 diabetes and is highly beneficial in treating Type 2 diabetes, and greater weight loss substantially reduces A1C and fasting glucose and may promote sustained diabetes remission.² Coverage of these drugs can treat obesity and prevent over 200 comorbidities that are not only expensive to the state but detrimental to the health, productivity, and quality of life of Minnesotans.

We urge you to oppose this legislation. Please do not hesitate to contact us with any questions or if we may be a resource in further policy discussions.

Respectfully,

A handwritten signature in black ink, appearing to read "Erin M. Callahan", with a long horizontal flourish extending to the right.

Erin M. Callahan
ecallahan@diabetespac.org
Chief Operating Officer
Diabetes Patient Advocacy Coalition

¹ Jastreboff, A. M., Aronne, L. J., Ahmad, N. N., Wharton, S., Connery, L., Alves, B., Kiyosue, A., Zhang, S., Liu, B., Bunck, M. C., Stefanski, A., & SURMOUNT-1 Investigators. (2022). Tirzepatide Once Weekly for the Treatment of Obesity. *The New England Journal of Medicine*, 387(3), 205–216. <https://doi.org/10.1056/NEJMoa2206038>

² American Diabetes Association. (2025). 8. Obesity and Weight Management for the Prevention and Treatment of Type 2 Diabetes: Standards of Care in Diabetes—2025. *Diabetes Care*, 48(Supplement_1), S167–S179. <https://doi.org/10.2337/dc25-S008>



Obesity Groups Oppose Efforts to Eliminate Minnesota Medical Assistance Coverage for FDA-Approved Obesity Management Medications

March 17, 2026

The Obesity Action Coalition (OAC), The Obesity Society (TOS) and the American Society for Metabolic and Bariatric Surgery (ASMBS) strongly opposes [HF 4142](#) – legislation introduced by Representative Nadeau, which would affect the Medicaid drug formulary managed by the Minnesota Department of Human Services by prohibiting coverage of prescription drugs used solely for weight loss.

Our organizations strongly support coverage of Food & Drug Administration (FDA) – approved obesity management medications (OMMs) in the context of comprehensive obesity care for Medicaid beneficiaries under Minnesota’s Medical Assistance program. Improved access to obesity treatments that have been proven safe and effective, including nutrition counseling, behavioral and lifestyle interventions, FDA-approved obesity management medications, endo-bariatric procedures, and metabolic and bariatric surgery is critical to ensuring the health and productivity of all state residents.

The total cost of obesity in the United States is \$1.7 trillion and healthcare costs are 34% higher for people with obesity. Maintaining access to obesity care will continue to help decrease the numerous illnesses and associated medical problems that plague Minnesota residents, while improving health outcomes and healthcare savings. In addition, continuing Medicaid coverage for FDA-approved obesity management medications will ensure that Medicaid beneficiaries who are affected by obesity have access to affordable, individualized medical coverage for science-based treatments in the same way other chronic diseases are managed, allowing them to be treated with dignity, respect, and equality that is offered to their peers.

We know that obesity disproportionately affects people of color and of lower socioeconomic status which are important factors that often determine access to health care. Disparities further exacerbate Minnesota obesity statistics and health outcomes with 35.6% of black and 34.6% of Hispanic state residents living with obesity compared to 33% of white residents. Persons with low incomes are more likely to be Medicaid recipients or uninsured, have poor-quality health care, and seek health care less often; when they do seek health care, it is more likely to be for an emergency.

A [January 2026 study](#) from the American Diabetes Association evaluated the clinical, economic, and social impacts of treating obesity among Medicaid adult beneficiaries. The study found that while medical savings offset only a portion of treatment costs, obesity interventions generate substantial social value through improved long-term health and productivity. These findings support expanded Medicaid coverage as a strategic investment in population health, demonstrating value that challenges conventional short-term, budget-focused coverage decisions that currently limit access to evidence-based obesity treatments for millions of adults. For these reasons, we find Representative’s Nadeau’s legislation to eliminate Medicaid coverage for GLP-1 medications penny wise and pound foolish.

