A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Bill Analysis Report: California Senate Bill 1089 Preventive Treatment Health Care Act

APRIL 14, 2026

California Health Benefits Review Program (CHBRP)
University of California, Berkeley

chbrp.org

KEY FINDINGS

Analysis of California Senate Bill 1089 Preventive Treatment Health Care Act

Summary to the 2025–2026 California State Legislature, April 14, 2026

CHBRP

The California Health Benefits Review Program (CHBRP) assumes the version of California Senate Bill (SB) 1089 analyzed would require California Public Employees' Retirement System (CalPERS) to include coverage of U.S. Food and Drug Administration (FDA)-approved GLP-1 medications for weight management (referred to as GLP-1s) in **one health plan offering**. GLP-1s would need to be offered at the most favored nation (MFN) pricing amount. Other potential interpretations of SB 1089 include:

- **Alternate 1:** Would require nearly all CalPERS plans to include coverage of GLP-1s;
- **Alternate 2:** Would require CalPERS to offer a "rider" to enrollees to purchase coverage of GLP-1s; or
- **Alternate 3:** Would require insurers to offer a "rider" to participating agencies or employers.

In 2027, approximately 1.2 million Californians would obtain health insurance through CalPERS.

Key Considerations and Assumptions

- Other interpretations of SB 1089 would result in estimates that are higher by orders of magnitude (alternate 1), or uncertain depending on the uptake rate of the rider (alternates 2 and 3).
- CHBRP assumes CalPERS would be able to obtain MFN pricing, although there is no current mechanism by which this is possible. Should unit cost reflect baseline unit cost versus the substantially lower MFN pricing, estimated premium impacts would be higher.
- CHBRP assumes CalPERS would add coverage to the PERS Platinum Preferred Provider Organization (PPO) plan only.

Benefit Coverage

Enrollment in a plan that includes coverage for GLP-1s would increase from 15.3% at baseline to 24.0% postmandate. Approximately 10,000 CalPERS enrollees would switch into the PERS Platinum PPO plan to gain access to coverage for GLP-1s.

Medical Effectiveness

There is *very strong evidence* for adults and *strong evidence* for children and adolescents that GLP-1s result in weight loss.

Cost Impacts

CHBRP estimates SB 1089 would increase the number of CalPERS enrollees using GLP-1s with plan coverage, from 4,912 enrollees at baseline to 17,335 enrollees postmandate. This includes the 9,237 enrollees who self-pay for GLP-1s at baseline and, postmandate, would use benefit coverage. The net increase in total GLP-1 users would be 3,186.

Annual premiums paid by employers (CalPERS) and enrollees for newly covered benefits would increase by $330 per member in the PERS Platinum PPO plan, a total of $35,273,000 (0.26%). CalPERS plans that do not add GLP-1 coverage would not experience a change in premiums. Premium increases are inclusive of cost offsets, which CHBRP projects would be $454 annually per GLP-1 user, due to improved health status and reductions in health care utilization.

Total annual cost sharing for covered benefits would increase by $2,982,000. Total annual expenses for noncovered benefits (i.e., GLP-1s purchased through self-pay) would decrease by $30,371,000. Enrollees self-paying for GLP-1s at baseline would reduce their annual expenses by approximately $3,048. Those who initiate GLP-1 therapy would incur $240/year in copays.

Public Health Impacts

Enrollees newly using GLP-1s would experience an average of 4.8% to 17.8% reduction in body weight and improvements in related health improvements over time. Because SB 1089 would not impact coverage for commercial or Medi-Cal enrollees, SB 1089 could exacerbate existing disparities in obesity and treatment.

Long-Term Impacts

Over time, utilization of GLP-1s among CalPERS enrollees would be expected to increase and therefore premium impacts would increase in the long term. Cost offsets from reduced obesity-related medical expenditures (cardiovascular events, diabetes management, kidney disease, joint replacement) are expected to grow over time as enrollees maintain therapy. Competition from new entrants, biosimilars, and evolving pricing of GLP-1s may also affect long-term unit costs.

Table of Contents

Lists of Tables and Figures

Acronyms and Terminology

Acronyms

AB – Assembly Bill

ACA – Affordable Care Act

AOM – anti-obesity medications

CalPERS – California Public Employees' Retirement System

CDC – Centers for Disease Control and Prevention

CDI – California Department of Insurance

CHBRP – California Health Benefits Review Program

COHS – County Organized Health System

DHCS – Department of Health Care Services

DMHC – Department of Managed Health Care

EHBs – essential health benefits

HMO – health maintenance organization

FDA – U.S. Food and Drug Administration

GLP – glucagon-like peptide

MASH – metabolic dysfunction-associated steatohepatitis

PPO – preferred provider organization

SB – Senate Bill

Terminology

CHBRP uses the following terminology for this analysis:

GLP-1 medications: refers to glucagon-like peptide-1 receptor agonist backbone medications, which include GLP-1 receptor agonists (GLP-1 RA) and dual GLP-1/GIP receptor agonists (GLP-1/GIP RA).[1]

Obesity: a chronic health condition characterized by an increase in the size and amount of fat cells in the body. Adults with a BMI of 25 to <30 are categorized as overweight and those with a BMI of 30 or higher are categorized as obese.

[1] Gastric inhibitory polypeptide (GIP) is a hormone that directly affects the pancreas, bone, fat, gastrointestinal tract, and brain (Seino et. al., 2010). GIPs contribute to the regulation of hunger sensation, among other metabolic functions (Ciardullo et. al., 2024).

Overview: SB 1089, Obesity, and GLP-1s

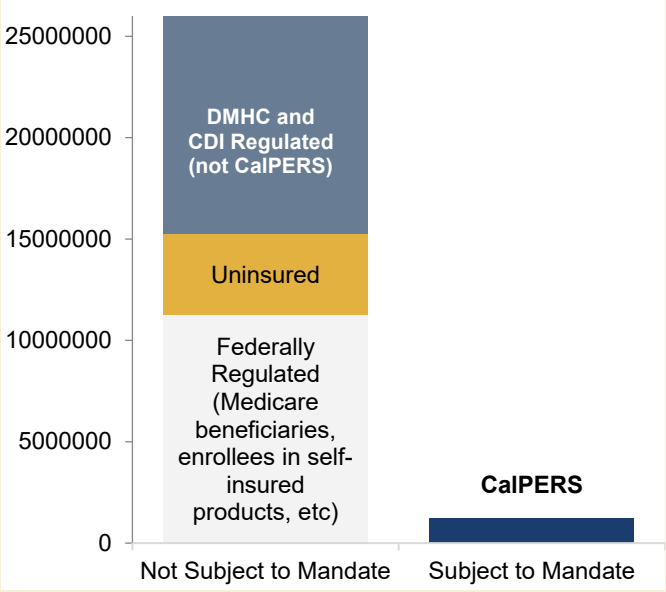
On February 13, 2026, the California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP)[2] conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 1089, Preventive Treatment Health Care Act. SB 1089 was amended on March 24, 2026 and CHBRP was provided with draft language in order to complete this analysis.

Bill Language of SB 1089

In consultation with the Senate Committee on Health, CHBRP provides analysis based on the following interpretation of SB 1089:

- California Public Employees' Retirement System (CalPERS) would include coverage of pens, vial injections, pills, and patches of U.S. Food and Drug Administration (FDA)-approved GLP-1 medications for weight management in **one health plan offering** beginning in January 2027.
- Covered medications would be available at the cost previously provided to Medi-Cal beneficiaries in the year 2025 or the most favored nation pricing, as set forth in federal Executive Order No. 14297 on May 12, 2025, or better pricing.
- *All* currently available FDA-approved GLP-1 medications for chronic weight management must be covered, as well as future chronic weight disease products.
- Coverage of medications cannot be more restrictive than FDA label indications.

Figure 1. Health Insurance in CA and SB 1089



Source: California Health Benefits Review Program, 2026.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[1]
Key: CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

SB 1089 would also make requirements for the California Department of Health and Human Services to enter into partnerships resulting in the acquisition of brand name prescription medications and the acquisition or production of GLP-1 medications. Since this provision is not a benefit mandate for CalPERS or other state regulated health insurance, it is outside the scope of this analysis.

See the full text of SB 1089 in the Technical Brief on SB 1089.

If enacted, SB 1089 would apply to the health insurance of approximately 1,224,000 enrollees (3.2% of all Californians) (see Figure 1).

