TECHNICAL BRIEF

SB 1089

Preventive Treatment Health Care Act

CHBRP

About the Technical Brief

This document provides details on the analytical foundation for CHBRP's analysis of SB 1089. While the main report synthesizes key findings for immediate policy consideration, this document is designed to support a deeper understanding of the background of the topic of the legislation and CHBRP's methodology and research in conducting its analysis. It contains the data sources, methods, assumptions, and other bill-specific considerations necessary for legislative staff, fiscal analysts, and other stakeholders to fully understand the scope and impact of the proposed measure.

Table of Contents

Lists of Tables and Figures

Acronyms and Terminology

Acronyms

AB – Assembly Bill

ACA – Affordable Care Act

AE – adverse event

AOM – anti-obesity medications

BMI – body mass index

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

DBP – diastolic blood pressure

DHCS – Department of Health Care Services

DMHC – Department of Managed Health Care

EHBs – essential health benefits

FDA – U.S. Food and Drug Administration

FPG – fasting plasma glucose

GLP – glucagon-like peptide

HMO – health maintenance organization

IWQOL – Impact of Weight on Quality of Life

MDRP – Medicaid Drug Rebate Program

PPO – preferred provider organization

SB – Senate Bill

SBP – systolic blood pressure

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)

Legislative Text Analyzed

CHBRP analyzed SB 1089 Preventive Care Act, as introduced on February 13, 2026, per the request of the California Senate Committee on Health. SB 1089 was amended on March 24, 2026, and CHBRP was provided with draft language in order to complete this analysis. The text analyzed is copied below.

SECTION 1.

This act shall be known, and may be cited, as the Preventive *Treatment Health* Care Act.

~~SEC. 2.Section 1374.6 is added to the Health and Safety Code, to read:~~

~~1374.6.~~

~~(a)A large group health care service plan contract issued, amended, or renewed on or after January 1, 2027, shall cover weight loss as a medical condition.~~

~~(b)A large group health care service plan contract that provides coverage for outpatient prescription drug benefits and is issued, amended, or renewed on or after January 1, 2027, shall include coverage for at least one FDA-approved antiobesity medication.~~

~~(c)This section does not prohibit a plan from applying utilization management to determine the medical necessity for weight loss under this section if appropriateness and medical necessity determinations are made in the same manner as those determinations are made for the treatment of any other illness, condition, or disorder covered by a contract.~~

~~(d)Coverage criteria for FDA-approved antiobesity medications shall not be more restrictive than the FDA-approved indications for those treatments.~~

~~(e)For purposes of this section, "FDA-approved antiobesity medication" means a medication approved by the United States Food and Drug Administration with an indication for chronic weight management in patients with obesity.~~

~~(f)This section does not apply to a specialized health care service plan contract that covers only dental or vision benefits or a Medicare supplement contract.~~

~~(g)This section does not limit existing prescription drug coverage requirements, including the requirements of Section 1300.67.24 of Title 28 of the California Code of Regulations.~~

SEC. 2.

The Legislature finds and declares all of the following:

(a) There are approximately 30,000,000 adults 18 years of age and older living in California.

(b) (1) According to the University of California, Los Angeles, California Health Interview Survey, nearly 61 percent of, or more than 24,500,000, California adults 18 to 64 years of age, inclusive, are suffering from chronic weight disease, thereby falling into the combined overweight or obese category.

(2) The body mass index (BMI) is a formula that screens for excess weight relative to height.

(3) The federal Centers for Disease Control and Prevention classifies weight into six categories. The BMI formula used is categorized as follows:

Underweight BMI below 18.5
Healthy weight BMI 18.5 to 24.9
Overweight BMI 25.0 to 29.9
Class 1 Obesity BMI 30.0-34.9
Class 2 Obesity BMI 35.0 to 39.9
Class 3 Obesity BMI 40.0 and above

(4) Further, BMI is measured to determine risk for weight-related disease often associated with a waist size of 35 inches or more in women and 40 inches or more in men.

(c) Californians with a greater determination of overweight beyond a BMI higher than 30.0 are clinically described as obese, which has increased from 19.3 percent in 2001 to over 29 percent in 2023. Even more alarming, without prevention, obesity could reach 41 percent by 2030 in California adults.

(d) Serious chronic weight disease with a BMI formula rating over 30 is recognized as such by major medical organizations, including the American Medical Association since 2013, the American Association of Clinical Endocrinology, the American College of Cardiology, the Endocrine Society, the American Society for Reproductive Medicine, the Society for Cardiovascular Angiography and Interventions, the American Urological Association, and the American College of Surgeons.

(e) (1) Chronic weight disease extends beyond the need to lose pounds but can also contribute to possible cancers and other comorbidities. From 2005 to 2014, several cancers that may be associated with chronic weight disease have increased in the United States, while cancers associated with other health factors decreased.

(2) Chronic weight disease reduces a patient's overall cancer-specific survival rate, as well as increases the risk of cancer recurrence.

(3) The 13 types of cancer related to chronic weight disease are:

(A) Adenocarcinoma of the esophagus.
(B) Postmenopausal breast.
(C) Colon and rectal, or colorectal.
(D) Endometrial of the uterus.
(E) Gallbladder.
(F) Gastric cardia, or upper stomach.
(G) Renal cell carcinoma of the kidney.
(H) Liver.
(I) Ovarian.
(J) Pancreatic.
(K) Thyroid.
(L) Meningioma, a type of brain cancer.
(M) Multiple myeloma, a blood cancer.
(4) Chronic weight disease is associated with an increased risk of more than 200 comorbid conditions. Some of those conditions are:

(A) Type 2 diabetes.
(B) High blood pressure.
(C) Heart disease.