Before moving to eliminate OMM coverage, we encourage Minnesota policymakers to consider many of the positive developments in GLP-1 pricing and access during the last six months that states can take advantage of to reduce their costs for Medicaid, including:

- The Center for Medicare and Medicaid Innovation BALANCE model that will allow Medicaid programs (that opt in) to purchase these GLP-1 medications at a monthly cost of \$245 as early as May 2026.
- Pharmaceutical manufacturers have publicly announced their willingness to negotiate directly with states for their employee health plans.
- Finally, the market has already experienced downward price pressure throughout the past several months.

Treating Obesity is Good Public Policy

Throughout the last 5 years, there have been numerous studies and reports issued on the cost effectiveness of providing coverage for obesity treatment – with the most recent being the release of the October 29, 2025, Institute for Clinical and Economic Review (ICER) Evidence Report assessing the comparative clinical effectiveness and value of semaglutide and tirzepatide. ICER found all three medications to be highly cost-effective at conventional thresholds with incremental cost-effectiveness ratios estimated at \$53,400 per quality-adjusted life year gained for tirzepatide, \$61,400 for injectable semaglutide, and \$69,300 for oral semaglutide.

Another example is the October 2025 report from Global Data, entitled the “Economic Benefits of Obesity Treatment,” which assessed previous literature findings on the value of obesity treatments to help policymakers be better informed regarding coverage and policy decisions. This included 31 studies (2012–2025) on the economic value of four major interventions -- lifestyle programs, first-generation medications, modern medications, and metabolic and bariatric surgery. The report’s key take away was that investing in effective obesity treatments not only improves health outcomes and quality of life but also delivers meaningful savings. The estimated annual medical savings (adjusted to 2025 dollars; varies by insurance type) would be as follows: \$200-\$1,220 for lifestyle programs and first-gen medications; \$760-\$4,720 for modern medications; and \$940-\$5,830 for metabolic and bariatric surgery.

The University of Southern California Schaeffer Center study (2023) on the [“Benefits of Medicare Coverage for Weight Loss Drugs”](#) found that treating obesity can reduce diabetes (-8.9%), hypertension (-2.3%), heart disease (-2.6%), cancer (-1.3%), and disability (- 4.7%) over 10 years in private insurance coverage and Medicare. These results would also likely apply to state Medicaid programs.

In addition, a recent [AON study](#) of 139,000 U.S. employees revealed that patients treated with GLP-1 medications experienced a 7% lower medical cost trend by year two compared to similar patients who did not receive treatment for their obesity. In contrast, the untreated group saw their medical cost trend rise to 14%. This is a 50% reduction in health care spending for patients taking obesity management medications. Most notably, GLP-1 use led to a greater than 40% reduction in major adverse cardiac events such as heart attacks and strokes and significantly reduced the incidence of diabetes—outcomes that directly benefit both patient lives and the state’s healthcare expenditures. The study was so impactful that the benefits consulting firm started a program to cover these obesity management medications for their own employees.

The goal of healthcare is not simply to save money, but to improve the health and quality of life of people. Current Minnesota Medical Assistance coverage for obesity management medications as part of a comprehensive obesity care plan meet these goals. Therefore, we strongly urge the legislature to oppose HF 4142, which would hold obesity care to a different standard than other medical conditions when it comes to insurance coverage.

For more information, please contact public policy consultant Chris Gallagher at chris@potomaccurrents.com.

March 17, 2026

The Honorable Jeff Backer, Co-Chair
The Honorable Robert Bierman, Co-Chair
The Honorable Danny Nadeau, Co-Vice Chair
The Honorable Liz Reyer, Co-Vice Chair
Health Finance and Policy Committee
Minnesota House of Representatives

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RE: HF 4142 – Testimony in Opposition

Chair Backer, Chair Bierman, Vice Chair Nadeau, Vice Chair Reyer, and Members of the Health Finance and Policy Committee,

The Academy of Nutrition and Dietetics, representing more than 2,500 registered dietitian nutritionists (RDNs), nutrition and dietetic technicians, registered (NDTRs), and advanced-degree nutrition professionals in Minnesota, appreciates the opportunity to provide comments on HF 4142 and respectfully **opposes** the bill.