- **Includes**: Enrollees in CalPERS health insurance regulated by the Department of Managed Health Care (DMHC) and self-insured products that are not regulated by DMHC.

[2] See CHBRP's authorizing statute.

- **Excludes**: Enrollees in commercial (non-CalPERS) health insurance regulated by the DMHC and the California Department of Insurance (CDI), and Medi-Cal beneficiaries enrolled in DMHC-regulated plans and county organized health plans (COHS).

Analytic Approach and Assumptions

CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of SB 1089, unless otherwise specifically mentioned.

CHBRP previously analyzed related bill language, SB 839 in 2023, SB 1008 in 2024, AB 575 in 2025, and SB 535 in 2025. Where applicable, this analysis builds off those previous analyses.

Language Interpretation

CHBRP made several assumptions based on the language of SB 1089.

SB 1089, amending the Government Code, states "Commencing January 1, 2027, a health benefit plan or contract that contracts with the board pursuant to this chapter shall offer optional coverage for chronic weight disease management, including nutritional information and pens, vial injections, pills, and patches of glucagon-like peptide-1 (GLP-1) semaglutide, GLP-1 receptor agonist (GLP-1RA), glucose-dependent insulinotropic polypeptide plus GLP-1 (GIP+GLP-1) tirzepatide, and future chronic weight disease products, as part of one of its health plan options." There are four potential interpretations of this language:

1. SB 1089 would require a health insurer that contracts with CalPERS to include coverage of GLP-1 medications for weight management as part of one of its health plan offerings. However, because most health insurers offer one plan option for CalPERS enrollees (see current CalPERS plan offerings), nearly all plan options would be required to include coverage of GLP-1s for weight management. CHBRP provided analysis of a similar requirement for the CalPERS enrollees in DMHC-regulated plans in the analysis of AB 575 in 2025. Estimated utilization and premium impacts of SB 1089 under this interpretation would be orders of magnitude higher than what is presented in this analysis.

2. SB 1089 would require coverage of GLP-1 medications for weight management in one CalPERS health plan offering. CHBRP assumes this health plan would need to be available to all enrollees. In consultation with the Senate Committee on Health, CHBRP provides analysis of this potential interpretation.

3. SB 1089 would require insurers to offer a "rider"[3] to CalPERS enrollees so they could choose to purchase coverage for GLP-1 medications for weight management. This coverage would be in addition to their health plan. Enrollee decisions of whether to purchase a rider would largely depend on the cost of this rider. Estimated utilization and premium impacts of SB 1089 under this interpretation would be higher or lower than presented in this analysis depending on the uptake of the rider; only enrollees purchasing the rider would experience impacts due to the cost of purchasing the rider.

4. SB 1089 would require insurers to offer a "rider" to participating agencies or employers so they could choose whether to purchase coverage for GLP-1 medications for weight management for all participants. This coverage would be in addition to current CalPERS offerings. Estimated utilization and premium impacts of SB 1089 under this interpretation could be higher or lower than presented in this analysis depending on uptake of the rider; participating agencies purchasing the rider would experience the direct costs due to the cost of purchasing the

[3] A rider is an addition to an existing insurance policy that allows an enrollee or purchaser to add specific insurance products to coverage.

rider. Enrollees gaining access under the rider, which would be all enrollees under a participating agency or employer, would also experience the impacts due to additional coverage.

Cost of GLP-1 Medications

It is unclear how SB 1089 would enable CalPERS plans to obtain GLP-1 medications at most favored nation (MFN) pricing or Medicaid 2025 pricing, since federal policy (as of April 3, 2026) does not require pharmaceutical manufacturers to offer this pricing to commercial plans. CHBRP has assumed that plans would be able to obtain MFN pricing in order to illustrate the impacts of SB 1089 as amended on March 24, 2026. MFN pricing was provided to Medicaid programs (see more in the *Policy Context* section), meaning California's Medi-Cal unit cost in 2025 for GLP-1 medications should be similar to MFN pricing amounts. However, MFN pricing may decrease over time as the unit cost of GLP-1 medications continues to decrease. Should CalPERS be unable to obtain MFN pricing for GLP-1 medications, estimated premium impacts would be orders of magnitude higher than presented in this analysis.

Another interpretation of SB 1089 as amended would require CalPERS plans to offer MFN pricing to enrollees who use GLP-1 medications. However, this price is substantially more than assumed enrollee cost sharing (see the *Cost-Related Analytical Approach and Assumptions* section below) and is closer to the amount enrollees self-pay for GLP-1s. Should the enrollee cost sharing for GLP-1 medications equate to MFN pricing, estimated impacts on utilization would be lower.

Requirements Related to GLP-1 Medications

The bill language requires coverage of "glucagon-like peptide-1 (GLP-1) semaglutide, GLP-1 receptor agonist (GLP-1RA), glucose-dependent insulinotropic polypeptide plus GLP-1 (GIP+GLP-1) tirzepatide." As mentioned in the *What is Obesity?* section, GLP-1 is a naturally occurring hormone and GLP-1 receptor agonists are synthetic, long-acting medications that mimic this hormone. GLP-1 receptor agonist medications are commonly referred to as GLP-1 medications. Due to lack of clarity, CHBRP assumes SB 1089 would require coverage of *all* currently available FDA-approved GLP-1 medications for weight management.

SB 1089 also states that coverage would be required for pens, vial injections, pills, and patches of GLP-1 medications. As of March 2026, only pens, vial injections, and pills are available. However, although vial injections are available, they are only available through direct purchase programs. CHBRP has not accounted for changes in coverage of vial injections because they are not commonly used by insured patients.

What Is Obesity?

Obesity is a chronic health condition characterized by an increase in the size and amount of fat cells in the body (NIH, 2022). 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 to <30 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 (NIH, 2023). Causes of obesity are multi-faceted and can include lifestyle habits, environment, stress, health conditions and certain medications, socioeconomic factors, and individual characteristics such as genetics and metabolism (CDC, 2024).

Overall, it is estimated that 15.2% of adolescents aged 12 to 17 years and 27.8% of adults aged 18 to 64 years with private health insurance in California have BMIs that categorize them as having obesity. Approximately 7% of the non-elderly adult population with private health insurance have BMIs ≥27 and <30 and also have comorbidities, such as heart disease and obstructive sleep apnea, which are also indications for treatment with GLP-1 medications (McGough et al., 2024). Within the CalPERS commercial (Basic) population, approximately 24% of enrollees have obesity and 22% of

enrollees have BMIs between 27 and <30.[4] Additionally, among all CalPERS enrollees (including Medicare enrollees) 10.5% have hypertension, 7% have diabetes, and 5.5% have high cholesterol (Albers and Logan, 2023).

Treatment of obesity is multi-faceted and includes behavioral and lifestyle changes, as well as anti-obesity medications (AOMs), and surgery if indicated. AOMs can be broken into two types of drugs: GLP-1 medications,[5] and non–GLP-1 medications. GLP-1 medications 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 (Zheng et al., 2024). GLP-1 medications have primary indications (e.g., type 2 diabetes, MASH[6]) and indications due to a combination of obesity and comorbidities such as obstructive sleep apnea and heart disease, among other conditions (Collins and Costello, 2024). Non–GLP-1 AOMs treat obesity through a variety of different mechanisms, including blocking fat absorption and deposition, suppressing appetite, and increasing metabolism (Aaseth et al., 2021; Verrotti et al., 2011). CHBRP assumes SB 1089 would only require coverage of GLP-1 medications for the treatment of obesity within one CalPERS plan offering.

As of April 2026, there are four GLP-1 medications approved for chronic weight management: liraglutide (brand name Saxenda), semaglutide (brand name Wegovy), tirzepatide (brand name Zepbound), and orforglipron (brand name Foundayo). Liraglutide, semaglutide, and tirzepatide are all available as subcutaneous injections, and the recommended frequency of administration varies from daily to weekly. In 2025, the FDA approved a daily oral formulation of semaglutide and in April 2026, the FDA approved a daily oral formulation of orforglipron; additional oral formulations of other GLP-1s, as well as new GLP-1 medications, are likely to be available in the near future. See additional information about these medications in the *Background* section in the Technical Brief on SB 1089.