(D) Stroke.
(E) Metabolic syndrome.
(F) Fatty liver diseases.
(G) Other types of cancers.
(H) Breathing problems.
(I) Osteoarthritis.
(J) Gout.
(K) Diseases of the gallbladder and pancreas.
(L) Kidney disease.
(M) Pregnancy problems.
(N) Fertility problems.
(O) Sexual function problems.
(P) Mental health problems.

(f) (1) In addition to individual health impacts of chronic weight disease, employee productivity and contributions to California's economy are impacted by the prevention and management of chronic weight disease.

(2) Chronic weight disease can be related to reduced labor participation and earnings and increased early mortality, absenteeism, disability, and health care costs exceeding $1 billion and a 2.6-percent reduction in the California gross domestic product.

(g) Barriers to the reduction, maintenance, or elimination of chronic weight disease are essentially access and cost.

(h) This act is intended to increase access to the California workforce, starting with state and local employees, to identify, counsel, and treat chronic weight disease, and ensure treatments available through the California Affordable Drug Manufacturing Act of 2020, including 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 are available at the former Medi-Cal 2025 price, most favored nation price, or a better price.

SEC. 3.

Section 22853.5 is added to the Government Code, to read:

22853.5.

(a) 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.

(b) Chronic weight disease management covered pursuant to subdivision (a) shall be offered 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.

(c) Chronic weight disease management covered pursuant to subdivision (a) shall follow United States Food and Drug Administration label indications for usage.

(d) The California Health and Human Services Agency shall make chronic weight disease management medications described in subdivision (a) available to state and local government employers, and shall determine if chronic weight

disease management medications described in subdivision (a) shall be made available to all Californians, including enrollees and insureds of licensed health care service plan contracts and health insurance policies, at the cost described in subdivision (b).

(e) This section shall remain in effect only until January 1, 2032, and as of that date is repealed.

~~SEC. 3.~~*SEC. 4.*

Section 127693 of the Health and Safety Code is amended to read:

127693.

(a) CHHSA shall enter into partnerships resulting in the *acquisition of brand name prescription drugs or* production, procurement, or distribution of generic prescription drugs, with the intent that these drugs be made widely available to public and private purchasers, providers and suppliers as defined in subdivision (b) of Section 1367.50, and pharmacies as defined in Section 4037 of the Business and Professions Code, as appropriate. The generic prescription drugs shall be produced or distributed by a drug company or generic drug manufacturer that is registered with the United States Food and Drug Administration.

(b) (1) CHHSA shall only enter into partnerships pursuant to subdivision (a) *to acquire brand name prescription drugs or* to produce a generic prescription drug at a price that results in savings, targets failures in the market for generic drugs, or improves patient access to affordable medications.

(2) For top drugs identified pursuant to the criteria listed in paragraph (5), CHHSA shall determine if viable pathways exist for partnerships to manufacture, procure, or distribute generic prescription drugs by examining the relevant legal, market, policy, and regulatory factors.

(3) CHHSA shall consider the following, if applicable, when setting the price of *an acquired brand name prescription drug or* a generic prescription drug:

(A) United States Food and Drug Administration user fees.

(B) Abbreviated new drug application acquisition costs amortized over a five-year period.

(C) Mandatory rebates.

(D) Total contracting and production costs for the drug, including a reasonable amount for administrative, operating, and rate-of-return expenses of the drug company or generic drug manufacturer.

(E) Research and development costs attributed to the drug over a five-year period.

(F) Other initial start-up costs amortized over a five-year period.

(G) The cost previously provided to Medi-Cal beneficiaries in the year 2025 or a lower cost.

(H) The cost previously provided as the most favored nation pricing as set forth in federal Executive Order No. 14297 on May 12, 2025.

(4) Each drug shall be made available to providers, patients, and purchasers, as appropriate, at a transparent price and without rebates, other than federally required rebates.

(5) CHHSA shall prioritize the selection of *brand name and* generic prescription drugs that have the greatest impact on lowering drug costs to patients, increasing competition and addressing shortages in the prescription drug market, improving public health, or reducing the cost of prescription drugs to public and private purchasers.

(c) (1) In identifying *brand name prescription drugs to be acquired or* generic prescription drugs to be produced, CHHSA shall consider the report produced by the Department of Managed Health Care pursuant to subdivision (b) of Section 1367.243, the report produced by the Department of Insurance pursuant to subdivision (b) of Section 10123.205 of the Insurance Code, and pharmacy spending data from Medi-Cal and other entities for which the state pays the cost of *brand name or* generic prescription drugs.

(2) The partnerships entered into pursuant to subdivision (a) shall include the production of at least one form of insulin *and the acquisition or production of 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* made available at production and dispensing costs, if one does not already exist in the market. Dispensing costs may include related expenses such as transportation, distribution, and market operations. Any partnership shall also consider:

(A) Guaranteeing priority access to insulin supply *and supply of pens, vial injections, pills, and patches of GLP-1 semaglutide, GLP-1RA, GIP+GLP-1 tirzepatide, and future chronic weight disease products* for the state.

(B) Guaranteeing the manufacture of at least four high-priority drugs for California, as identified pursuant to paragraph (5) of subdivision (b).

(C) Creating a state brand identifying biosimilar ~~insulin~~ *insulin, pens, vial injections, pills, and patches of GLP-1 semaglutide, GLP-1RA, GIP+GLP-1 tirzepatide, and future chronic weight disease products,* and generic prescription drugs sold in California under this section.

