



April 10, 2024

The Honorable Richard D. Roth
Chair, California Senate Committee on Health
State Capitol, Room 2191
10th and L Streets
Sacramento, CA 95814

The Honorable Mia Bonta
Chair, California Assembly Committee on Health
State Capitol, Room 6005
10th and L Streets
Sacramento, CA 95814

Re: CHBRP Analysis of SB 1008 Obesity Treatment Parity Act

Dear Senator Roth and Assembly Member Bonta:

The California Health Benefits Review Program (CHBRP) was asked by the Senate Health Committee staff on February 16, 2024, to provide a letter regarding Senate Bill (SB) 1008 (Bradford) Obesity Treatment Parity Act. CHBRP analyzed similar legislation in an analysis provided to the Legislature in December of 2023. This letter details the differences between the two bills and provides some updates to the information provided within CHBRP's prior analysis of the similar bill.

As amended on March 14, 2024, SB 1008, for health plans regulated by the California Department of Managed Care (DMHC) and health insurers regulated by the California Department of Insurance (CDI), would require comprehensive coverage for obesity treatments, including:

- Bariatric surgery
- Intensive behavioral therapy (IBT)
- At least one drug approved by the U.S. Food and Drug Administration (FDA) with an indication for chronic weight management in patients with obesity — and coverage criteria for the drug could not be more restrictive than the FDA-approved indications

The two groups of prescription drugs approved by the FDA with an indication for chronic weight management in patients with obesity are:

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- Glucagon-like peptide 1 (GLP-1) receptor agonists, such as Liraglutide (Saxenda), Semaglutide (Wegovy), and Tirzepatide (Zepbound)¹
- Non-GLP-1s, such as Bupropion/ Naltrexone (Contrave), Orlistat (Xenical), Phentermine/Topiramate (Qsymia), Setmelanotide (Imcivree), and Phentermine (Adipex-P, Lomaira)

SB 1008's requirements are similar to what was proposed in the 2023 bill CHBRP analyzed, SB 839 (Bradford). However, there are some differences between the two bills, as noted below:

- SB 1008 would require coverage of only one drug (either a GLP-1 or a non-GLP-1), whereas SB 839 would likely have required coverage of at least two drugs - one GLP-1 and one non-GLP-1
- SB 1008 is silent regarding cost sharing, whereas SB 839 would have required that cost-sharing not be different or separate from benefit coverage for any other illness, condition, or disorder

Below are findings from CHBRP's analysis of SB 839, as well as updated information, that may be useful for consideration of SB 1008.

Context

Nearly 3 million Californians with obesity and an additional 500,000 overweight Californians with comorbidities are enrolled in health insurance that would be subject to SB 1008, about the same as was estimated for SB 839. 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 a patient's body mass index (BMI), which considers 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.

Analytic Approach

Although the language of SB 1008 could be interpreted as creating benefit coverage requirements for additional obesity tests, treatments, and services, it directly refers to a particular set of treatments: prescription drugs, bariatric surgeries, and intensive behavioral therapy (IBT). SB 839 used the same broad language and made the same direct references. Therefore an analytic focus on the same drugs, surgeries, and IBT seems appropriate. For the SB 839 analysis, CHBRP assumed that the existing supply chain issues for GLP-1s would be fully resolved in 2024 due to changes and increasing capacity in manufacturing, as well as another prescription drug coming to market. The assumption seems appropriate as well for SB 1008's potential 2025 impacts.

Medical Effectiveness

As SB 1008 directly references the same treatments that were directly referenced by SB 839, the results of the medical effectiveness analysis seem relevant to consideration of both bills. There is **clear and convincing** evidence that the 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

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

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 $\geq 5\%$ 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.