RDNs are the nation’s food and nutrition experts and are uniquely qualified to provide medical nutrition therapy (MNT), an evidence-based service that plays a critical role in the prevention and management of obesity and related chronic diseases.¹

Obesity is a complex chronic disease and individuals living with obesity benefit from evidence-based, comprehensive obesity care, including medical, nutrition, lifestyle, and pharmacological interventions.² Together, these approaches can improve health outcomes and help reduce the burden of obesity and related chronic diseases such as diabetes and cancer.

The Academy opposes proposed clause (6) under Minnesota Statutes section 256B.0625, subdivision 13d(b) which would prohibit Medicaid coverage of prescription medications used for weight management. Limiting coverage for one category of treatment restricts access to clinically appropriate options which can create gaps in care and undermine efforts to improve health outcomes.

Coverage policies should support a coordinated, patient-centered approach that allows providers to determine the most appropriate course of treatment based on individual clinical needs.

¹ Moloney, L., Rozga, M., Steiber, A., & Handu, D. (2026). The effectiveness of medical nutrition therapy in prevention and treatment of chronic disease: A position paper of the Academy of Nutrition and Dietetics. *Journal of the Academy of Nutrition and Dietetics*, 126(2), 156219. <https://doi.org/10.1016/j.jand.2025.10.010>

² Nadolsky K, Garvey WT, Agarwal M, Bonnecaze A, Burguera B, Chaplin MD, Griebeler ML, Harris SR, Schellinger JN, Simonetti J, Srinath R, Yumuk V. American Association of Clinical Endocrinology Consensus Statement: Algorithm for the Evaluation and Treatment of Adults with Obesity/Adiposity-Based Chronic Disease - 2025 Update. *Endocr Pract.* 2025 Nov;31(11):1351-1394. doi: 10.1016/j.eprac.2025.07.017.

For these reasons, we respectfully request that the committee amend the bill to remove clause (6) under section 256B.0625, subdivision 13d(b), which excludes coverage for drugs or active pharmaceutical ingredients used solely for weight loss.

Thank you for your consideration.

Sincerely,

Kim Iles, MS, RDN

Kim Iles, MS, RDN
Sr. Manager, Nutrition Services Coverage
Academy of Nutrition and Dietetics

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March 17, 2026

RE: HF 4142

Dear Colleagues,

Please accept this letter on behalf of the University of Minnesota Center for Pediatric Obesity Medicine regarding HF 4142, "Medical assistance coverage of prescription drugs solely for weight loss prohibited." Our Center is recognized as a world leader in the treatment of pediatric obesity, and part of our mission is to drive educational and advocacy efforts on behalf of the millions of children and adolescents who struggle with the disease of obesity.

Obesity affects nearly 1 out of every 3 people in the State of Minnesota. Obesity is a chronic, biologically-based disease that is primarily determined by genetics. Obesity is no one's fault. Obesity directly causes other diseases such as diabetes, heart disease, and cancer. It also negatively impacts quality of life, productivity and employment. The annual per capita healthcare cost for obesity was estimated to be between \$2,741 to \$6,899 in the U.S.

Standard of care treatment for this disease includes obesity medications. Numerous medications are now FDA-approved for the treatment of adult and adolescent obesity. Some of these medications are now covered by medical assistance in the State of Minnesota. If this assistance were to be stopped, countless citizens of our State would no longer have access to evidence-based standard of care to treat their disease. The research is clear - when obesity medication is stopped, the disease comes roaring back and any health improvements (e.g., reduced blood pressure, cholesterol, diabetes and heart disease risk) are lost. This can be devastating for patients and is a major health equity issue. Furthermore, without medical assistance coverage of these medications, the long-term health consequences for individuals with obesity will be significant and the healthcare expenditure faced by the State of Minnesota will be substantial.

The physicians, scientists, and clinical care providers representing the Center for Pediatric Obesity Medicine **urge you to reject this bill** and continue to provide access to life-saving FDA approved obesity medications through medical assistance coverage. This will ensure that all patients with obesity will continue to have access to the treatment best suited to their clinical circumstance and allow medical providers to deliver equitable care for their patients.

If you have any questions or would like assistance on any issue involving the care of individuals with obesity, please contact: Center for Pediatric Obesity Medicine Phone: (612) 626-2349 Email: cpom@umn.edu.