~~(3)The partnerships entered into pursuant to subdivision (a) shall include the production of at least one glucagon-like peptide-1 (GLP-1) or GLP-1 receptor agonist (GLP-1RA) made available at production and dispensing costs, if one does not already exist in the market. Dispensing costs may include related expenses such as transportation, distribution, and market operations. Any partnership shall also consider guaranteeing priority access to GLP-1 or GLP-1RA supply for the state.~~

~~(4)~~ *(3)* CHHSA shall prioritize drugs for chronic and high-cost conditions, and shall consider prioritizing those that can be delivered through mail order.

(d) CHHSA shall consult with all of the following public and private purchasers, as appropriate, to develop a list of generic prescription drugs to be ~~manufactured~~ *acquired, manufactured,* or distributed through partnerships:

(1) The Public Employees' Retirement System, the State Department of Health Care Services, the California Health Benefit Exchange (Covered California), the State Department of Public Health, the Department of General Services, and the Department of Corrections and Rehabilitation, or the entities acting on behalf of each of those state purchasers.

(2) Licensed health care service plans.

(3) Health insurers holding a valid outstanding certificate of authority from the Insurance Commissioner.

(4) Hospitals.

(e) Before effectuating a partnership pursuant to this section, CHHSA shall consider the volume of each *brand name prescription drug or* generic prescription drug over a multiyear period to support a market for a lower cost generic

prescription drug, if volume is an important factor in driving down the cost of the drug. For partnerships involving procurement, CHHSA shall determine minimum thresholds for procurement of an entity's expected volume of a targeted drug from the company or manufacturer over a defined target period. In making advance commitments, CHHSA may consult with the Statewide Pharmaceutical Program and the California Pharmaceutical Collaborative.

(f) The listed entities in paragraphs (2) to (4), inclusive, of subdivision (d) shall not be required to purchase prescription drugs from CHHSA or entities that contract or partner with CHHSA pursuant to this chapter.

(g) CHHSA shall not be required to consult with every entity listed in paragraphs (2) to (4), inclusive, of subdivision (d), so long as purchaser engagement includes a reasonable representation from these groups.

(h) Any partnership entered into pursuant to this section may include representation and involvement with the governance of the contractor entity.

~~SEC. 4.Section 130514 is added to the Health and Safety Code, immediately following Section 130513, to read:~~

~~130514.~~

~~An employer with 100 or more employees may negotiate directly with a drug manufacturer to provide a discount for a glucagon-like peptide-1 (GLP-1) or GLP-1 receptor agonist.~~

~~SEC. 5.Section 10123.62 is added to the Insurance Code, to read:~~

~~10123.62.~~

~~(a)A large group health insurance policy issued, amended, or renewed on or after January 1, 2027, shall cover weight loss as a medical condition.~~

~~(b)This section does not apply to a specialized health insurance policy that covers only dental or vision benefits or a Medicare supplement policy.~~

~~SEC. 6.Section 2805 is added to the Labor Code, to read:~~

~~2805.~~

~~An employer with 100 or more employees shall offer its employees access to all of the following:~~

~~(a)Exercise programs, gym memberships, or both.~~

~~(b)Nutrition services.~~

~~(c)Coverage for a glucagon-like peptide-1 (GLP-1) or GLP-1 receptor agonist.~~

~~SEC. 7.~~

~~No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

Additional Policy Context

This brief provides additional material to support the findings and recommendations presented in CHBRP's Analysis of Senate Bill 1089 Preventive Treatment Health Care Act.[2] The following sections contain details on the federal landscape. Although this information is essential to the completeness of the analysis, it has been placed in this separate brief to maintain the flow of the main report. Readers are encouraged to consult this material for deeper insights into existing laws, comprehensive data sets, and technical details that informed the analysis and conclusions of the main report.

Federal Policy Landscape

Federal law authorizes the Medicaid Drug Rebate Program (MDRP), a program designed to help offset federal and state costs of most outpatient prescription drugs dispensed to Medicaid beneficiaries. The program is a collaboration between the Centers for Medicare & Medicaid Services (CMS), state Medicaid agencies, and participating drug manufacturers. MDRP requires a drug manufacturer to enter into a written agreement with the Secretary of the Department of Health and Human Services that it will provide a rebate to states for a portion of the Medicaid payment for each drug. The states then share the rebate with the federal government. In return, most of the manufacturer's drugs are covered under state Medicaid programs (CMS, 2025). Some drugs or classes of drugs may be excluded from coverage under the MDRP, including drugs used for weight loss.[3] This means that states can decide whether to include coverage for obesity drugs in their Medicaid program. As of January 2026, 13 states covered GLP-1s for obesity treatment under their Medicaid programs, not including California (Williams, 2026).

Medicare

Medicare beneficiaries enrolled in Part D prescription drug plans or Medicare Advantage may have coverage to GLP-1s for weight loss through the Centers for Medicare and Medicaid Services (CMS) Better Approaches to Lifestyle and Nutrition for Comprehensive hEalth (BALANCE) Model (beginning January 2027) and a short-term demonstration "Medicare GLP-1 Bridge" (beginning July 2026) (CMS, 2026). Medicare Part D plans must apply to CMS in order to participate in the BALANCE Model. Participation in the BALANCE Model is optional for group retiree health plans, such as CalPERS. As of April 2026, CMS has defined a specified market wide enrollment threshold of 80% for implementation of the BALANCE program. If enrollment threshold is not obtained, the program will not be implemented.

[2] California Health Benefits Review Program (CHBRP). (2026). *Analysis of California Senate Bill 1089 Preventive Treatment Health Care Act.* Berkeley, CA.
[3] 42 U.S. Code § 1396r–8 - Payment for covered outpatient drugs.

