

Key Findings

Analysis of California Senate Bill 839

Obesity Treatment Parity

Summary to the 2023–2024 California State Legislature, December 22, 2023



SUMMARY

Senate Bill (SB) 839 would require comprehensive coverage for obesity treatments, including intensive behavioral therapy (IBT), bariatric surgery, and the two groups of prescription drugs approved by the Food and Drug Administration (FDA) with an indication for weight management: glucagon-like peptide 1 (GLP-1) receptor agonists and non-GLP-1s. SB 839 would also require that cost sharing for obesity treatments not be different or separate from treatments for other illnesses, conditions, or disorders.

Benefit Coverage: At baseline, almost all enrollees have fully compliant coverage for IBT and bariatric surgery with cost-sharing parity. At baseline, for weight management, 86.8% have no coverage for GLP-1s and 10.1% have on-formulary coverage for at least one GLP-1 with cost-sharing parity. At baseline, for weight management, 64% have no coverage for non-GLP-1s and 32.5% have on-formulary coverage for at least one GLP-1 with cost-sharing parity. Postmandate, all would have fully compliant, on-formulary coverage for at least one GLP-1 and one non-GLP-1.

Medical Effectiveness: For adults, there is *clear and convincing evidence* that both FDA-approved GLP-1 and non-GLP-1 weight management drugs are effective adjuncts to usual care, that bariatric surgery is effective, and that IBT is effective.

Cost and Health Impacts: Almost no change would be expected in the use or impacts of bariatric surgery or IBT. There would be a 951% increase in use of GLP-1s and a 197% increase in use of non-GLP-1s, resulting in a total net annual expenditure increase of 0.9%. Increases in premium would result in 10,000 persons losing or dropping health insurance. The 124,000 enrollees newly using the drugs would experience a 5% to 15% body weight reduction. Reduced cardiovascular events would be expected in the second year, and maintained weight loss could reduce cardiovascular disease, hypertension (i.e., high blood pressure), type 2 diabetes, and certain types of cancer; as well as a reduction in downstream effects such as impacts on premature death.

BILL SUMMARY

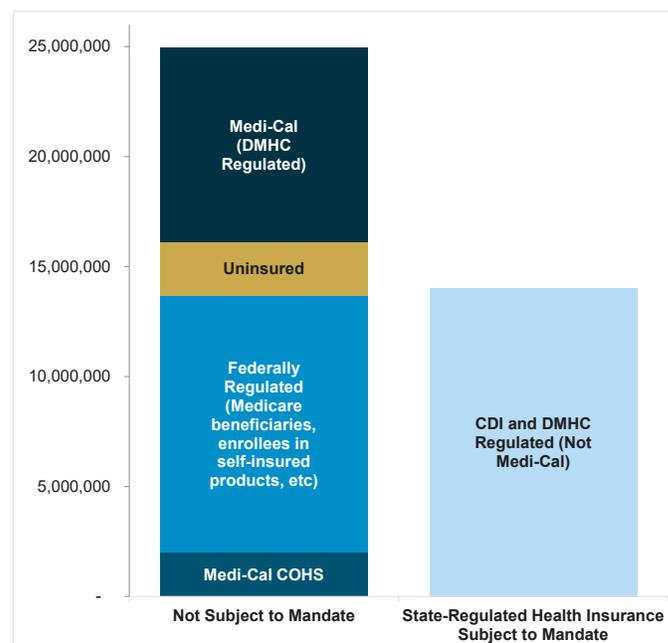
SB 839 would require comprehensive coverage for obesity treatments, including:

- Drugs approved by the FDA with an indication for chronic weight management — coverage criteria for the drugs could not be more restrictive than the FDA-approved indications;
- Bariatric surgery; and
- Intensive behavioral therapy (IBT).

SB 839 would also require that cost sharing for obesity treatments not be different or separate from treatments for other illnesses, conditions, or disorders.

Because SB 839 specifies “group and individual” plans and policies, the health insurance of Medi-Cal beneficiaries enrolled in DMHC-regulated plans would not be subject to SB 839’s requirements.

Figure A. Health Insurance in CA



Source: California Health Benefits Review Program, 2023.

ANALYTIC APPROACH

Although the bill language could be interpreted as creating benefit coverage requirements for additional obesity tests, treatments, and services, this analysis focuses on the prescription drugs, surgeries, and behavioral therapy that seem most directly referenced in SB 839:

- The two groups of prescription drugs approved by the FDA with an indication for chronic weight management:
 - Glucagon-like peptide 1 (GLP-1) receptor agonists¹
 - Non-GLP-1s
- Bariatric surgeries
- Intensive behavioral therapy (IBT)

For the prescription drugs, CHBRP has assumed that SB 839 would require on-formulary coverage with cost sharing parity for one GLP-1 and one non-GLP-1.