The Center for Pediatric Obesity Medicine (CPOM) **Executive Committee**



Claudia Fox, MD, MPH, FAAP

Co-Director, Center for Pediatric Obesity Medicine



Aaron Kelly, PhD

Co-Director, Center for Pediatric Obesity Medicine



Amy Gross, PhD, LP, BCBA-D

Associate Director of Clinical Care

CPOM Faculty Members:

Eric Bomberg, MD, MAS

Megan Bensignor, MD, MSHP

Carolyn Bramante, MD, MPH

Alicia Kunin-Batson, PhD, LP

Sarah Raatz, MD

Testimony for HF 4142 March 18, 2026

Thank you, Chairman and Legislators, for your time.

I am Dr. Claudia Fox. I am a Professor of Pediatrics and co-director of the Center for Pediatric Obesity Medicine at the Univ of MN. I have been taking care of children and adolescents with obesity for the past 20 years and I direct the Univ of MN Pediatric Weight Management Clinic. I am an internationally-recognized expert in the use of obesity medications for children and adolescents.

I am here to urge you to reject the proposed changes to the Medicaid formulary that would prohibit coverage of obesity medications.

To start, I want to talk about what obesity is and is not.

Obesity is a chronic disease that stems from an abnormal energy regulation system. It is a biological condition that is largely determined by genetics.

Obesity is not a choice, or related to poor parenting, or to laziness or lack of will-power. Obesity is no one's fault; it is a disease, that needs treatment.

In Minnesota, about 15% of children and 43% of adults have obesity and the consequences are tremendous – both to society at large and to the individual who is affected.

Take Derek, one of my patients who I have had the privilege of treating for the past year. He was 14 years old and weighed 270 lbs when we first met.

He came to the clinic with his dad who also struggles with extra weight. His dad is worried because he knows, first hand, how hard it is to grow up being the heavy kid in class and he does not want his son to suffer the same fate. Unfortunately, Derek is already ostracized by his classmates and suffers from depression and anxiety. As if that is not enough, when I checked his blood tests, we found out that Derek has type 2 diabetes, a common complication of obesity.

Derek is a 14 yo boy with depression and anxiety and severe obesity complicated by diabetes – all because he happened to be born into a family that has the disease of obesity. His fate is an insulin pump and because he developed diabetes at such a young age, he is likely be on dialysis in 20 yrs, when he is in his 30s. A heart attack or stroke is likely to be the cause of his early death.

We immediately started him and his family on a lifestyle therapy program. I wanted to start him on an obesity medication at our first visit, as recommended by the American Academy of Pediatrics, but he was apprehensive about this because he and his dad thought that these medications “were the easy way out.” Over the next 2 mos, he gained another 7 lbs. Finally, with my coaching he realized that obesity medications are not a “crutch.” They are standard of care and integral to correcting the underlying abnormal biology that is causes obesity.

We started him on semaglutide, which is on the Medicaid formulary. Semaglutide, also called Wegovy, is FDA approved for treating obesity in adolescents as young as age 12. In 9 months, his weight decreased

from 277 lbs to 220 lbs. He lost 57 lbs. More importantly, his diabetes test normalized. His mood was brighter and he started hanging out with friends.

Unfortunately, his insurance plan changed and he was unable to obtain semaglutide for 3 mos. I saw him on Monday and he regained 23 lbs during this time.

Because obesity is a chronic disease, it gets worse when treatment is stopped. His diabetes is going to worsen again too. This is what will happen if Medicaid stops coverage for obesity medications. Patients who have finally experienced evidence based, standard of care obesity treatment are going to experience a relapse of their disease; their weight will increase and their obesity-related health problems will resurface.

It is unclear why MN Medicaid should call out “obesity” as a disease that does not merit standard of care medical treatment by not covering obesity medications. One reason could be that some may not view obesity as a medical disease – that the State should not be paying for something that is deemed to be the patient’s fault. Afterall, we would never accept the discontinuation of coverage for cancer treatment, for example. We must acknowledge the abundant scientific evidence that proves that obesity is a chronic progressive biological neuroendocrine disorder. Not covering obesity medications is a parity issue.