Background on 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. The adult obese category can be further delineated into three categories (CDC, 2024a):

- Class 1: BMI of 30 to <35
- Class 2: BMI of 35 to <40
- Class 3: BMI of 40 or higher

In children, BMI categories to define overweight and obesity are defined based on sex-specific BMI-for-age percentiles. The BMI categories for children and teens aged 2 to 19 years are provided below (CDC, 2024b):

- Underweight: BMI in <5th percentile
- Healthy weight: BMI in 5th-<85th percentile
- Overweight: BMI in 85th percentile – <95th percentile
- Obesity: BMI in 95th percentile or greater
- Severe obesity: BMI in 120% of the 95th percentile or greater, or 35 kg/m^2 or greater

Within the CalPERS commercial (Basic) population, approximately 24% of enrollees have obesity and 22% of enrollees have BMIs between 27 and <30.[4] While more detailed information is not available about CalPERS enrollees, Table 1 describes the prevalence of overweight and obesity in the privately insured population in California by age. Data in Table 1 show patterns in overweight and obesity by age, with rates increasing with age.

Table 1. Prevalence of Overweight and Obesity in California's Privately Insured Population by Age, 2024

Age, Years	Overweight, % (a) (BMI 25.0 to <30)	Obese, % (BMI ≥30)
12-17 (b)	16.8	15.2
18-24	25.1	22.3
25-39	31.6	27.6
40-64	34.5	32.2
18-64 (c)	33.0	27.8

Source: California Health Benefits Review Program, 2026, analysis of the 2024 California Health Interview Survey Data.

Notes: Analysis was limited to respondents with employment-based and privately purchased health insurance.
(a) A proportion of those who have BMIs between 27 and 29.9 would also be eligible for obesity treatments if they have additional comorbidities. This has been estimated to be 7% of the privately insured non-elderly adult population (McGough et. al., 2024).
(b) Overweight for children under age 18 years is defined as having a BMI between the 85th and 95th percentile, whereas obesity is defined as having a BMI in the 95th percentile or above (CDC, 2024b). Estimates for teens (aged 12-17 years) are presented because the data source did not include information on obesity rates for children aged 0 to 12 years.
(c) In addition, rates for adults >65 years are not presented because the vast majority of that population is enrolled in Medicare and thus not enrolled in health insurance subject to SB 1089.
Key: BMI = body mass index.

[4] Personal communication with CalPERS, April 6, 2026.

In addition, approximately 7% of the non-elderly adult population with private health insurance have BMIs ≥27 and <30 and also have comorbidities (McGough et. al., 2024). Within CalPERS, approximately 10.5% of all enrollees, regardless of BMI, have hypertension, 7% have diabetes, and 5.5% have high cholesterol (Albers and Logan, 2023). Among Californians with private insurance who have BMIs between 27 and 30, 12.3% have ever been diagnosed with diabetes, 7.2% have heart disease and 10.9% have ever been diagnosed with high blood pressure (Table 2).

Table 2. Prevalence of Diabetes, Heart Disease, and High Blood Pressure Among Overweight and Obese Adults Aged 18–64 Years in California's Privately Insured Population, 2024

	Overweight, %* (BMI 27 to <30)	Obese, % (BMI ≥30)
Ever diagnosed with diabetes	12.3	19.8
Has heart disease	7.2	8.1
Blood pressure not under control in the past year	10.9	14.5

Source: California Health Benefits Review Program, 2026, analysis of the 2024 California Health Interview Survey (CHIS) Data.
Analysis is limited to respondents with employment-based and privately purchased health insurance.
Note: * A proportion of those who have BMIs between 27 and 29.9 would also be eligible for obesity treatments if they have additional comorbidities. This has been estimated to be 7% of the total, non-elderly adult population with private insurance (McGough et. al., 2024).
Key: BMI = body mass index.

Treatments for Obesity Weight Management

Drugs With FDA Indication for Chronic Weight Management

There are two main types of drugs approved by the U.S. Food and Drug Administration (FDA) with an indication for chronic weight management – known as anti-obesity medications (AOMs): glucagon-like peptide 1 (GLP-1) receptor agonists and non–GLP-1s. SB 1089 would only require coverage of GLP-1 medications. GLP-1 medications were first discovered in 1984 and initially approved by the FDA in 2005 for the treatment of type 2 diabetes.[5] In 2014, the FDA approved Saxenda (liraglutide) as the first GLP-1 medication specifically indicated for weight management. As of April 2026, there are seven different FDA-approved GLP-1 medications of which four are FDA-approved specifically for the treatment of obesity. GLP-1 medications also have other 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). Table 3 displays the GLP-1 medications that are FDA-approved for chronic weight management and therefore relevant to SB 1089. These medications are all available as subcutaneous injections, and the frequency varies between daily and weekly. In 2025, the FDA approved a daily oral formulation of semaglutide, and in April 2026, a second oral formulation, orforglipron, was approved; new GLP-1 medications are likely to be available in the near future. The drug name, brand name, year of FDA approval, mode of administration, and population for which the drug is approved are also presented in the table.

[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).

