KEY FINDINGS

Analysis of California Assembly Bill 575 Obesity Prevention Treatment Parity Act

Summary to the 2025–2026 California State Legislature April 22, 2025

CHBRP

Summary

The version of California Assembly Bill (AB) 575 analyzed by California Health Benefits Review Program (CHBRP) would require coverage without prior authorization for intensive behavioral therapy (IBT) and at least one glucagon-like peptide-1 (GLP-1) anti-obesity medication (AOM) for the treatment or prevention of obesity.

In 2026, of the 22.2 million Californians enrolled in state-regulated health insurance, 13.6 million of them would have insurance subject to AB 575.

Benefit Coverage

At baseline, nearly all the population with health insurance subject to AB 575 has coverage for IBT (99.8% enrollees). Approximately 17.4% of enrollees have coverage for GLP-1 AOMs. Postmandate, 100% would have coverage for both treatments. AB 575 would likely not exceed essential health benefits (EHBs).

Medical Effectiveness

CHBRP found *very strong evidence* that IBT is effective in reducing weight and improving related health outcomes in adults, adolescents, and children. There is *very strong evidence* that U.S. Food and Drug Administration (FDA)-approved GLP-1 AOMs are effective in reducing weight in adults, and *conflicting evidence* that they are effective in reducing weight in children and adolescents.

Cost and Health Impacts[1]

In Year 1 (2026), CHBRP estimates that AB 575 would result in an additional 182,520 enrollees using FDA-approved GLP-1 AOMs and 35 enrollees receiving IBT. These enrollees would experience a 5% to 21% reduction in body weight, and related health improvements.

AB 575 would increase total premiums by approximately $1 billion in the first year postmandate. In addition, CHBRP estimates that cost sharing would increase by approximately $153 million. Enactment of AB 575 would also reduce previously noncovered expenses by approximately $256 million.

In Year 2, increases in utilization would continue to impact premiums for a total of approximately $1.5 billion, resulting in greater than 1% increase in all but one market segment. CHBRP estimates this would lead to 12,600 newly uninsured Californians. Assuming persistent use of GLP-1 medications, CHBRP estimates that medical costs for each GLP-1 user would decrease by $100 due to a reduction in risk of heart failure after 12 to 18 months of treatment.

Context

Obesity is a chronic health condition characterized by an increase in the size and amount of fat cells in the body.[2] Health care providers screen for obesity by calculating patients' body mass index (BMI), which takes into account an individual's height and weight. Adults with a BMI of 25 or higher are categorized as overweight, and those with a BMI of 30 or higher are categorized as obese.

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

There are several methods used to treat obesity. AB 575 focuses on two treatment types: intensive behavioral therapy (IBT) and glucagon-like peptide-1 (GLP-1) anti-obesity medications (AOMs).

- **IBT** is a particular form of behavioral intervention that is structured and has several components. Patients are provided with tools to support and

[1] Similar cost and health impacts could be expected for the following year, though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

[2] Refer to CHBRP's full report for full citations and references.

maintain weight loss (e.g., food scales, pedometers).

- **GLP-1 AOMs,** also known as glucagon-like peptide-1 (GLP-1) receptor agonists are a class of drugs that activate the body's GLP-1 receptors. This activation triggers several downstream effects, including lowering glucose (sugar) levels within the bloodstream, reducing digestion rate, and increasing the sensation of fullness for longer. GLP-1 medications are indicated for type 2 diabetes and obesity, among other conditions.

Bill Summary

AB 575 would require coverage without prior authorization for intensive behavioral therapy and at least one GLP-1 receptor agonist, for the treatment or prevention of obesity. In addition, the bill would prohibit coverage criteria from being more restrictive than the U.S. Food and Drug Administration (FDA)-approved indications for those treatments.