There is **limited** evidence from one network meta-analysis that some GLP-1s are more effective than non-GLP-1s. Network meta-analysis is a method for comparing multiple treatments (in this case drugs) by combining direct and indirect evidence of effectiveness. The network meta-analysis found that people with obesity (without diabetes mellitus) who received semaglutide (a GLP-1) experienced statistically greater weight loss than people who received phentermine/topiramate (high dose) or bupropion/naltrexone (both non-GLP-1s) and had the greatest odds of achieving 5% and 10% weight loss at 1 year following initiation of treatment (Atlas et al., 2022). However, this network meta-analysis also reported that phentermine/topiramate (high dose) demonstrated statistically greater weight loss than liraglutide (a GLP-1) among people with obesity (without diabetes mellitus). Among participants with obesity and diabetes mellitus, people who received GLP-1s experienced greater percentage weight loss than people who received non-GP-1s, but the differences were not statistically significant. CHBRP did not identify any studies that compared the effect of tirazepatide on weight to the effects of non-GLP-1s on weight loss.

The Atlas et al., 2022 network meta-analysis also assessed the impact of GLP-1s and non-GLP-1s on systolic blood pressure (SBP). Among people with obesity (without diabetes mellitus), semaglutide and liraglutide were associated with greater improvement in SBP than bupropion/naltrexone but there was no statistically significant difference between their effect on SBP and the effect of phentermine/topiramate (high dose). Among participants with obesity and diabetes mellitus, semaglutide demonstrated statistically greater improvement in SBP than bupropion/naltrexone, and liraglutide demonstrated statistically greater improvement in SBP than phentermine/topiramate (high dose) and bupropion/naltrexone (Atlas et al., 2022). CHBRP did not identify any studies that compared the effect of tirazepatide on SBP to the effects of non-GLP-1s on SBP.

Benefit Coverage, Total Expenditure, and Public Health Impacts

As SB 1008 is silent regarding cost-sharing and would require coverage for only one of the drugs, the fiscal impacts would be less than what was projected for SB 839 **by orders of magnitude**. Due to its more limited requirements,

- SB 1008 would be likely to impact benefit coverage for 64% or less of enrollees, rather than the nearly 90% of commercial/CalPERS enrollees for whom changes in benefit coverage were expected for SB 839.
- CHBRP assumed that compliance would principally be through coverage of Non-GLP-1 rather than coverage of GLP-1s. Therefore, while SB 839 assumed an increase in enrollees using GLP-1s of 951%, CHBRP would estimate a 0% increase based on SB 1008. GLP-1 medications typically have higher costs than non-GLP-1 medications.
- As a result of less change in benefit coverage, utilization projections would be less for SB 1008. The number of new users of the treatments would be approximately 29,000 or less, rather than the 124,000 that was projected for SB 839. The impact of SB 1008 on utilization would be 23% of what was projected for SB 839.

- As the medical effectiveness literature finds that people on non-GLP-1s have a lower reduction in weight loss than compared to people on GLP-1s, lower weight loss results would be expected for SB 1001 than were expected for SB 839.
- As a result of less change in utilization and the expectation that the increase would be for use of the lower-cost non-GLP-1s, expenditure projections would be less for SB 1008. **Total expenditures would be approximately \$136 million or less, rather than the \$1.27 billion that was projected for SB 839.** The impact of SB 1008 on total expenditures would be 11% of what was projected for SB 839.

Uninsured

As SB 1008 is silent regarding cost-sharing and would only require coverage for one of the drugs, the impacts on total expenditures, including premiums, would be less by orders of magnitude than what was projected for SB 839. Because the change in average premiums would not exceed 1%, SB 1008 would not be expected to increase the number of uninsured persons.

With consideration of the points discussed in this letter, CHBRP believes its analysis of SB 839 is relevant to the Legislature's consideration of SB 1008. CHBRP's full analysis of SB 839 can be accessed at <https://www.chbrp.org/analysis/completed-analyses>.

CHBRP's faculty and staff appreciate the opportunity to provide these analyses and we will be happy to respond to any of your questions.

Sincerely,

A handwritten signature in blue ink, appearing to read "Garen L. Corbett".

Garen L. Corbett, MS
Director
California Health Benefits Review Program