Table 3. FDA-Approved GLP-1 Medications for Weight Management Relevant to SB 1089, as of April 2026

Drug (Brand Name)	FDA Approval Year and Population	Frequency/Mode of Administration	Population Approved/ Indicated For
Liraglutide (Saxenda)	2014 adults 2020 aged 12+ years	Daily, subcutaneous	Adults with BMI of ≥30 kg/m^2 or ≥27 kg/m^2 with comorbid condition (e.g., hypertension, type 2 diabetes mellitus, or dyslipidemia). 12+ years with body weight above 60 kg and an initial BMI corresponding to 30 kg/m^2 for adults by international cut-offs.
Semaglutide (Wegovy)	2021 adults 2023 aged 12+ years 2025 oral administration	Weekly, subcutaneous, gradually increase dose every 4 weeks. Daily, orally, gradually increase dose every 30 days	Adults with BMI ≥30 kg/m^2 or ≥27 kg/m^2 in the presence of comorbid condition. 12+ years with BMI at the 95th percentile or greater standardized for age and sex.
Tirzepatide (Zepbound)*	2023 adults	Weekly, subcutaneous	Adults with BMI ≥30 kg/m^2 or ≥27 kg/m^2 with comorbid condition.
Orforglipron (Foundayo)	2026 adults	Daily, oral	Adults with BMI ≥30 kg/m^2 or ≥27 kg/m^2 with comorbid condition.

Source: California Health Benefits Review Program, 2026; FDA, 2025a.
Note: * Tirzepatide (Zepbound) is a dual glucose-dependent insulinotropic polypeptide (GIP)/GLP-1.
Key: BMI = body mass index; FDA = U.S. Food and Drug Administration; GLP-1 = glucagon-like peptide-1.

GLP-1s work by activating GLP-1 receptors in the body, which slows down how quickly food moves through the body and increases the sensation of fullness for longer (Ard et al., 2021).

A recent poll found that 18% of U.S. adults have used a GLP-1 medication, with 12% currently taking one (an increase of 6% from 2024) (Montero et al., 2025). Among those who have ever used GLP-1s, 38% took them for chronic conditions such as diabetes or heart disease, whereas 30% used them primarily for weight loss, and 32% used them to both lose weight and to treat a chronic condition (Montero et al., 2025). Specifically, among those who had ever used GLP-1s, approximately 57% had ever been diagnosed with diabetes, 40% had ever been diagnosed with heart disease, and 34% are overweight or obese (Montero et al., 2025).

Most adults obtained GLP-1s from their primary care doctor or a specialist (75%), while 17% obtained GLP-1s from an online provider or website, and 9% obtained GLP-1s from a medical spa or aesthetic medical center (Montero et al., 2025).

Distribution of GLP-1s and the role of compounding pharmacies

Compounding pharmacies are a specialized type of pharmacy that combines, mixes, or alters ingredients of a drug to create a medication that is tailored to specific patient needs (FDA, 2024). Compounding pharmacies do not make FDA approved products, but they are permitted to replicate commercially available drugs when the active ingredients are listed on the FDA's drug shortage list (NCSL, 2024). Three GLP-1 medications FDA-approved to treat obesity (liraglutide, semaglutide, and tirzepatide) were previously on the FDA's drug shortage list, but as of March 2025, these shortages were deemed resolved by the FDA (FDA, 2025b). As a result, compounding pharmacies have been asked to stop producing and selling these drugs (FDA, 2025b).

Clinical practice guidelines for adults

In 2018, the United States Preventive Services Task Force (USPSTF) recommended that clinicians promote behavioral interventions as the primary intervention for weight management in adults (USPSTF, 2018). Multiple additional studies of weight management drugs have been published since the USPSTF systematic review was published in 2018 recommending behavioral interventions as the first line of therapy. The 2022 American Gastroenterological Association *Clinical Practice Guidelines on Pharmacological Interventions for Adults With Obesity* recommends the use of pharmacotherapy in addition to lifestyle modifications in adults with overweight or obesity who have inadequate response to lifestyle interventions (Grunvald et al., 2022). In addition, this guideline recommends that semaglutide 2.4 mg be prioritized over other AOMs, though the guideline was published before tirzepatide was approved by the FDA.

Guidance on weight management drugs for children and adolescents

In 2023, the American Academy of Pediatrics issued a clinical practice guideline regarding weight management drugs for children and adolescents with obesity that states "Pediatricians and other pediatric health care providers should offer adolescents 12 years and older with obesity (BMI ≥ 95th percentile) weight loss pharmacotherapy, according to medication indications, risks, and benefits, as an adjunct to health behavior and lifestyle treatment" (Hampl et al., 2023).

Other Treatments for Weight Loss

Beyond anti-obesity medications, treatment options include bariatric surgery and intensive behavioral therapy (IBT).

Five surgical procedures are used to treat obesity: sleeve gastrectomy, Roux-en-Y gastric bypass (RYGB), adjustable gastric band (AGB), biliopancreatic diversion with duodenal switch (BPD/DS), and single anastomosis duodena-ileal bypass with sleeve gastrectomy (SADI-S). These procedures work by reducing stomach size, limiting food intake, and in some cases decreasing nutrient absorption and altering hunger-related hormones (Eisenberg et al., 2023). Current guidelines recommend bariatric surgery for adults with a BMI ≥35 (regardless of comorbidities) and consider it for those with BMI 30 to 34.9 with metabolic disease.

IBT is a structured, multicomponent lifestyle intervention lasting 1 to 2 years, typically involving at least 12 sessions in the first year (USPSTF, 2018). It focuses on achieving and maintaining at least 5% weight loss through dietary changes, increased physical activity, self-monitoring, problem-solving, peer support, and relapse prevention. IBT is recommended for adults with BMI ≥30.

Disparities[7] in Obesity Prevalence and Treatment

Disparities are noticeable and preventable or modifiable differences between groups of people. Health insurance benefit mandates or related legislation may impact disparities. Where intersections between health insurance benefit mandates and social drivers or systemic factors exist, CHBRP describes relevant literature. CHBRP found literature identifying disparities by race/ethnicity, income, and geography.