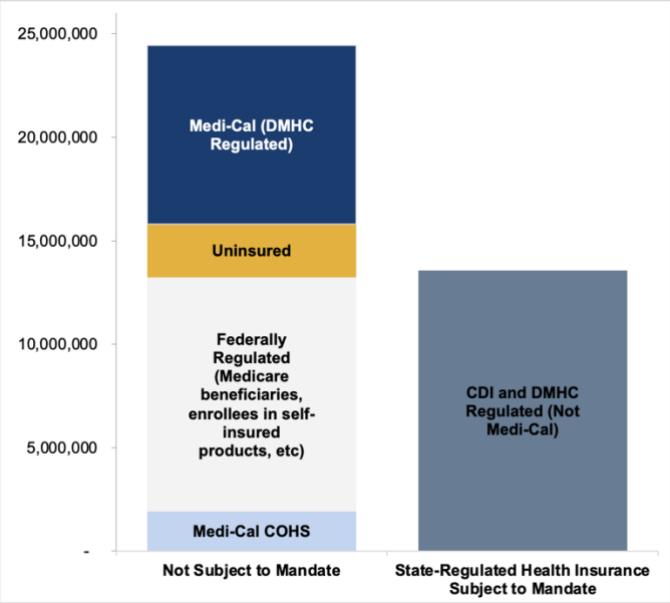
There are currently no FDA-approved GLP-1 drugs with an indication for obesity prevention. Three FDA-approved GLP-1's are indicated for chronic weight management and are included in this analysis: liraglutide (Saxenda), semaglutide (Wegovy), and tirzepatide (Zepbound.

Figure A notes how many Californians have health insurance that would be subject to AB 575.

Impacts

AB 575 requires the coverage of at least one GLP-1 drug for treatment of obesity. CHBRP assumes that health plans and health insurance policies that are noncompliant with the mandate will choose to cover the lowest priced options, which in this case will be the two newer, weekly GLP-1 drugs (Wegovy and Zepbound). Because Saxenda, which is also manufactured by the same company that makes Wegovy (Novo Nordisk) has been on the market longer, is a daily regimen, has more side effects than Zepbound, and maintains a higher price point, CHBRP assumes that health plans and insurance policies will not rely on Saxenda to comply with AB 575.

Figure A. Health Insurance in CA and AB 575.



Source: California Health Benefits Review Program, 2025.
Note: CHBRP generally assumes alignment of Medi-Cal Managed Care plan benefits, with limited exceptions.[3]
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

Benefit Coverage

CHBRP estimates that at baseline, 11.21 million Californians (82.6%) with state-regulated insurance subject to the mandate are enrolled in plans or policies that do not currently cover a GLP-1 indicated for chronic weight management, as required by AB 575. Approximately 30,000 enrollees (0.2%) do not have coverage for IBT at baseline.

Utilization

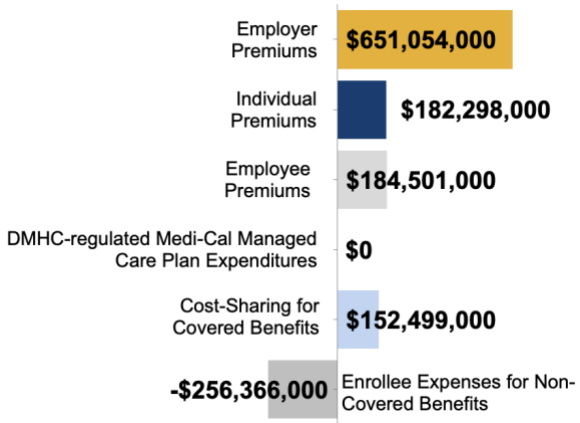
At baseline, CHBRP estimates there are 42,813 enrollees using GLP-1 AOMs without coverage, and zero enrollees receiving IBT without coverage. Postmandate, AB 575 would lead to an increase in utilization of GLP-1 AOMs by approximately 182,520 enrollees. An additional 35 enrollees would receive IBT postmandate.

[3] Although COHS plans are not subject to the Knox-Keene Act, DHCS generally updates Medi-Cal Managed Care plan contracts, All Plan Letters, and other appropriate authorities for alignment of managed care plan benefits, except in cases when the benefit is carved out of the Medi-Cal Managed Care plan contract or the law exempts specified Medi-Cal contracted providers.

Expenditures

CHBRP estimates AB 575 would increase total premiums by approximately $1 billion in the first year postmandate. In addition, CHBRP estimates that cost sharing would increase by approximately $153 million. Enactment of AB 575 would also reduce previously noncovered expenses by approximately $256 million.