Disparities in Obesity and Barriers to Accessing GLP-1 Medications for Weight Management

Obesity rates are lowest among those with the highest incomes and educational attainment (CHIS, 2024). Rates of obesity vary in California by race and ethnicity, with Asian adults reporting the lowest rates of obesity (11.1%), followed by White adults (24.8%), Black adults (37.1%), Latino adults (39.4%), and American Indian/Alaska Native adults (45.6%). In addition, adults residing in urban locations reported lower rates of obesity compared to adults residing in rural locations (27.6% versus 30.4%, respectively). Finally, rates of obesity did not vary significantly by gender or sexual orientation.

While not everyone with obesity is diagnosed and attempts to seek treatment, among those who do, there are still many factors that serve as barriers to accessing treatment such as:

- **Stigma:** People with obesity often face stigma and discrimination, which make them less likely to engage with the health care system. Physicians may negatively stereotype patients with higher BMIs resulting in a lower likelihood of recommending treatments (Washington et al., 2023).
- **Racism and discrimination:** In addition to disparities in obesity rates by race and ethnicity, there are also disparities in use of anti-obesity medications (Narain and Scannell, 2026). Specifically, it was found that Black and Hispanic adults with obesity were more likely to have financial barriers to accessing GLP-1 medications and were less likely to receive prescriptions compared to White adults (Lu et al., 2022). Furthermore, people of color who have obesity are less likely to be assessed for and diagnosed with obesity and offered treatments for obesity (Gasoyan et al., 2024; Washington et al., 2023).
- **Location:** People living in rural areas are more likely to face challenges in finding a health care provider that specializes in obesity medicine and are likely to live farther away from major surgery centers. Approximately 8.3% of CalPERS enrollees live in rural areas, 64% live in suburban areas, and 27.7% live in urban areas. More

[4] Personal communication with CalPERS, April 6, 2026.
[5] Note that GLP-1 is a naturally occurring hormone and GLP-1 receptor agonists are synthetic, long-acting medications that mimic this hormone. GLP-1 receptor agonist medications are commonly referred to as GLP-1 medications.
[6] MASH, or metabolic dysfunction-associated steatohepatitis, is a severe, progressive fatty liver disease directly linked to obesity, type 2 diabetes, and metabolic syndrome. It causes liver inflammation, cell damage, and fibrosis (scarring), which can lead to cirrhosis or liver cancer. Losing 10% or more of body weight is the primary treatment to reverse damage (Cleveland Clinic, 2025).

enrollees in CalPERS PPO products live in rural areas compared with enrollees in CalPERS health maintenance organization (HMO) products.

- **Comorbidity factors:** A recent study suggests that most patients seek treatment for obesity-related comorbidities such as type 2 diabetes and cardiovascular disease rather than for obesity itself, leading providers to prioritize these conditions instead (Aboueid et al., 2018; Hersch et al., 2021).
- **Expense:** The high cost of some obesity treatments can make them inaccessible for patients with lower incomes (Levi et al., 2023).

The extent to which these disparities and barriers exist for CalPERS enrollees is unknown.

For an in-depth look at existing disparities and barriers to access to care for obesity and weight management, please see the *Background* section in CHBRP's Technical Brief on SB 1089.

How Effective Are GLP-1 Medications for Weight Management?

CHBRP previously conducted a literature review on AOMs for the analyses of AB 575 and SB 535 in 2025. The following summarizes findings from those analyses, with updates where necessary. Please see the analyses of AB 575 and SB 535 for complete information.[7] CHBRP limited its review of literature on AOMs to medications that the FDA has approved for weight management because AB 575 and SB 535 would have only required health plans and policies to cover medications that are specifically FDA-approved for chronic weight management, as would SB 1089. The summary presented below is limited to findings for GLP-1 medications (liraglutide, semaglutide, tirzepatide).

Primary outcomes assessed included: change in body weight; percent weight loss; weight reduction of 5%,[8] 10%, 15%, or 20%; change in body mass index (BMI); and change in waist circumference. Health outcomes associated with obesity included: impact on quality of life and physical functioning; diabetes risk; changes in hemoglobin (A1c); and changes in systolic blood pressure and diastolic blood pressure. CHBRP also reviewed literature on harms of FDA-approved GLP-1 medications.

Effectiveness of GLP-1 Medications for Weight Management for Adults

There is *very strong evidence*[9] that FDA-approved GLP-1 medications (liraglutide, semaglutide, tirzepatide) for chronic weight management are effective when used as adjuncts to usual care (which includes standard diet and activity and lifestyle recommendations) for adults (Figure 2). Use of these medications increases the amount of weight loss and percentage of body weight loss, and reduces BMI, compared to placebo or usual care alone. Mean percent weight loss compared to placebo among adults with overweight or obesity and without diabetes was between 4.8% and 17.8%, and at least one-third of patients lost more than 20% of their body weight.

Figure 2. Level of Evidence of Effectiveness for GLP-1s for Adults

[7] All completed analyses are available on CHBRP's website.
[8] The U.S. Food and Drug Administration considers a weight loss of 5% as clinically important (LeBlanc et al., 2018).
[9] *Very strong evidence* indicates that there are multiple studies of a treatment, and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.

There is *very strong evidence* GLP-1 medications result in improvement in health related quality of life, physical functioning, cardiometabolic health, blood pressure, and HbA1c compared with usual care (Figure 3).

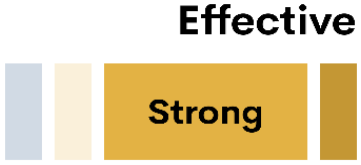
Comparisons across the medications as well as direct evidence suggest that among GLP-1 medications, on average, treatment with tirzepatide provides the greatest amount of weight loss compared with placebo and also results in greater weight loss when directly compared with semaglutide. Treatment with liraglutide results in the least amount of weight loss.

Figure 3. Level of Evidence of Effectiveness for GLP-1s on Other Health Outcomes for Adults

Effectiveness of GLP-1s for Weight Management for Children and Adolescents

There is *strong evidence*[10] that GLP-1s improve weight loss in children and adolescents (Figure 4).[11,12] For liraglutide, one study in adolescents and one study in children found statistically significant reductions in BMI, compared to placebo (Fox et al., 2025; Kelly et al., 2020). Two studies reported that adolescents who received semaglutide had a greater improvement in BMI than adolescents who received a placebo (Kelly et al., 2023; Weghuber et al., 2022).

Figure 4. Level of Evidence of Effectiveness of GLP-1s for Children and Adolescents



In children and adolescents, there is *conflicting evidence*[13] that GLP-1s have an impact on other health outcomes (Figure 5). There is evidence that semaglutide improves health related quality of life, physical functioning, and cholesterol, and HbA1c levels. Conversely, there is evidence that liraglutide does not improve weight-related quality of life measures and HbA1c levels; and liraglutide and semaglutide did not improve blood pressure.

Figure 5. Level of Evidence of Effectiveness of GLP-1s on Health Outcomes for Children and Adolescents

Harms of GLP-1s

For adults, gastrointestinal adverse events such as nausea, vomiting, indigestion, loss of appetite, headaches, abdominal pain, constipation, and diarrhea were more commonly experienced by GLP-1 groups than control groups. Liraglutide was also associated with higher rates of gallbladder-related and pancreatic adverse events.

Policy Context

Existing California Law and Regulations

California Medi-Cal had previously opted to cover GLP-1 medications with an FDA indication for weight management,[14] with quantity limits and labeler restrictions.[15] However, this coverage was eliminated as of December 31, 2025. Coverage for GLP-1 medications for Medi-Cal beneficiaries with other FDA-approved indications for GLP-1 medications (e.g., diabetes) remains.[16]

[10] *Strong evidence* indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.
[11] As of March 2026, two GLP-1s are approved for use in adolescents ages 12 years or older.
[12] Based on recently identified studies, CHBRP changed the level of evidence from *conflicting evidence*, as shown in previous CHBRP analyses.
[13] *Conflicting evidence* indicates that a similar number of studies of equal quality suggest the treatment is effective as suggest the treatment is not effective.
[14] See Medi-Cal Rx Contract Drugs List as of March 1, 2026.
[15] Labeler restriction means the brand name (specific labeler) version of the drug must be used on the claim, rather than the generic alternative, for the claim to be paid.
[16] See Medi-Cal Rx Contract Drugs List as of March 1, 2026.

In addition, Californians with health insurance through Federal employment have coverage for obesity treatment that include drugs with an FDA indication for weight loss (OPM, 2023).

Essential Health Benefits and the Affordable Care Act

Because CalPERS plans are not subject to the essential health benefits (EHBs), there is no potential for SB 1089 to exceed EHBs.