Table 4 demonstrates patterns in overweight and obesity by key demographics among California adults. Obesity rates are lowest among those with the highest incomes and educational attainment. 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%), with Black adults (37.1%), Latino adults (39.4%), and American Indian/Alaska Native adults (45.6%) all reporting the highest rates. In addition, adults residing in urban locations reported lower rates of obesity compared to adults residing in rural locations. Finally, rates of obesity did not vary significantly by gender or sexual orientation.

[7] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population. (Wyatt et al., 2016).

Table 4. Prevalence of Overweight and Obesity Among California Adults (18–64 Years) by Key Demographic Characteristics, 2024

Demographic Characteristic	Overweight, % (a, b) (BMI 25.0 – <30)	Obese, % (BMI ≥30)
Race/ethnicity		
American Indian/Alaska Native	26.1	45.6
Asian	27.9	11.1
Black	35.1	37.1
Latino	35.4	39.4
White	33.5	24.8
Gender[8]		
Female	28.0	29.6
Male	38.4	26.0
Transgender or gender nonconforming	19.9	33.9
Sexual orientation		
Straight/heterosexual	33.4	27.8
Gay, lesbian, bisexual, asexual	29.4	29.0
Federal poverty level		
0%-99%	30.7	34.8
100%-199%	31.9	34.3
200%-299%	33.2	33.7
300%+	33.9	23.0
Location of residence		
Urban	32.9	27.6
Rural	34.0	30.4
Education		
<High school	34.5	35.0
High school graduate	30.5	34.5
Some college/vocational school	32.8	32.8
College graduate	33.9	20.3

Source: California Health Benefits Review Program, 2026, analysis of 2024 California Health Interview Survey (CHIS) Data.
Notes: (a) A proportion of those who have BMIs between 27 and 29.9 would also be eligible for obesity treatments if they have additional comorbidities. This has been estimated to be 7% of the privately insured non-elderly adult population (McGough et. al., 2024).
(b) Overweight for children under age 18 years is defined as having a BMI between the 85th and 95th percentile, whereas obesity is defined as having a BMI in the 95th percentile or above (NIH, 2022).
Key: BMI = body mass index.

[8] CHBRP uses the NIH distinction between "sex" and "gender": "'Sex' refers to biological differences between females and males, including chromosomes, sex organs, and endogenous hormonal profiles. 'Gender' refers to socially constructed and enacted roles and behaviors which occur in a historical and cultural context and vary across societies and over time." (NIH, 2019).

Barriers to Accessing Obesity Treatments

It is estimated that only 10% of those with obesity seek help from a professional to lose weight, with approximately 6.4% consulting a non-physician health professional (dietician, personal trainer, etc.) and 3.6% consulting a physician (Stokes et al., 2018). A recent study found that approximately 7% of patients who saw a primary care provider and had a BMI of 30 or more received a recommended weight management treatment option (Henderson, et al., 2024). Although not everyone with obesity is diagnosed and attempts to seek treatments, among those who do, there are still many factors that serve as barriers to accessing treatments 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). Furthermore, concerns about the unintentional stigmatization of patients and maintaining the patient–provider relationship may further contribute to reluctance among providers to address obesity as an issue (Mekonnen et al., 2024).
- **Racism and discrimination**: People of color have higher rates of obesity. This is in part because they are more likely to live in neighborhoods with obesogenic food environments (Washington et al., 2023). Black and Latino adults are also more likely to develop an obesity-related disease such as high blood pressure, heart attack, and stroke (Washington et al., 2023). In addition to there being 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-1s 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:** Rates of obesity are higher among rural adults (31.0%) compared to urban adults (25.2%). In addition, the concentration of obesity medicine specialists in more urban and suburban areas makes it more difficult for adults diagnosed with obesity in rural areas to access care. 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 further away from major surgery centers. It is estimated that the travel time to an obesity medicine specialist is almost five times as long for adults in rural areas compared to adults in urban areas (43 vs. 9 minutes) (Washington et al., 2023). Among CalPERS enrollees, 8.3% live in rural areas, 64% live in suburban areas, and 27.7% live in urban areas. More enrollees in CalPERS PPO products live in rural areas compared with enrollees in CalPERS 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). As shown in Table 4, those in the highest income group (>300% FPL) have much lower rates of obesity than those in the lower income groups. This is in part because people with lower incomes are more likely to find it challenging to address lifestyle factors contributing to obesity such as a lack of time and money to dedicate to healthy meal preparation and exercise, a higher likelihood of living in a built environment that is not conducive to eating healthy and exercising, and a higher likelihood of experiencing stress (Washington et al., 2023). More than half (56%) of those who have taken GLP-1 drugs found them difficult to afford, even with insurance covering part of the expense (Montero et al., 2025).

Societal Impact of Obesity in the United States and California

The treatment of obesity-related diseases places a large economic burden on society. In a report by the Milken Institute, researchers estimated that the total economic costs attributed to overweight and obesity in the United States exceeded $1.72 trillion – comprising $480.7 billion in direct health care costs due to diseases caused by overweight and obesity, and an additional $1.24 trillion in indirect costs due to lost productivity in 2016 (Waters and Graf, 2018). Translated into 2025

dollars,[9] the total direct and indirect costs related to overweight and obesity equate to $2.3 trillion per year in the United States.