Figure B. Expenditure Impacts of AB 575



Source: California Health Benefits Review Program, 2025.
Key: DMHC = Department of Managed Health Care.

Medi-Cal

There would be no impact on Medi-Cal expenditures as AB 575 only applies to group and individual health plans and policies; therefore, it does not apply to the health insurance of any Medi-Cal beneficiaries, including those in managed care plans regulated by DMHC.

CalPERS

For enrollees associated with California Public Employees' Retirement System (CalPERS) in DMHC-regulated plans, premiums would increase by approximately $62 million (0.79%).

Covered California – Individually Purchased

Premiums would increase by approximately $140 million (0.89%) for DMHC-regulated Covered California individual market plan enrollees, and mirror plans available to individuals outside of Covered California would see an increase in premiums of approximately $42.3 million (0.70%).

Number of Uninsured in California

In the first year postmandate, because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of AB 575. However, the premium increase in Year 2, as additional enrollees obtain GLP-1 drugs will be above 1% in all but one market segment, resulting in an estimated 12,600 newly uninsured people in 2027.

Medical Effectiveness

CHBRP's medical literature review focused on determining the effectiveness of IBT and FDA-approved GLP-1s indicated for chronic weight management on a reduction in the incidence of adult and adolescent obesity and associated health outcomes, compared with no intervention, or in conjunction with another treatment.

Measurable health outcomes relevant to AB 575 include primary outcomes such as change in body weight of 5%, 10%, 15%, or 20%, waist circumference, and mean BMI change. Additional health-related outcomes included diabetes risk, hemoglobin, systolic and diastolic blood pressure, and functional quality of life. CHBRP also reviewed literature on harms of FDA-approved GLP-1s. The results of the literature review are as follows:

- FDA-approved GLP-1s:
  - *Very strong evidence* that use of GLP-1s combined with usual care (including diet and activity and lifestyle recommendations) results in greater weight loss than usual care alone in adults.
  - *Very strong evidence* of improvement in health-related quality of life, physical functioning, and cardiac-related health outcomes in adults.
  - *Conflicting evidence* that GLP-1 AOMs improve weight loss in children and adolescents.
- IBT:
  - *Very strong evidence* that IBT is effective in reducing weight and the risk of developing type 2 diabetes in adults.
  - *Very strong evidence* that IBT is effective for weight management and is associated with greater improvements in diabetes and blood pressure control in adolescents and children.

Public Health

It is estimated that as a result of AB 575, utilization of obesity treatments would increase, with approximately 182,520 enrollees using FDA-approved GLP-1 AOMs and 35 enrollees receiving IBT for weight loss. As a result, these enrollees would experience a 5% to 21% reduction in body weight and related health improvements, which is supported by evidence that obesity treatments are medically effective.

Long-Term Impacts

CHBRP estimates that enrollees would continue to use GLP-1 AOMs to treat obesity due to AB 575. During Year 2 postmandate, additional increases in use will have implications for increases in premiums. CHBRP estimates there would be an approximate $1.5 billion impact on premiums in Year 2 postmandate, and an increase in cost sharing responsibilities for enrollees of $226 million. Enrollee expenses for noncovered benefits would decrease by approximately $385 million.

Public health impacts would be likely to accrue for individuals impacted by AB 575 outside of the first year postmandate, such as the overall presence of obesity and obesity-related chronic disease (e.g., hypertension, cardiovascular disease, type 2 diabetes, certain cancers, obstructive sleep apnea, liver disease, and neurodegenerative diseases); however, the magnitude of these benefits is unknown. Although GLP-1 use has been shown generate reduction in heart failure/heart attacks between 12 and 18 months of use, there is no current evidence on long-term benefits and reductions in avoidable care. However, GLP-1s appear to hold promise in treating other conditions, including substance use disorders, that may have long-term effects. Over time, additional GLP-1 AOMs may be introduced to market which may have different side effect profiles and additional benefits. Because AB 575 requires coverage of at least one GLP-1 AOM, the per unit cost of the medication may be a factor in adoption by health plans and insurance companies.

Essential Health Benefits and the Affordable Care Act

As the obesity treatments that are the focus of this analysis are regularly covered in the essential health benefit (EHB) benchmark plan, it seems unlikely that AB 575 would exceed the definition of EHBs in California.