Similar Legislation and Coverage Offerings in Other States

One state, North Dakota, has added requirements for coverage for GLP-1 medications for enrollees in some commercial plans through amending the state's EHB-benchmark plan (North Dakota Insurance Department, 2026). As of March 2025, 16 states cover GLP-1 medications for weight management under their state employee health plan (Alaska, Connecticut, Delaware, Idaho, Illinois, Indiana, Georgia, Kansas, Kentucky, Massachusetts[17], Michigan, New Jersey, New Mexico, New York, Tennessee, Wyoming) (Ingmire, 2025).

At least four states (Colorado, Massachusetts, North Carolina, and West Virginia) have terminated coverage of GLP-1 medications for weight management within state employee health plans due to the high costs associated with use of GLP-1 medications.

Most Favored Nation Pricing

MFN pricing is a policy that sets prices for prescription medications to levels in line with prices paid by other developed countries. President Trump released an Executive Order on May 12, 2025, that directs the Secretary of Health and Human Services to facilitate direct-to-consumer purchasing programs so manufacturers can sell medications directly to consumers and to coordinate with other federal agencies to make these prices available for "American patients."[18]

As part of these efforts, the Trump Administration has announced several agreements with pharmaceutical manufacturers implementing MFN pricing.[19] A new CMS payment model is designed to make MFN pricing available to state Medicaid programs through manufacturer rebates. Additionally, many medications are available directly to consumers at MFN pricing or at prices negotiated with pharmaceutical manufacturers through TrumpRx (a website that directs consumers to sources to purchase medications directly). However, the pricing available through TrumpRx may not be less expensive than an enrollee's cost sharing if they access medications through their health insurance.

Back to Table of Contents

[17] The Group Insurance Commission of Massachusetts voted in February 2026 to terminate coverage of GLP-1 medications for weight loss, effective July 2026.
[18] Executive Order, May 12, 2025.
[19] Fact Sheet: President Donald J. Trump Announces Largest Developments to Date in Bringing Most-Favored-Nation Pricing to American Patients. December 19, 2025.

SB 1089 Impacts: Benefit Coverage and Cost

Cost-Related Analytical Approach and Assumptions

This analysis reports the estimated incremental impact of full-scale implementation of SB 1089 on benefit coverage, utilization, and cost for a single year.[20] Full-scale implementation typically requires a "ramp up" period which may include educating enrollees, providers and insurance carriers on the new benefits or coverage, updating procedures and policies, and increasing provider capacity for marginal utilization resulting from SB 1089. Furthermore, some policies may have staggered implementation or longer-term changes in utilization. The incremental impact estimates below assume there is no "ramp up" period and represent ongoing annual costs at full-scale implementation of SB 1089, including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.[21] For a discussion of long-term impacts of SB 1089, see the *Long-Term Impacts* section.

As discussed in the *Overview* section, there are four potential interpretations of SB 1089: nearly all CalPERS plans would be required to include coverage for GLP-1 medications for weight management; one plan would be required to include coverage; a rider would be available for enrollees to purchase; a rider would be available for participating agencies or employers to purchase. CHBRP has modeled the second interpretation of SB 1089. Estimated impacts of the first interpretation would be orders of magnitude higher than presented below, whereas estimated impacts of the third and fourth interpretations would be substantially lower.

For further details on the underlying data sources, methods, and assumptions used in this analysis, please see the technical brief for this report, entitled "Technical Brief: SB 1089," available at www.chbrp.org.

Approach and Assumptions on Baseline Coverage and Utilization

- There is baseline coverage for GLP-1 medications for weight management within the Blue Shield HMO plan. However, because Blue Shield HMO is geographically restricted, CHBRP assumes this plan would not alone satisfy SB 1089's requirement that CalPERS offer one plan option with GLP-1 coverage; nor is Blue Shield required to continue this coverage in 2027. CHBRP therefore assumed compliance would involve adding GLP-1 medication coverage to the PERS Platinum PPO, which is available statewide.
- CHBRP assumes no impact for Medicare beneficiaries in this analysis, as CalPERS may be able to offer GLP-1 medication coverage in 2027 under the CMS BALANCE Model. See more information about the BALANCE Model in the *Additional Policy Context* section of the Technical Brief on SB 1089. Medicare beneficiaries comprise approximately 22% of total CalPERS enrollees (CalPERS, 2024).
- More patients are obtaining GLP-1 medications under recently approved FDA indications for non-obesity conditions. However, such coverage is generally for conditions that are much less prevalent than obesity; as stated in the *Overview*, only about 7% of privately insured people have BMIs between 27 and <30 and have a weight-related comorbidity. Furthermore, the formularies CHBRP reviewed either omitted GLP-1 medications entirely or excluded coverage for weight management. Therefore, CHBRP assumed that enrollees with BMIs between 27 and <30 and with a weight-related comorbidity who did not have coverage of GLP-1 medications at baseline were also unable to obtain coverage for the medications through weight-related comorbidities such as sleep apnea and MASH. This approach likely

[20] For some analyses, impacts as a result of changes to health insurance benefits may occur over multiple years (e.g., impacts in pregnancy and childbirth rates resulting from changes to utilization of fertility services, staggered implementation, or long-term changes in utilization). CHBRP's estimates represent the full impact of the mandate in 1 year even if changes in coverage, utilization offsets, and costs may be realized in more than 1 year.
[21] CHBRP's Cost and Coverage Model also assumes enrollees maintain one form of health insurance for the entire calendar year. Examples of state and industry policies and behavior include medications that may be developed or approved in the future, health insurance market changes beyond what is known at the time of publication of this analysis, and statutory changes resulting from other health benefit mandates.

underestimates baseline utilization of GLP-1 medications with health insurance coverage, although the impact is minimal.

- CHBRP estimates that 22.8% of CalPERS Basic non-Medicare enrollees (approximately 280,000 enrollees) have obesity and 5.5% of CalPERS Basic non-Medicare enrollees (approximately 67,000 enrollees) have BMIs between 27 and <30 with a weight-related comorbidity.

Approach and Assumptions on Postmandate Coverage and Utilization

- CHBRP estimates that 11.5% of enrollees with obesity or who are overweight with a comorbidity and full coverage by their health plan would use these medications in 2027 based on internal Milliman research (see more information the Technical Brief on SB 1089).
- CHBRP assumes that enrollees with obesity or who are overweight with a comorbidity who are enrolled in other plans at baseline that do not cover GLP-1 medications and who plan to use GLP-1 medications would switch to the PERS Platinum PPO to obtain coverage. CHBRP assumed that 40% of these enrollees who would use GLP-1 medications if fully covered would switch plan options to obtain GLP-1 coverage (this results in 1% of all enrollees in all other plans switching to PERS Platinum, or 5% of enrollees with obesity or who are overweight with a comorbidity).
- Estimated utilization increases are consistent with observed trends in claims data for these medications, inclusive of future growth in utilization, and an assumption that supply chain issues are and remain fully resolved at baseline.

Approach and Assumptions on Unit Cost (GLP-1 Medications per 30-Day Supply)

- CHBRP assumed a unit cost of $550 for GLP-1 medications covered under the Blue Shield HMO and that this unit cost would not change postmandate. CHBRP estimated this unit cost by averaging current direct-to-consumer pricing ($349) and estimated net prices ($717 to $761 per month) (Hernandez and Sulliman, 2024). The estimated unit cost is consistent with the trend of decreasing costs for GLP-1 medications. If medications covered by the Blue Shield HMO would be subject to the MFN pricing, then costs for covering these medications would result in a decrease in premiums for enrollees in this plan.
- For PERS Platinum PPO unit cost, CHBRP assumed MFN pricing ($245/month) postmandate (CMS, 2026; Montero et al., 2025). As stated in the Overview section, should CalPERS be unable to obtain this unit cost in accordance with MFN pricing, unit cost would likely be reflective of the unit cost for the Blue Shield HMO of $550 for a 30-day supply. As a result, premium impacts presented below would be substantially higher due to the near doubling of unit cost.
- CHBRP assumed a self-pay unit cost of $274/month, reflecting an assumption that 50% of enrollees obtain medications through compounding pharmacies ($199 unit cost) and 50% obtain medications through direct-to-consumer providers ($349 unit cost).