When evaluating direct medical care costs attributed to obesity in the United States, Cawley et al. (2021) found that the annual average medical expenditures for adults with obesity ($5,010) were approximately twice as high at those incurred by adults with normal weight ($2,504). In addition, obesity increased costs within every level of medical care (i.e., inpatient, outpatient, and medications). Furthermore, Cawley et al. (2021) found that as the class of obesity increased (Class 1, 2, and 3), so did the amount of annual medical expenditures. Relative to those with normal weight (BMI 18.5 to $\leq$25), additional medical expenditures increased by 68.4% (or $1,713) among those with class 1 obesity, by 120% (or $3,005) among those with class 2 obesity, and by 233.6% (or $5,850) among those with class 3 obesity, respectively.

Within California, Cawley et al. (2021) estimated the total annual medical expenditure related to adult obesity (i.e., BMI $\geq$30). In 2016, the total annual medical care expenditures (i.e., direct costs comprised of public and private health insurance expenditures as well as out-of-pocket costs) due to obesity in California was equal to $5.3 billion (Cawley et al., 2021). Translated into 2025 dollars, the total medical expenditures attributed to obesity in California is equal to $7.1 billion.

[9] Translated into 2025 dollars using https://www.usinflationcalculator.com/.

Medical Effectiveness

CHBRP previously conducted a literature review on AOMs for the analyses of AB 575 and SB 535 in 2025. The following information is from those analyses, with updates where necessary. Please see the analyses of AB 575 and SB 535 for complete information.[10] 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).

Research Approach and Methods

A total of 24 studies were included in the medical effectiveness review for this report. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in CHBRP's Medical Effectiveness Analysis and Research Approach document.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.[11] Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

1. In adults and adolescents with obesity, what is the effect of FDA-approved GLP-1 medications on a reduction in the incidence of adult and adolescent obesity compared with no intervention or in conjunction with another treatment?
2. What is the effect of FDA-approved GLP-1 medications on additional associated health outcomes in adults and adolescents with obesity compared with no intervention or in conjunction with another treatment?
3. What are the harms of FDA-approved GLP-1 medications for adults and adolescents with obesity compared with no intervention or in conjunction with another treatment?

Methodological Considerations

CHBRP limited its review of literature on GLP-1 medications to medications that the FDA has approved for weight management because SB 1089 would only require coverage medications that are specifically FDA-approved for chronic weight management. In some cases, the FDA-approved GLP-1 medications were compared to placebo. In other cases, the FDA-approved GLP-1 medications were provided in conjunction with lifestyle intervention or another intervention and were compared with placebo plus lifestyle intervention or another intervention.

Outcomes Assessed

Primary outcomes assessed included: change in body weight; percent weight loss; weight reduction of 5%,[12] 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 (SBP) and diastolic blood pressure (DBP). CHBRP also reviewed literature on harms of FDA-approved GLP-1 medications.

[10] All completed analyses are available on CHBRP's website.
11 Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. See CHBRP's website for more information.
[12] The U.S. Food and Drug Administration considers a weight loss of 5% as clinically important (LeBlanc et al., 2018).

Study Findings

This following section summarizes CHBRP's findings regarding the strength of evidence for the effectiveness of FDA-approved GLP-1 medications indicated for chronic weight management. Each section is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms are included in the box below.

The following terms are used to characterize the body of evidence regarding an outcome:

Very strong evidence (formerly called *clear and convincing 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.

Strong evidence (formerly called *preponderance of 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.

Some evidence (formerly called *limited evidence*) indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.

Conflicting evidence (formerly called *inconclusive evidence*) indicates that of the studies of equal quality, the number suggesting the treatment is effective is similar to the number of those suggesting the treatment is not effective.

Not enough research (formerly called *insufficient evidence*) indicates that (1) there are no studies of the treatment **or** (2) the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. *Not enough research* does not indicate that a treatment is not effective.

Effectiveness of GLP-1 Medications for Weight Management for Adults

Liraglutide 3.0 mg (Saxenda)

One randomized controlled trial (RCT) of adults with overweight or obesity and symptomatic knee osteoarthritis found that liraglutide led to significantly greater reductions in body weight and waist circumference compared to placebo, with significantly higher proportions of liraglutide participants achieving ≥5% weight loss (Gudbergsen et al., 2021).

Two studies of adults with overweight or obesity reported that liraglutide resulted in significantly greater percent body weight loss and higher proportions of participants achieving ≥5% and ≥10% weight loss compared to control treatments (Atlas et al., 2022; Shi et al., 2024).

Semaglutide (Wegovy)

Three RCTs found significantly greater reductions in percent body weight with injectable semaglutide compared to control treatments among adults with overweight or obesity (Shi et al., 2024, Wharton et al., 2025a) and adults with obesity-related heart failure and type 2 diabetes (Kosiborod et al., 2024). One RCT found that treatment with oral semaglutide also results in substantial weight loss compared to placebo (Wharton et al., 2025b).

Three RCTs reported significantly greater reductions in body weight and waist circumference with semaglutide compared to control treatments among adults with overweight or obesity and type 2 diabetes (Davies et al., 2021), pre-existing cardiovascular disease but no diabetes (Lincoff et al., 2023), or prediabetes (McGowan et al., 2024).

One systematic review and meta-analysis found significantly greater reductions in percent body weight, absolute body weight, BMI, and waist circumference with semaglutide compared to placebo in adults with overweight or obesity without diabetes (Qin et al., 2024).

Significantly higher proportions of semaglutide participants achieved ≥5% and ≥10% weight loss (Davies et al., 2021; McGowan et al., 2024; Qin et al., 2024; Shi et al., 2024), ≥15% weight loss (Davies et al., 2021; McGowan et al., 2024; Qin et al., 2024), and ≥20% weight loss (McGowan et al., 2024; Qin et al., 2024) compared to control group participants. Weight loss varied by dose, with semaglutide 7.2 mg resulting in greater mean weight loss than semaglutide 2.4 mg (Wharton.et al., 2025a).