CHBRP has assumed that existing supply chain issues for GLP-1s will be fully resolved in 2024 due to changes and increasing capacity in manufacturing, as well as another prescription drug coming to market.

CONTEXT

Obesity is a chronic health condition characterized by an increase in the size and amount of fat cells in the body. Healthcare providers screen for obesity by calculating patients' body mass index (BMI), which takes into account an individual's height and weight. Individuals with a BMI of 25 or higher are categorized as overweight and those with a BMI of 30 or higher are categorized as obese.

Causes of obesity are multifaceted and can include lifestyle habits, environment, socioeconomic factors, and individual characteristics such as genetics and metabolism.

There are many health consequences of obesity such as an increased risk of heart disease, diabetes, and certain cancers, as well as reduced life expectancy.

Nearly 3 million Californians with obesity are enrolled in health insurance that would be subject to SB 839. An additional 500,000 overweight Californians with comorbidities would also be subject to SB 839.

¹ One drug, Tirzepatide (Zepbound), is a dual glucose-dependent insulinotropic polypeptide (GIP)/GLP-1

IMPACTS

Medical Effectiveness

There is *clear and convincing evidence* that use of both GLP-1 and non-GLP-1 weight management drugs in addition to usual care (including standard diet and activity and lifestyle recommendations) is associated with greater weight loss in adults than usual care alone.

There is *limited evidence* that some GLP-1 and non-GLP-1 weight management drugs improve weight loss in adolescents.

There is *clear and convincing evidence* that bariatric surgery is effective in adults, with studies reporting that patients lose significantly more weight after surgery compared to patients who receive nonsurgical interventions.

There is *limited evidence* that bariatric surgery is effective for adolescents with obesity, with studies reporting that adolescents lose significantly more weight and reduced BMI after surgery compared to similar adolescents who do not have surgery.

There is *clear and convincing evidence* that adults who receive IBT for weight loss are more likely to achieve a ≥5% weight loss than adults who receive less intensive treatments.

There is *clear and convincing evidence* that IBT for weight loss is effective in reducing weight and BMI for children and adolescents.

Benefit Coverage, Utilization, and Cost

Benefit Coverage

At baseline, 99.9% of enrollees with health insurance that would be subject to SB 839 already have fully compliant coverage for IBT and bariatric surgery with parity in cost sharing. Therefore, there would be very limited change to coverage or cost sharing due to the enactment of SB 839.

At baseline, 10.1% of enrollees with health insurance that would be subject to SB 839 already have fully compliant coverage for GLP-1 weight management drugs with parity in cost sharing. Another 3.1% have coverage for the medication without parity in cost sharing, while the remaining 86.8% of enrollees with

health insurance that would be subject to SB 839 have no coverage for GLP-1 weight management drugs. Postmandate, all enrollees with health insurance that would be subject to SB 839 would have fully compliant coverage for GLP-1 weight management drugs with parity in cost sharing. These newly covered enrollees represent 90% of enrollees (an 887% increase from baseline).

At baseline, 32.5% of enrollees with health insurance that would be subject to SB 839 already have fully compliant coverage for non-GLP-1 weight management drugs with parity in cost sharing. Another 3.5% have coverage for the medication without parity in cost sharing, while the remaining 64.0% of enrollees with health insurance that would be subject to SB 839 have no coverage for non-GLP-1 weight management drugs. Postmandate, all enrollees with health insurance that would be subject to SB 839 would have fully compliant coverage for non-GLP-1 weight management drugs with parity in cost sharing. These newly covered enrollees represent 68% of enrollees (a 208% increase from baseline).

Unit Costs

There would be no expected increase in unit costs due to the enactment of SB 839. GLP-1 weight management drugs (\$845) and non-GLP-1 weight management drugs (\$331) would maintain the same average unit cost per year postmandate. However, average cost sharing would increase for GLP-1 weight management drugs by \$27 and decrease for non-GLP-1 weight management drugs by \$12. The increase in cost sharing for GLP-1 drugs would be driven by the plans that do not currently cover GLP-1 weight management drugs having higher coinsurance amounts than the plans that already cover GLP-1 weight management drugs. As utilization increases in those plans that had no coverage and higher coinsurance requirements, the average cost sharing would increase. There would also be no change in per-unit costs for bariatric surgery (\$29,522) or IBT (\$500) or their associated cost sharing because of existing coverage for all enrollees at parity.