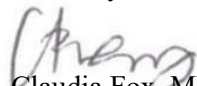
We also have to recognize that the use of obesity medications is not a matter of vanity. My 15 year old patient who weighs 300 lbs and needs to lose weight in order to get a heart transplant is not worried about his looks, nor is my 12 year old patient who weighs 210 lbs who has sickle cell disease and needs to wear CPAP at night for sleep apnea. These are individuals who have severe illness.

I understand that the impetus to discontinue coverage of obesity medications is the current high price of many of these medications. However, prices are coming down and investing in coverage obesity medications will pay off. The lifetime cost of a child with obesity is nearly \$20,000 more than for a child without obesity. The healthcare cost of an adult with obesity is 150% more than that of an adult without obesity. These extra costs are directly related to management of weight related health problems such as high blood pressure, heart disease, diabetes and cancer. In addition to these high direct costs, obesity has huge indirect costs in terms of lost productivity. Obesity medications directly reduce these health care and societal costs.

In summary, I urge you to continue coverage of obesity medications. Please use your powerful voice to negotiate better prices with the drug manufacturers rather than let your constituents bear the burden of losing evidence-based health care.

Thank you for your time and attention.

Sincerely,



Claudia Fox, MD, MPH
Professor of Pediatrics
Co-Director, Center for Pediatric Obesity Medicine
Medical Director, Pediatric Weight Management Clinic
University of Minnesota



March 17, 2026

Minnesota House Health Finance and Policy Committee
Minnesota House of Representatives
658 Cedar Street
St. Paul, MN 55155

Re: Opposition to HF 4142

Co-Chairmen Backer and Bierman and Members of the Committee,

I write on behalf of the National Taxpayers Union—the nation’s oldest taxpayer advocacy organization—to respectfully oppose HF 4142, which would prohibit Minnesota’s Medicaid program formulary from including prescription medications used for weight loss. I also bring the perspective of a former Wisconsin State Senator and a pediatric nurse practitioner, having worked both on healthcare policy and directly with patients affected by chronic disease.

While the bill is framed as a well-intentioned cost-containment measure, restricting access to effective obesity treatments is likely to increase long-term costs to Minnesota taxpayers and worsen health outcomes for Medical Assistance enrollees. A growing body of clinical and economic research—including analysis cited in [NTU’s comments](#) to the Centers for Medicare and Medicaid Services and peer-reviewed studies in journals such as the [Journal of the American Medical Association](#)—shows that sustained weight loss in adults is associated with lower health care utilization and spending over time.

Obesity is a chronic disease that drives many of Medicaid’s most expensive conditions, including type 2 diabetes, cardiovascular disease, and stroke. This challenge is significant in Minnesota, where roughly one in three adults—about 33%—meet the clinical definition of obesity, according to the Centers for Disease Control Behavioral Risk Factor Surveillance System [data](#). For Minnesota’s Medical Assistance program, these conditions represent some of the costliest and fastest-growing categories of spending.

Addressing obesity upstream – *before* other conditions become acute in the patient – is therefore not simply a clinical priority, it is a fiscal imperative for the state budget. Nationally, the Centers for Disease Control and Prevention [estimates](#) obesity-related medical costs at \$173 billion annually. Minnesota faces similar downstream pressures, particularly from diabetes care, dialysis treatment, and cardiovascular hospitalizations among publicly insured populations.

The fiscal cost of inaction is substantial. Treating advanced diabetes, kidney failure, and cardiovascular events imposes high long-term costs. A prohibition on AOM coverage risks locking Medical Assistance into paying for expensive complications rather than investing in prevention that can moderate long-term spending growth.

Additionally, restricting access to these medications in Medicaid raises equity concerns. Low-income patients—who experience higher rates of obesity and related chronic disease—would be denied access to treatments increasingly available to those with private insurance. This disparity is likely to widen health gaps and increase future public costs.