Offsets

CHBRP uses the term “cost offset” to describe the decrease in total health insurance expenditures due to reduced utilization of other, often more expensive, services. For this analysis, CHBRP assumed medical costs would be reduced by $454 per GLP-1 medication user per year [approximately $37.80 per member per month (PMPM) for each GLP-1 user] at steady state, based on the ICER Interactive Modeler (see more information in the Technical Brief on SB 1089) (ICER, 2025). These offsets reflect reductions in cardiovascular events, end-stage kidney disease, cirrhosis, obstructive sleep apnea, and joint replacements. CHBRP applied a 20% annual discontinuance rate of GLP-1 medications, which reflects an average of discontinuation over several years. A higher share of GLP-1 medication users discontinue use within the first year, but rates are lower in subsequent years. Long-term savings will take several years to accrue (see more information in the *Long Term and Utilization and Cost Impacts* section and the Technical Brief on SB 1089).

Benefit Coverage

CHBRP estimates that at baseline, 187,000 CalPERS enrollees (15.3%) with state-regulated insurance subject to the mandate are enrolled in a plan that covers GLP-1 medications for weight management – specifically, Blue Shield HMO, which added this coverage as of January 1, 2026 (Table 1). The remaining 1,037,000 enrollees (84.7%) are in plans that do not cover GLP-1 medications. Postmandate, CHBRP estimates that 294,000 CalPERS enrollees (24.0%) would be enrolled in a plan that covers GLP-1 medications for weight management, reflecting the addition of coverage in the PERS Platinum PPO and enrollee migration to that plan, which would increase its enrollment by approximately 10,000 new enrollees.

Table 1. Impacts of SB 1089 on Benefit Coverage for CalPERS Enrollees, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees with health insurance subject to SB 1089	1,224,000	1,224,000	0	0.0%
Total enrollees in plans assumed to be impacted by SB 1089 (PERS Platinum PPO enrollees)	97,000	107,000	10,000	10.3%
Enrollees with coverage for GLP-1 anti-obesity medications				
Percentage of enrollees with coverage for GLP-1 anti-obesity medications	15.3%	24.0%	8.7%	56.5%
Percentage of enrollees without coverage for GLP-1 anti-obesity medications	84.7%	76.0%	(8.7%)	-10.2%

Source: California Health Benefits Review Program, 2026.
Key: CalPERS = California Public Employees' Retirement System; GLP-1 = glucagon-like peptide 1.

Utilization and Unit Cost

SB 1089 would increase the number of CalPERS enrollees using GLP-1 medications for weight management with plan coverage, from 4,912 to 17,335, while eliminating self-pay use as those enrollees migrate to covered options. The net increase in total GLP-1 users is 3,186. CHBRP estimates that approximately 1% of all PERS Platinum PPO enrollees would utilize GLP-1 medications at baseline; this would increase to approximately 12% of PERS Platinum PPO enrollees postmandate.

At baseline and postmandate, the average unit cost for enrollees with coverage under the Blue Shield HMO formulary is $550/month. Self-pay enrollees are assumed to purchase GLP-1 medications at an average cost of $274/month (a blend of 50% compounding pharmacies at $199 and 50% direct-to-consumer at $349), which would remain unchanged postmandate.

The average unit cost per 30-day supply is expected to decrease from $370 to $331 (a decrease of 10.4%), reflecting the shift to utilization of GLP-1 medications with MFN pricing ($245/month) for PERS Platinum PPO enrollees. The $370 baseline average is a weighted blend of Blue Shield HMO users ($550) and self-pay users ($274). Postmandate, the average decreases to $331 as the self-pay cohort, along with new utilizers, gains coverage in PERS Platinum PPO at MFN pricing ($245/month), while Blue Shield HMO unit cost holds at $550. Blue Shield HMO enrollees are not assumed to receive MFN pricing.

Average cost sharing remains unchanged at $20 per prescription (brand-tier copay).

Table 2 provides estimates of the impacts of SB 1089 on utilization and unit cost of GLP-1 medications.

Table 2. Impacts of SB 1089 on Utilization and Unit Cost, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Utilization impacts				
Number of enrollees with obesity or with BMI between 27 and <30 and a weight-related comorbidity	346,000	346,000	-	0.0%
Number of enrollees using GLP-1 FDA-approved anti-obesity medication with coverage	4,912	17,335	12,423	252.9%
Number of enrollees using GLP-1 FDA-approved anti-obesity medication without coverage	9,237	-	(9,237)	-100%
Unit cost impacts				
Average unit cost of GLP-1 FDA-approved anti-obesity medication	$370	$331	($38)	-10.4%
Average cost sharing for GLP-1 FDA-approved anti-obesity medication	$20.00	$20.00	$0	0.0%
Average reduction in cost PMPM due to GLP-1 therapy (per GLP-1 user per month)*	$37.80	$37.80	-	0.0%

Source: California Health Benefits Review Program, 2026.
Note: * The offset in medical expenses is expected to increase over time as enrollees continue therapy. These cost offsets represent a "steady state" and are described in additional detail in the section titled *Long-Term Utilization and Cost Impacts*.
Key: ACA = Affordable Care Act; CDI = California Department of Insurance; DMHC = Department of Managed Health Care; FDA = U.S. Food and Drug Administration; GLP-1 = glucagon-like peptide 1; PMPM = per member per month.

Expenditures and Premium Impacts

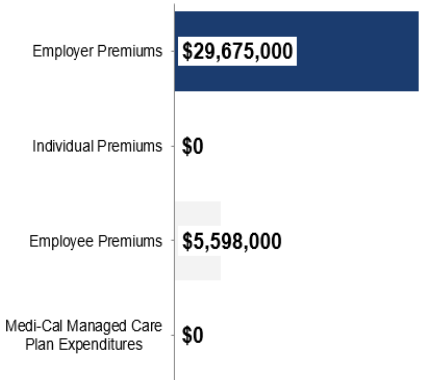
Policies affecting health insurance benefits, such as benefit coverage mandates, impact stakeholders in distinct ways. In terms of direct costs, these stakeholders can generally be grouped into two categories: (1) enrollees who utilize the benefit,[22] and (2) those who pay for the benefit but do not utilize it. Enrollees who use a benefit may be responsible for paying premiums and any out-of-pocket expenses related to the benefit. All enrollees within a risk pool share in these costs through the benefit's impact on plan premiums.

[22]Depending on their health insurance and the benefit in question, enrollees may or may not also pay for the benefit. For example, most Medi-Cal beneficiaries do not have cost sharing and do not pay health insurance premiums, whereas enrollees with health insurance a plan in the individual market may pay both insurance premiums and cost sharing or other out-of-pocket expenses.

Expenditure Impacts on Employers and All Enrollees

As shown in Figure 7, SB 1089 would increase total premiums paid by employers (CalPERS) and enrollees for newly covered benefits by approximately $35,273,000, an overall 0.26% increase in CalPERS premiums. This equates to a $27.50 increase in monthly premium per enrollee in the PERS Platinum PPO plan (or $330 annually per enrollee). This premium is divided between the employer and the employee – see more information in the Enrollee Expenses for Benefit Users section below about enrollee share of premiums. Additional details are also included in Table 6 in the Appendix. Premiums calculated include premiums for those enrollees using the benefit in addition to those not using the benefit.

Figure 6. Expenditure Impacts of SB 1089 on Employers and Enrollees



CHBRP projects cost offsets of $37.80 per member per month (PMPM) per GLP-1 medication user (approximately $454 per user per year), reflecting steady-state reductions in medical expenditures. These offsets were estimated using the ICER Interactive Modeler (ICER, 2025), with more information and parameters described in detail in the Technical Brief on SB 1089. Since offsets take time to accrue, estimated offsets are expected to be lower initially and fully realized within five or more years.

Changes in premiums as a result of SB 1089 would be concentrated in the CalPERS PERS Platinum PPO plan (see also Table 7 and Table 8 in the Appendix). The potential for these premium changes to influence enrollment and premiums across CalPERS plan options is discussed in the Insurance Pooling Impacts section in the *Long-Term Impacts* section.

Table 3 provides estimates of the aggregate impacts of SB 1089 on premiums.