Utilization

There would be no material change in utilization of IBT or bariatric surgery postmandate due to the existing 99.9% compliant benefit coverage at baseline. There is also no evidence that IBT or bariatric surgeries would increase due to the increased use of GLP-1 or non-GLP-1 weight management drugs.

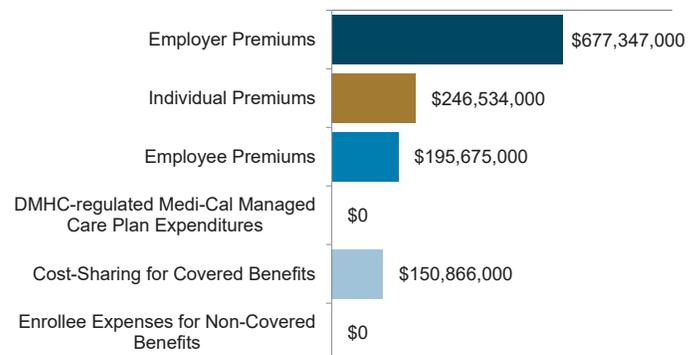
There are 2,972,677 enrollees with obesity and 513,625 overweight enrollees with comorbidities in plans subject to SB 839. At baseline, only 10,008 enrollees use GLP-1

weight management drugs, while 14,838 use non-GLP-1 weight management drugs. Postmandate, due to the 90 percentage point increase in coverage for GPL-1 and 68 percentage point increase in non-GLP-1 weight management drugs, 105,156 enrollees would be expected to use GPL-1 and 44,057 enrollees would be expected to use non-GLP-1 weight management drugs.

Expenditures

SB 839 would increase total net annual expenditures by \$1.27 billion or 0.9% for enrollees with plans and polices regulated by the California Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI). This is due to a \$1.12 billion increase in total health insurance premiums paid by employers and enrollees for newly covered benefits and a \$150.9 million increase in enrollee expenses for covered benefits. In the following year, the increase in estimated expenditures would be higher.

Figure B. Expenditure Impacts of SB 839



Source: California Health Benefits Review Program, 2023.

Uninsured Persons

Because the change in average premiums would exceed 1% for several health insurance market segments, CHBRP would expect a measurable change in the number of uninsured persons due to the enactment of SB 839, especially in markets where the enrollee bears the majority of any added premium costs. For example, despite an estimated 1.18% increase in the DMHC-regulated individual market, about 75% of the enrollees are in Covered California plans where tax credits are linked to the 2nd lowest silver premium available in the region, such that enrollees are partially protected from premium increases for new benefit mandates because they also cause the tax credits to increase commensurately. The premium increases in the CDI-regulated and DMHC-regulated California Public Employees' Retirement System (CalPERS) market segments are not above 1%, so CHBRP anticipates that coverage losses would be limited to enrollees in DMHC-

regulated plans, with a specific focus on individual market plans offered outside of Covered California where tax credits to subsidize the cost are unavailable.

Due to an estimated premium increase of greater than 1% due to SB 839 in several market segments, CHBRP estimates that the increases in premiums would cause more than 10,000 enrollees to lose or drop health insurance. This could lead to an increase in the uninsured of 0.43%, but the majority of newly uninsured would likely come from enrollees in the DMHC-regulated individual market and the DMHC-regulated small-group market where premium increases are more likely to be passed on as enrollee out-of-pocket premium costs rather than absorbed by federally funded tax credits or employer contributions to health insurance coverage.

Public Health

In the first year postmandate, 14 million enrollees with health insurance subject to SB 839 would experience a change in benefit coverage and 124,000 would newly utilize obesity treatments. As a result, these enrollees

would experience a 5% to 14% reduction in body weight and related health improvements, which is supported by evidence that obesity treatments are medically effective.

Long-Term Impacts

Although CHBRP anticipates initial year offsets related to fewer cardiovascular events, other reductions in utilization might occur in the long-term if people are able to continue taking GLP-1 drugs long-term and maintain weight loss, which would improve health status. These health impacts include a reduction in the overall prevalence of obesity and obesity-related chronic disease, including a reduction in cardiovascular disease, hypertension (i.e., high blood pressure), type 2 diabetes, and certain types of cancer; as well as a reduction in downstream effects such as impacts on premature death.