Rather than an outright prohibition, policymakers could pursue more fiscally responsible alternatives that balance access and cost control, including:

- Prior authorization tied to clinical criteria to ensure appropriate prescribing and prevent misuse
- Targeting coverage to high-risk populations such as patients with diabetes, hypertension, or severe obesity, where the cost savings are most likely
- Outcomes-based purchasing agreements that tie payment to measurable health improvements
- Step therapy protocols that prioritize lower-cost interventions first while preserving access when clinically necessary

These tools allow the state to manage utilization and budget exposure while still investing in treatments that can produce healthier Minnesotans and reduce long-term spending.

HF 4142 takes an overbroad approach to a complex and evolving area of medicine. By excluding coverage for AOMs, the state risks higher downstream costs, poorer health outcomes, and increased inequities in care.

For these reasons, I respectfully urge the Committee to reject HF 4142 and instead pursue evidence-based policies that recognize obesity as a chronic disease and prioritize the long-term value of treatment for patients and taxpayers.

Thank you for your consideration.

Sincerely,

Leah Vukmir
Senior Vice President of State Affairs
National Taxpayers Union
lvukmir@ntu.org

Written Testimony in Opposition to HF 4142

House Health Finance and Policy Committee

March 18, 2026

Members of the committee, my name is Dr. Jessica Sanchez-Alfaro. I am a family medicine physician board-certified in obesity medicine, and I have been treating patients living with obesity for the last ten years. I am the Vice President of the Minnesota Obesity Society, but I submit this testimony representing myself, in defense of my patients who have benefited and continue to benefit from these life-changing medications. I respectfully urge you to vote against HF 4142.

Obesity is a medical condition that is already present before a patient ever steps on a scale. What has changed is the brain's "body weight set point", and once that set point is elevated, the body launches a cascade of metabolic changes: increased hunger signaling, hormonal disruption, insulin resistance, systemic inflammation. The elevated weight is a marker, just as a high temperature on a thermometer is a marker of fever. What is happening inside the body is not simply a higher number. It is a storm of changes as the body defends a set point that is causing harm. In the old days, we treated fever by submerging patients in ice water. Today, we use acetaminophen to reset the brain's thermostat so people can heal and live productive lives. GLP-1 medications do the same thing for obesity. They act on the brain's dysregulated appetite and weight regulation centers to address the underlying disease. But unlike fever, obesity is not acute. It is chronic, just like cancer, hypertension, and diabetes. No one argues we should stop blood pressure medication because blood pressure rises when you stop it. No one proposes removing GLP-1 coverage for diabetes patients because their blood sugar would return if they discontinued. Chronic diseases require chronic treatment.

HF 4142 would prohibit Medical Assistance coverage of prescription drugs used "solely for weight loss." But that is not what obesity medications do. These medications target the underlying condition that causes the weight to go up: the dysregulated hunger signaling, the elevated set point, the metabolic derangement. Weight loss is a secondary result, not the primary target. We do not say that blood pressure medications treat "solely a number on a cuff." We do not say that GLP-1s prescribed for diabetes treat "solely a number on an A1c." We recognize that those medications treat the underlying disease, and the improved number is evidence that the treatment is working. Obesity deserves the same standard, with GLP-1 medications as a cornerstone alongside comprehensive nutritional counseling, exercise guidance, and behavioral support.

I understand these medications are expensive. But their benefits outweigh the cost. These drugs will become generic in the coming years and prices will come down. In the meantime, every patient we treat effectively is a patient who may need less financial assistance in the near future. Medicaid patients want to be productive members of society, but many times their metabolic conditions and the physical burden of excess weight prevent them from contributing financially to themselves and to their communities. Treating obesity is not a cost. It is an investment in a healthier, more independent, more productive population.

These medications are not weight loss drugs. They are health gain medications. My patients do not come to me for a smaller number on a scale. They come because they want their lives back. When these treatments work, they gain back their mobility, their energy, their mood, their self-esteem, and the ability to be present for the people who depend on them. They become more engaged parents, more active community members, and healthier role models for the next generation. That ripple effect extends across families and communities and generations. Denying Medical Assistance patients access to these treatments while we continue to cover the same medications for diabetes and cardiovascular disease is not a policy based in science. It is a policy based in stigma. I respectfully urge this committee to vote against HF 4142.