Table 3. Impacts of SB 1089 on Premiums, 2027

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Non-enrollee premiums				
Employer-sponsored (a)	$75,730,916,000	$75,730,916,000	$0	0.00%
CalPERS employer (b)	$11,322,138,000	$11,351,813,000	$29,675,000	0.26%
Medi-Cal (c)	$42,982,384,000	$42,982,384,000	$0	0.00%
Enrollee premiums				
Enrollees, individually purchased insurance	$25,775,325,000	$25,775,325,000	$0	0.00%
Outside Covered California	$9,551,761,000	$9,551,761,000	$0	0.00%
Through Covered California	$16,223,564,000	$16,223,564,000	$0	0.00%
Enrollees, group insurance (d)	$22,339,393,000	$22,344,818,000	$5,598,000	0.03%
Total premiums	$178,150,156,000	$178,185,429,000	$35,273,000	0.02%

Source: California Health Benefits Review Program, 2026.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes all CalPERS enrollees in CalPERS Basic (non-Medicare) plans.

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans.
(d) Enrollee premium expenditures include contributions by enrollees to employer (or union or other organization)-sponsored health insurance, health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
Key: CalPERS = California Public Employees' Retirement System; DMHC = Department of Managed Health Care.

Enrollee Expenses for Benefit Users

SB 1089 would impact expenses for those using the benefit by increasing cost sharing by a total of $2,982,000 annually and decreasing total annual expenses for noncovered benefits (i.e., GLP-1 medications purchased through self-pay) by $30,371,000 (see Table 6). Because SB 1089 applies only to CalPERS, these changes are concentrated entirely in that market segment. Enrollees in CalPERS plans that do not add GLP-1 coverage would not experience a change in premiums.

CHBRP projects no change to copayments or coinsurance rates but does project an increase in utilization of GLP-1 medications and therefore an increase in enrollee cost sharing.

For CalPERS enrollees with coverage at baseline (approximately 15.3% of CalPERS enrollees), no change in out-of-pocket expenses or premiums is projected, assuming cost sharing and unit cost for these enrollees remain unchanged.

For existing PERS Platinum PPO enrollees obtaining GLP-1 medications through self-pay and who gain GLP-1 coverage under their current plan (approximately 1,700 enrollees, or 0.14% of CalPERS), SB 1089 would add coverage without requiring a plan switch. These enrollees, as well as enrollees in other plans who switch into the PERS Platinum PPO, who were previously self-paying $274/month, would only have to pay a $20 monthly copay, thereby reducing their annual out-of-pocket expenses by approximately $3,048 (from $3,288/year self-pay to $240/year in copays). Enrollees who initiate GLP-1 therapy postmandate as a result of increased benefit coverage due to SB 1089 would incur $240/year in copays.

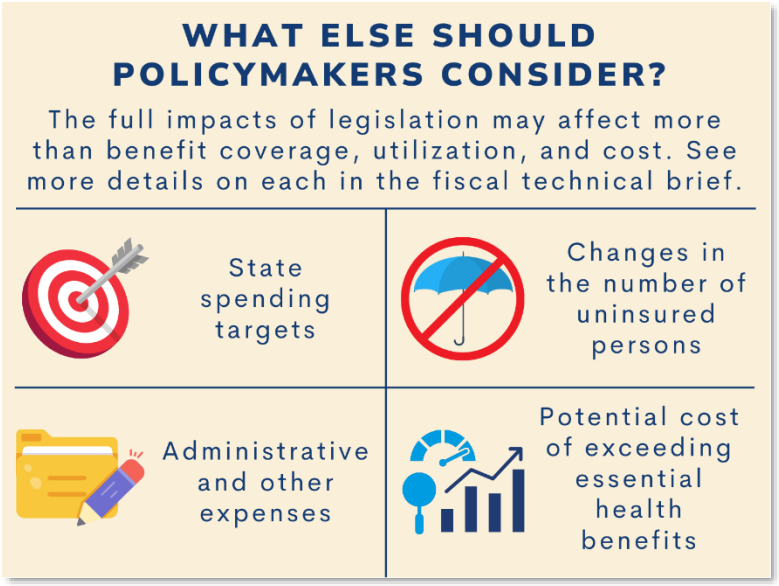
The enrollee share of premiums in the PERS Platinum PPO would increase by $4.36 PMPM ($52.31 annually). This increase would apply to all PERS Platinum PPO enrollees, including both GLP-1 users and non-users.

Table 4 shows the per-user annual impact in the form of premium increases (shared across all CalPERS PERS Platinum PPO enrollees) and out-of-pocket expense changes (for enrollees who gain or already have GLP-1 coverage). Cost sharing expenses reflect population averages and will vary significantly for individual members. Sources of variation include the specific GLP-1 medication utilized, whether the enrollee was previously self-paying or had no utilization, and the cost-sharing and utilization management protocols applicable to their specific CalPERS plan option. An enrollee may experience a mandate impact significantly higher or lower than those included in Table 4.

Enrollees who hit the annual out-of-pocket maximum[23] would have no further cost sharing in that plan year.

As noted previously, these estimates are reflective of CHBRP's assumed interpretation of SB 1089. Should SB 1089 be interpreted to require different benefit coverage (i.e., requiring nearly all CalPERS plans to include coverage for GLP-1 medications for weight management, requiring CalPERS to offer a rider to enrollees to purchase GLP-1 medication coverage, or requiring insurers to offer a rider to agencies or employers to purchase GLP-1 medication coverage), impacts would be substantially higher or lower than what is presented in this analysis.

[23] For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copays and coinsurance for prescription medications is limited to $250, or $500 for enrollees in the "bronze plans" available from Covered California, the state's ACA marketplace (HSC 1342.73; INS 10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible.



See more information in the Technical Brief on SB 1089, including what else policymakers should consider such as state spending targets, impacts to the number of uninsured in California, how lack of benefit coverage shifts costs to other payers, changes in public program enrollment, and administrative and other expenses.

Back to Table of Contents

Table 4. Impact of SB 1089 on Average Annual User Expenses and Non-User Premiums

	CalPERS
Self-pay users at baseline with new benefit coverage postmandate	
% of CalPERS enrollees shifting from self-pay to covered GLP-1 benefits	0.75%
Annual out-of-pocket expense reduction per newly covered GLP-1 user (a)	$3,048
Non-users at baseline newly using benefit coverage postmandate	
% of CalPERS enrollees shifting from non-use to covered GLP-1 benefits	0.26%
Annual out-of-pocket expense increase for new GLP-1 user (b)	$240
Premium impacts (users and non-users)	
Annual increase in enrollee share of premiums for PERS Platinum PPO plan option only (c)	$52.31
Premiums increase in unaffected CalPERS plans	$0

Source: California Health Benefits Review Program, 2026.
Notes: (a) Reflects the annual reduction in out-of-pocket spending for enrollees who were previously self-paying for GLP-1 medications and shift to plan-covered benefits with a $20 monthly copay postmandate. Within this average, individual savings range from $2,148 (enrollees previously purchasing from compounding pharmacies at $199/month) to $3,948 (enrollees previously purchasing at direct-to-consumer pricing of $349/month).
(b) Reflects the annual increase in out-of-pocket spending for enrollees who were previously not using GLP-1 medications and shift to plan-covered benefits with a $20 monthly copay postmandate.
(c) Assumes that the increase in enrollee premiums would be funded at the same proportion as other CalPERS options.
Key: CalPERS = California Public Employees' Retirement System; GLP-1 = glucagon-like peptide 1; PPO = preferred provider organization.

SB 1089 Impacts: Public Health

The public health impact analysis includes estimated impacts in the short term (within 12 months of full implementation) and in the long term (beyond the first 12 months following full implementation). This section estimates the short-term impact[24] of SB 1089 on change in body weight and additional health-related outcomes, barriers to diagnosis and treatment, potential treatment harms, and potential disparities. See the *Long-Term Impacts* section for discussion of premature death and economic loss.

Estimated Public Health Outcomes

As presented in the *How Effective Are GLP-1 Medications?* section, there is *very strong evidence* that FDA-approved GLP-1 medications are effective for weight management in adults and *strong evidence* GLP-1 medications are effective for weight management in children and adolescents. There is also *strong evidence* that GLP-1 medications result in improved health outcomes for adults, and *conflicting evidence* that GLP-1 medications result in improved health outcomes for children and adolescents.

