Testimony of Dr. Ryan Farrell, MD
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Substitute Senate Bill 33
Senate Health Committee
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NOTE: Testimony must be provided to the Chairman's office 24 hours in advance of committee. Thus, the deadline for submission is at 9am on Tuesday, May 9.

Chairman Huffman, Vice Chairman Johnson, Ranking Member Antonio and members of the committee, my name is Dr. Ryan Farrell, and I am a pediatric endocrinologist at Rainbow Babies and Children's Hospital in Cleveland, Ohio. I am writing to testify as a proponent for the language within Substitute House Bill 33 that requires the Ohio Department of Medicaid to cover the treatment of obesity.

As a pediatric endocrinologist, I have witnessed a significant increase in the development of overweight and obesity among patients at our institution. Statewide, nearly 20% of children ages 10-17 years old are obese, above the national average. The incidence of obesity is not uniformly distributed, and rates tend to be higher among socioeconomically disadvantaged individuals as well as Black and Hispanic children. It is clear that there are long-term health consequences for obesity in children, including hypertension, lipid disorders, non-alcoholic fatty liver disease (NAFLD), and youth-onset type 2 diabetes (T2D). It has become readily apparent that children that develop youth-onset type 2 diabetes have exceptionally high rates of complications related to diabetes, and preventing the development of youth-onset T2D will have meaningful benefits for children and their families while also likely reducing the cost of health care spending over the longer-term.

While we continue to advocate for healthy nutrition and regular aerobic exercise as part of family-based lifestyle interventions, there are barriers that may limit the success of these interventions in vulnerable populations. With the recent FDA approval of several different medications to manage obesity (specifically liraglutide, semaglutide, and extended release phentermine/topiramate) in the last 3 years, many providers and patient families have expressed hope in preventing these complications of obesity, particularly among those children who may have limited access to behavioral intervention programs throughout the state. The extent of weight loss that has been seen with each of these medications is clinically meaningful and likely to prevent many of the health complications discussed above, especially in circumstances where these treatments are initiated earlier. Moreover, their adverse effects appear to be manageable in most circumstances.

The coverage of these medications have the potential to not only benefit this generation's children, but also subsequent generations of children. There are clear implications in the medical literature that obese individuals (both male and female) may biologically program their offspring to be predisposed to obesity and other medical conditions. Given the already present health disparities between those on public and private health insurances, there is a risk for perpetuating these health disparities into future generations as well.

As the American Academy of Pediatrics has now updated their guidelines in the management of pediatric obesity, it is clear that anti-obesity medications need to be part of the armamentarium of health care providers for children. I am hopeful that our state can support our pediatricians and children in addressing this health crisis that differentially threatens our most vulnerable children and families. Thank you for giving this the consideration it deserves.

I would be happy to discuss this with you further or answer questions on any of the above testimony in the coming weeks. Thank you so much for your time.

Sincerely,

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