Respectfully submitted,

Jessica Sanchez-Alfaro, MD, DABOM

Family Medicine | Obesity Medicine

As a Physician Associate practicing obesity medicine for the past five years and primary care for about 20 years before that, I am submitting my testimony opposing the bill in the house that is proposed to prohibit Medicaid coverage of anti-obesity medications.

Obesity is a serious and complex disease that can lead to the development of multiple chronic diseases such as type 2 diabetes, cardiovascular diseases, hypertension, sleep apnea, cancers, orthopedic conditions, depression, and many others. It significantly impacts the overall health and well-being of many patients, making it imperative to address effectively.

Over the years, healthcare providers as well as health insurance plans have consistently emphasized the importance of weight management for patients diagnosed with obesity. Traditional approaches, including diet and exercise, have been recommended; however, numerous medical studies conducted since the 1990s have highlighted the challenges associated with sustainable weight loss through these methods. The bottom line is eating less and exercising more does not work for the vast majority of people who struggle with their weight. Regardless of the approach – whether low fat, low carb, keto, counting calories, or counting points – most patients struggle to achieve and maintain significant weight loss. This is not because people with obesity are gluttons or because they haven't tried diet after diet after diet. It's because obesity is a metabolic disorder – a medical condition – that warrants treatment with the most effective treatments available, just like any other medical condition such as hypertension, hyperlipidemia, depression, asthma, diabetes. It could be viewed as malpractice to tell patients with these obesity that they should not have access to medications for their condition, and to “just try diet and exercise again”, because we know they will fail, and their condition will worsen.

In recent years, a breakthrough in the treatment of obesity has been witnessed with the introduction of Semaglutide and Tirzepatide. These medications have shown remarkable efficacy in helping patients achieve meaningful and sustained weight loss. Many individuals who have struggled with obesity for years have reported experiencing a sense of relief and newfound control over their eating habits and hunger, thanks to these drugs. For these patients, these new anti-obesity medications represent a beacon of hope, providing them with an opportunity to address their obesity and its associated health risks effectively.

However, the high cost of these drugs poses a significant barrier to access for the majority of patients. Without insurance coverage, a substantial portion of patients will be unable to afford this life-changing medication. It is essential to recognize that the inability to access GLP1 or other innovative anti-obesity treatment due to financial constraints will lead to weight regain, negating the progress achieved and potentially worsening their overall health

and other chronic conditions. Medicaid provides health coverage to millions of low-income Americans. It is imperative that coverage for anti-obesity medications, including GLP1 medications, continues.

Sincerely,

Kimberly Bleasdale, PA-C

Maple Grove, MN

March 17, 2026

To Health Finance and Policy Committee,

As a family physician and obesity medicine specialist practicing in Minnesota, I am writing to express strong opposition to House File 4142, which would prohibit Medical Assistance coverage of prescription medications for weight loss. This proposal raises serious concerns about patient care, clinical autonomy, and long-term health outcomes.

Obesity is a chronic, relapsing disease—not a matter of personal choice or cosmetic preference. The medications targeted by this bill, including GLP-1 receptor agonists, are FDA-approved, evidence-based treatments that I prescribe to patients who meet clear medical criteria. These therapies are not about helping someone “lose a few pounds”—they are essential tools to treat a complex disease that significantly impacts overall health.

In my practice, I see firsthand how effective these medications can be. They reduce the risk of serious conditions such as type 2 diabetes, heart disease, and stroke. Patients experience improvements in blood pressure, cholesterol, mobility, and overall quality of life. For many, these treatments are life-changing—allowing them to function better, remain employed, and avoid progression to more severe disease.

Denying coverage for these medications creates real harm. Patients who cannot access treatment often experience worsening health, leading to increased emergency room visits, hospitalizations, and higher long-term healthcare costs. What may appear to be a cost-saving measure in the short term ultimately shifts the burden to more expensive and intensive care down the line.

This bill also undermines the physician-patient relationship. Medical decisions should be made based on clinical evidence and individual patient needs—not restricted by broad policy decisions that remove effective treatment options. As clinicians, we are trained to tailor care to each patient. HF 4142 would limit our ability to do so.

There are also important equity implications. Patients with financial means may still be able to access these medications out-of-pocket, while those relying on Medical Assistance—often the most vulnerable populations—would be left without effective treatment. This creates a two-tiered system of care that is inconsistent with our commitment to fairness and health equity.