As presented in the *Benefit Coverage and Cost Impacts* section, at baseline, it is estimated that 15.3% of CalPERS enrollees are in a plan with coverage for GLP-1s for weight management. Postmandate, this would increase to 24.0% of CalPERS enrollees in plans with coverage for GLP-1 medications for weight management because of the addition of coverage to the PERS Platinum PPO plan and 5% of CalPERS enrollees with obesity or who are overweight with a comorbidity switching from other plans into the PPO plan to access coverage. Utilization of GLP-1 medications due to weight management with plan coverage would increase from 4,912 enrollees at baseline to 17,335 enrollees postmandate. The increase in utilization includes CalPERS enrollees who are self-paying for GLP-1 medications at baseline (9,237 enrollees) and new users of GLP-1s due to new benefit coverage (3,186 enrollees).

Enrollees using GLP-1 medications would have an average weight loss of between 4.8% and 17.8% compared to non-utilizers. The level of weight loss would depend on a number of factors, including the specific treatment utilized and specific patient-level factors. In addition, there would be, on average, some level of improvement in obesity-related health outcomes such as decreased diabetes risk and improvement in HbA1c levels, improvement in blood pressure, and improved functional quality of life. As a result of these improvements in health outcomes, there would be an average per member per month reduction in costs of $37.80 for each GLP-1 user. Enrollee share of premiums for all enrollees in the PERS Platinum PPO plan would increase by $4.36 PMPM (or $52.31 annually). Expenses for enrollees who self-paid for GLP-1 medications at baseline would be reduced by an average of $3,048 annually; cost sharing for new GLP-1 users would increase by $240 annually.

In the first year postmandate, 3,186 CalPERS enrollees would newly utilize GLP-1s for weight management. As a result, these enrollees would experience an average of 4.8% to 17.8% reduction in body weight and improvement in related health outcomes over time, which is supported by evidence that obesity treatments are medically effective. Enrollees who self-paid for GLP-1 medications due to lack of benefit coverage at baseline would experience a reduction in out-of-pocket costs.

As discussed in the *Overview* section, there are four potential interpretations of SB 1089: nearly all CalPERS plans would be required to include coverage for GLP-1 medications for weight management; one plan would be required to include coverage; a rider would be available for enrollees to purchase; a rider would be available for participating agencies or employers to purchase. CHBRP has modeled the second interpretation of SB 1089. Estimated public health impacts of

[24] CHBRP defines short-term impacts as changes occurring within 12 months of full implementation of an enacted law.

the first interpretation would be orders of magnitude higher than presented above, while estimated public health impacts of the third and fourth interpretations are uncertain, but could be substantially lower.

Potential Harms From SB 1089

When data are available, CHBRP estimates the marginal change in relevant harms associated with interventions affected by the proposed mandate. In the case of SB 1089, there is evidence to suggest that an increase in the use of obesity treatments could result in harm. Potential harms associated with the use of FDA-approved GLP-1s for weight management include gastrointestinal-related symptoms, including nausea, constipation, diarrhea, and dyspepsia (i.e., discomfort or pain in the upper abdomen); paresthesia (i.e., burning or prickling sensation, often occurring in the hands, arms, legs, or feet); dry mouth; insomnia; irritability; anxiety; headache; and increased blood pressure and heart rate. Adverse events may contribute to discontinuation of the drug, which can impact overall medical effectiveness of the treatment. It is unclear if long-term use is associated with more severe and persistent harms.

Impact on Disparities[25] and Barriers

As described in the *Overview* section, there are many factors that serve as barriers to seeking and accessing obesity treatments. These barriers can serve to create disparities in rates of utilization of obesity treatments and overall rates of obesity. Each of these factors and the impact that SB 1089 may have on addressing these barriers and resulting disparities is described below. To the extent the disparities identified exist within the CalPERS population, SB 1089 could improve disparities by location and expense. It is unlikely SB 1089 would reduce barriers due to stigma and racism and discrimination.

- **Stigma:** It is unclear how SB 1089 would impact stigma surrounding obesity and obesity treatments.
- **Racism and discrimination:** SB 1089 could result in a decrease in disparities in utilization by race and ethnicity within the CalPERS population. However, this impact is dependent upon the extent to which disparities by race and ethnicity exist within the CalPERS population and if these enrollees are enrolled in the CalPERS PERS Platinum PPO or choose to switch into this plan to access coverage for GLP-1 medications.
- **Location:** It is possible that people living in rural areas who are more likely to face challenges in accessing GLP-1 medications may benefit from SB 1089 if an increase in coverage includes medications available via mail that could be sent to individuals living in more remote settings.
- **Expense:** The high cost of some obesity treatments, including GLP-1 medications, makes them inaccessible for patients with lower incomes (Levi et al., 2023). Because SB 1089 would result in one plan with coverage for GLP-1 medications for weight management to be available to CalPERS enrollees, enrollees who were previously paying out of pocket for access to GLP-1 medications would experience a reduction in their out-of-pocket expenses and more than 3,000 enrollees would newly utilize GLP-1 medications due to the increase in benefit coverage. It is possible a portion of the enrollees newly utilizing GLP-1s postmandate did not self-pay for GLP-1s at baseline due to cost.

Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts

SB 1089 applies to the health insurance of CalPERS enrollees but would not be applicable to the health insurance of enrollees in commercial CDI-regulated policies and commercial (non-CalPERS) DMHC-regulated plans, in addition to Medi-Cal beneficiaries. As found in CHBRP's previous analyses of AB 575 and SB 535, benefit coverage for GLP-1 medications for weight loss is limited for enrollees in commercial plans and policies. Medi-Cal terminated coverage of GLP-1 medications for weight management as of January 2026. SB 1089 could contribute to increasing disparities in coverage for GLP-1 medications for weight management.

Back to Table of Contents

[25] For details about CHBRP's methodological approach to analyzing disparities, see the *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts* document.

SB 1089 Impacts: Long-Term

In this section, CHBRP estimates the long-term impact of SB 1089, which CHBRP defines as impacts occurring beyond the first 12 months after legislation is fully implemented.[26] These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

Over time, utilization of GLP-1 medications among CalPERS enrollees would be expected to increase. Awareness of coverage availability, clinician familiarity with prescribing, and patient adoption are all expected to grow. Additionally, the increased availability of oral formulations and continued expansion of FDA-label indications for use other than obesity alone will contribute to increased utilization of GLP-1 medications in the long term. Furthermore, additional enrollees may switch to the PERS Platinum option in subsequent open enrollment periods to access GLP-1 coverage. If CalPERS elects to extend coverage to additional plan options beyond the minimum required by SB 1089, utilization would further increase.

Cost Impacts

Long-term cost impacts depend on several factors. Cost offsets from reduced obesity-related medical expenditures (cardiovascular events, diabetes management, kidney disease, joint replacement) are expected to grow over time as enrollees maintain therapy. CHBRP's offset analysis, based on the ICER model, estimates average steady-state savings of $454 per user per year ($37.80 PMPM per user). Since the medical benefits of GLP-1 take time to accrue, full realization of these savings would occur only in the longer run, within five or more years from initiation of a GLP-1 medication. Estimated savings are lower in earlier years.

Competition from new entrants, biosimilars, and evolving MFN pricing may also affect long-term unit costs.

These projections are subject to fundamental uncertainty in three areas: (1) real-world year-over-year continuation rates for GLP-1 therapy, which directly affect both costs and offsets and for which current evidence suggests persistent use yields more substantial benefits; (2) long-term recommended dose for users who achieve desired weight loss, including frequency of doses; and (3) longer-term health impacts of GLP-1 medications, for which the clinical evidence base beyond several years remains limited. See *Detailed Cost Notes* in the Technical Brief on SB 1089 for further discussion.

Insurance Pooling Impacts

The $52.31 annual increase in the enrollee share of premiums for PERS Platinum PPO may alter relative premiums across CalPERS plan offerings. Premium differentials can influence enrollment decisions in subsequent cycles, reshaping each plan's risk pool composition and, consequently, its per-member costs. This analysis does not account for such second-order enrollment responses or the premium adjustments they may trigger. The magnitude and direction of these effects are empirically uncertain – enrollment decisions in employer-sponsored insurance often exhibit substantial inertia, with enrollees frequently remaining in their current plan despite financial incentives to switch (Handel, 2013) – but the potential for downstream shifts in risk pool composition warrants monitoring.

[26] Full-scale implementation typically requires a “ramp up” period which may include educating enrollees, providers and insurance carriers on the new benefits or coverage, updating procedures and policies, and increasing provider capacity for marginal utilization resulting from SB 1089. Furthermore, some policies may have staggered implementation or longer-term changes in utilization. The short-term, incremental impact estimated by CHBRP assumes there is no “ramp up” period and represent ongoing annual costs at full-scale implementation of SB 1089, including potential short-term offsets. CHBRP further assumes that state and industry policies and provider and patient behaviors would remain constant throughout the time period it takes for the full impact of the bill to be realized.