While I recognize the importance of responsible healthcare spending, outright exclusion of effective, evidence-based treatments is not the solution. More thoughtful, cost-conscious approaches can expand access while managing expenditures—without denying patients medically necessary care.

For these reasons, I respectfully urge you to oppose House File 4142 and to support policies that prioritize patient health, clinical judgment, and equitable access to evidence-based treatment.

Sincerely,

Britta Reiersen, MD, FAAFP, FOMA, DABOM

As a resident of Minnesota, I am writing in opposition to HF 4142 – legislation introduced by Representative Nadeau, which would affect the Medicaid drug formulary managed by the Minnesota Department of Human Services by prohibiting coverage of prescription drugs used solely for weight loss.

Obesity is a chronic disease, and FDA-approved medications for obesity management have helped Medicaid beneficiaries manage their health for many years. Taking away access would be detrimental and unfair. Medicaid beneficiaries who are affected by obesity deserve access to affordable, individualized medical coverage for science-based treatments in the same way other chronic diseases are managed, allowing them to be treated with dignity, respect, and equality that is offered to their peers.

As a person living with obesity, I have been unable to access obesity treatments due to insurance exclusions, only when the FDA approved other indications for GLP-1s was I finally able to get the care I needed and deserved. Individuals should not have to wait for their health to get worse to have access to care that currently exists and is effective. Treatment has improved my health and life by not only helping me significantly reduce my weight, but also lowering my blood pressure, improving my mobility and ability to exercise, lowering my A1C bringing me out of the prediabetic range, and improving my sleep apnea. Though I am still live with obesity my health is vastly improved with treatment.

Taking treatment away from those who are effectively managing their health is just wrong.

People with lower socioeconomic status are disproportionately affected by obesity and are more likely to be Medicaid recipients or uninsured, have poor-quality health care, and seek health care less often; when they do seek health care, it is more likely to be for an emergency. Obesity is a disease, and a disease with serious health consequences when left untreated. People deserve the ability to access treatment that will help them improve their health. I urge you to oppose HF 4142.

Liz Paul

Mankato, MN

Vice Chair, Obesity Action Coalition

Written Testimony in Opposition to H.F. No. 4142

Date: March 16, 2026

To: Members of the House Health Finance and Policy Committee

Subject: Strong Opposition to H.F. No. 4142 – Prohibiting Medical Assistance Coverage for Weight Loss Drugs

Chairs Backer and Bierman, and Members of the Committee,

I am writing today as a parent and concerned citizen to express my **strong opposition** to **H.F. No. 4142**. This legislation seeks to amend Minnesota Statutes to explicitly prohibit Medical Assistance coverage for prescription drugs or active pharmaceutical ingredients when used solely for weight loss.

As a conscientious member of this community, I believe this bill creates a dangerous barrier to essential healthcare for Minnesota's most vulnerable populations. My opposition is based on the following points:

- **Necessity of Allopathic Intervention:** For many individuals, maintaining a healthy weight is not simply a matter of "willpower." Obesity is a complex medical condition, and many patients are unable to achieve significant weight loss without allopathic (pharmaceutical) intervention.
- **Preventative Health and Long-term Savings:** It is well-documented that maintaining a healthy weight leads to better overall health outcomes and fewer chronic medical issues, such as Type 2 diabetes and heart disease. If a patient has tried other methods in earnest and pharmaceutical intervention is the only effective measure, the state should support that treatment to prevent more costly and debilitating medical conditions later.
- **Equity in Healthcare:** Prohibiting this coverage specifically within Medical Assistance disproportionately affects low-income Minnesotans. Those with private insurance may still have access to these life-changing medications, while those relying on state programs will be denied the same standard of care.
- **Government Interference in Medical Decisions:** This bill inserts the legislature into the exam room, overhauling the drug formulary to exclude treatments that a prescribing practitioner may deem medically necessary for a patient's long-term health.

I urge this committee to recognize that weight loss medication is a vital tool for many Minnesotans striving for better health. Please vote **NO** on H.F. No. 4142.

Respectfully,

Michael Babcock
Saint Paul, MN 55106