Long-Term Public Health Impacts

Some interventions in proposed mandates provide immediate measurable impacts (e.g., maternity service coverage or acute care treatments), whereas other interventions may take years to make a measurable impact (e.g., coverage for tobacco cessation or vaccinations). When possible, CHBRP estimates the long-term effects (beyond 12 months postmandate) to the public's health that would be attributable to the mandate, including impacts disparities, premature death, and economic loss.

In the case of SB 1089, CHBRP estimates approximately 3,187 enrollees would newly use treatments for obesity within 1-year postmandate. It is estimated that these individuals would lose an average of between 4.8% and 17.8% of their body weight over time. Therefore, public health impacts would continue for these individuals outside of the 1-year time frame as they continue to lose and maintain their weight loss. There is limited, but growing, evidence to evaluate the long-term benefits of obesity treatments, particularly regarding persistent use of medication and sustained weight loss and other benefits after discontinuation. Therefore, although this limited evidence suggests that we would continue to see 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, the magnitude of these benefits is unknown.

Impacts on Premature Death and Economic Loss

Premature death

Premature death, measured by years of potential life lost (YPLL), is often defined as death occurring before the age of 75 years (NCI, 2019).[27] Fontaine et al. (2003) found that the life expectancy for an adult with a class 3 obesity (i.e., BMI > 45) reduced by a range of 5 to 20 YPLL – depending on sex and race and ethnicity. Specifically, overweight men aged 20 to 39 years lost an estimated 2.7 years of life, whereas obese and severely obese (i.e., class 2 or class 3 obesity) men lost 5.9 and 8.4 years, respectively, compared to men with a healthy body weight (Grover et al., 2015). Additionally, obese women in the same age group experienced up to 6.1 years of life lost, with the highest impact seen in younger individuals. Increased body weight was also associated with a significant reduction in healthy life years, with young severely obese men losing 18.8 years and young very obese women losing 19.1 years (Grover et al., 2015). According to the CDC Wonder online database, 881 adult deaths in California were directly attributed to obesity, equal to a rate of 3.0 per 100,000 persons, in 2023 (CDC, 2023). Although SB 1089 has the potential to impact premature death, the extent to which this may occur is unknown.

Economic loss

Economic loss associated with disease is generally presented in the literature as an estimation of the value of the YPLL in dollar amounts (i.e., valuation of a population's lost years of work over a lifetime). In addition, morbidity associated with the disease or condition of interest can also result in lost productivity by causing a worker to miss days of work due to illness or acting as a caregiver for someone else who is ill.

Cawley et al. (2021) found that obesity increases job absenteeism (either due to injury or illness) by an average of 4.68 days per year per obese individual in California. In addition, they estimated that each additional unit of BMI increased the average number of days of work lost by 0.20 days per year. This translated into productivity losses ranging from $1.12 billion to $2.13 billion in productivity losses per year in California.[28] It is estimated that SB 1089 would increase utilization of obesity treatments by 3,187 people per year. Assuming an average weight loss of 11.3% (i.e., the mid-point of the range of 4.8%-17.8%), this would translate into an approximate decrease in lost productivity of 2,679 days per year or $324,000 to $649,000 per year. This savings would grow over time as the cumulative pool of people who have lost weight using obesity treatments grows, assuming persistent use of medication and sustained weight loss. Similarly, estimates

[27] For more information about CHBRP's public health methodology, see CHBRP's Public Health Impact Analysis and Research Approach.
[28] Translated into 2026 dollars using https://www.usinflationcalculator.com/.

across the United States have shown that a reduction in the average BMI by 5% could save nearly $30 billion in 5 years, save more than $150 billion in 10 years, and more than $600 billion in 20 years (Wang et al., 2011).

Back to Table of Contents

Appendix. Impacts of SB 1089 on Expenditures, 2027

Table 5. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	1,224,000	8,078,000	965,000	315,000	42,000	41,000	23,135,000
Total enrollees in plans/policies subject to SB 1089	0	0	0	1,224,000	0	0	0	0	0	1,224,000
Premiums										
Average portion of premium paid by employer (e)	$619.33	$539.05	$0.00	$770.84	$367.89	$632.17	$780.34	$573.31	$0.00	$130,035,438,000
Average portion of premium paid by enrollee	$134.02	$263.52	$864.90	$145.41	$0.00	$0.00	$184.88	$242.16	$832.16	$48,114,718,000
Total premium	**$753.35**	**$802.56**	**$864.90**	**$916.25**	**$367.89**	**$632.17**	**$965.22**	**$815.47**	**$832.16**	**$178,150,157,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$56.38	$184.07	$271.63	$70.59	$0.00	$0.00	$126.72	$213.52	$192.93	$19,681,002,000
Expenses for noncovered benefits (f)	$0.00	$0.00	$0.00	$2.07	$0.00	$0.00	$0.00	$0.00	$0.00	$30,371,000
Total expenditures	**$809.72**	**$986.63**	**$1,136.53**	**$988.91**	**$367.89**	**$632.17**	**$1,091.94**	**$1,029.00**	**$1,025.09**	**$197,861,530,000**

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) CalPERS is generally regulated by DMHC, but this includes all CalPERS enrollees in CalPERS Basic (non-Medicare) plans, including those not regulated by DMHC.[29].
(c) Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[30]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

[29] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance.*
[30] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Table 6. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2027

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	7,929,000	2,097,000	2,444,000	1,224,000	8,078,000	965,000	315,000	42,000	41,000	23,135,000
Total enrollees in plans/policies subject to SB 1089	0	0	0	1,224,000	0	0	0	0	0	1,224,000
Premiums										
Average portion of premium paid by employer (e)	$0.0000	$0.0000	$0.0000	$2.0203	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$29,675,000
Average portion of premium paid by enrollee	$0.0000	$0.0000	$0.0000	$0.3811	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$5,598,000
Total premium	$0.0000	$0.0000	$0.0000	$2.4014	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	**$35,273,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0000	$0.0000	$0.0000	$0.2030	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	$2,982,000
Expenses for noncovered benefits (f)	$0.0000	$0.0000	$0.0000	-$2.0677	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	-$30,371,000
Total expenditures	$0.0000	$0.0000	$0.0000	$0.5367	$0.0000	$0.0000	$0.0000	$0.0000	$0.0000	**$7,883,000**
Percent change										
Premiums	0.0000%	0.0000%	0.0000%	0.2621%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0198%
Total expenditures	0.0000%	0.0000%	0.0000%	0.0543%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0040%

Source: California Health Benefits Review Program, 2026.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) CalPERS is generally regulated by DMHC, but this includes all CalPERS enrollees in CalPERS Basic (non-Medicare) plans, including those not regulated by DMHC.[31] .
(c) Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[32]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that will be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Back to Table of Contents

[31] For more detail, see CHBRP's resource *Pharmacy Benefit Coverage in State-Regulated Health Insurance*.
[32] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

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CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs CHBRP reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuarial firm, **Milliman, Inc.**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

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CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at chbrp.org.

Garen Corbett, MS Director

Please direct any questions concerning this document to: California Health Benefits Review Program, MC 3116, Berkeley, CA 94720-3116; info@chbrp.org; or chbrp.org.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. CHBRP's mission is to inform and support policymaking in California through the creation of impartial, evidence-based resources. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. CHBRP is dedicated to providing academic rigor on a Legislature's timeline.

The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. An independent actuarial firm helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

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CHBRP analyzes bills in the current environment given current law and regulations at both the state and federal levels. Each analysis assumes that policy frameworks and stakeholder behaviors remain constant, unless otherwise noted. All estimates are based on current data and do not take into consideration any future or potential changes to factors that may influence the impacts of the legislation, unless otherwise specifically mentioned. Differences between CHBRP's estimated impacts and actual impacts of legislation will depend on alignment with the assumptions used in this analysis, the timeline of implementation, and the final language of the legislation, should it be signed into law. Since actual experience is unlikely to match assumptions perfectly, final impacts will differ from those projected in this analysis.

This analysis is based on existing literature and public sources identified through systematic search methods. This evidence informs the California Legislature about potential impacts of proposed health benefit legislation and does not constitute a policy recommendation from CHBRP.

For more information about CHBRP's methods and approach, please visit our website.

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