Tirzepatide (Zepbound)

One RCT and one systematic review/meta-analysis reported that tirzepatide (5 mg, 10 mg, and 15 mg) led to significantly greater reductions in percent body weight (Jastreboff et al., 2022; Liu et al., 2024) as well as BMI and waist circumference (Liu et al., 2024) than control treatments.

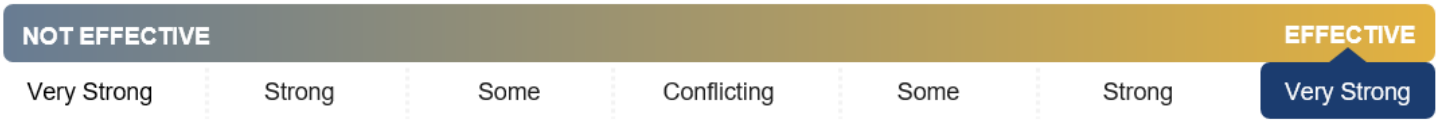
Significantly greater proportions of participants achieved ≥5% weight loss for all tirzepatide dosages, and significantly more participants in the 10 mg and 15 mg groups achieved ≥20% weight loss (Jastreboff et al., 2022). Significantly higher proportions of tirzepatide participants achieved ≥5%, ≥10%, ≥15%, ≥20%, and ≥25% weight loss versus placebo (Liu et al., 2024).

Orforglipron (Foundayo)

One RCT reported that orforglipron (6 mg, 12 mg, and 36 mg) led to mean decrease in body weight of 9% compared with placebo, and that more than half of participants had a weight reduction of greater than 10% (Wharton et al., 2025c). Treatment also led to improvements in blood pressure, lipids, and waist circumference compared to placebo.

There is *very strong evidence* based on 11 RCTs and 2 meta-analyses that FDA-approved GLP-1 medications (liraglutide, semaglutide, tirzepatide, orforglipron) for chronic weight management are effective when used as adjuncts to usual care (which includes standard diet and activity and lifestyle recommendations) for adults. 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%.

Figure 1. Level of Evidence of Effectiveness of FDA-Approved GLP-1 Medications for Weight Management for Adults



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

Liraglutide 3.0 mg (Saxenda)

One RCT reported a statistically significant difference in reduction in BMI of at least 5% for children with obesity ages 6 to <12 years taking liraglutide plus lifestyle intervention, compared with participants taking a placebo plus lifestyle intervention (Fox et al., 2025).

Another RCT reported statistically significant differences in reduction of BMI and body weight for participants taking liraglutide plus lifestyle intervention compared with placebo plus lifestyle intervention for adolescents ages 12 to <18 years (Kelly et al., 2020).

Semaglutide 2.4 mg (Wegovy)

One RCT reported significantly greater BMI reduction and a significantly higher likelihood of achieving ≥5% weight loss with semaglutide compared to placebo among adolescents aged 12 to 18 years with obesity or with overweight and at least one weight-related coexisting condition (Weghuber et al., 2022).

A post hoc analysis of the aforementioned Weghuber et al. (2022) trial found that semaglutide participants were significantly more likely to be reclassified to a normal-weight or overweight BMI category and had significantly higher odds of achieving an improvement of at least one BMI category (Kelly et al., 2023).

Tirzepatide (Zepbound)

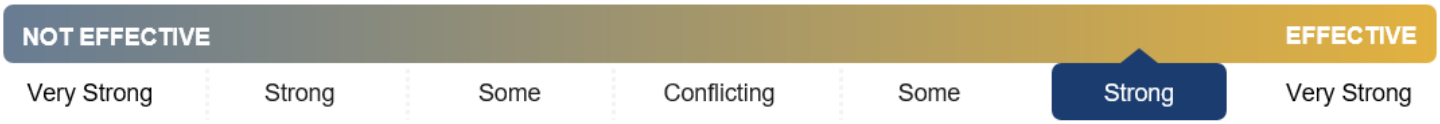
Tirzepatide is not approved for use in children and adolescents.

Orforglipron (Foundayo)

Orforglipron is not approved for use in children and adolescents.

There is *strong evidence*[13] based on four RCTs that GLP-1s improve weight loss in children and adolescents.[14,15] For liraglutide, one study in adolescents and one study in children found statistically significant reductions in BMI, compared to placebo. 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 2. Level of Evidence of Effectiveness of FDA-Approved GLP-1 Medications for Weight Management for Children and Adolescents



Drug-to-Drug Comparison of FDA-Approved GLP-1 Medications for Weight Management

In a network meta-analysis of five RCTs[16] (N = 11,414) involving adults with overweight or obesity without diabetes, Alkhezi et al. (2023) found that tirzepatide 10 mg and 15 mg, semaglutide 2.4 mg, and liraglutide 3.0 mg were associated with significantly more weight loss and significantly greater proportions of participants with ≥5%, ≥10%, ≥15%, and ≥20% weight loss than placebo (except liraglutide for the ≥15% and ≥20% comparisons). Tirzepatide 15 mg resulted in significantly greater percentage weight loss than semaglutide and liraglutide, whereas semaglutide yielded significantly greater weight loss than liraglutide. Tirzepatide 10 mg and 15 mg and semaglutide had significantly higher odds of achieving ≥5% to 20% weight loss than liraglutide. In a head-to-head trial, treatment with tirzepatide resulted in almost 7% greater weight loss compared with injectable semaglutide (Aronne et al., 2025).

[13] *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.
[14] As of March 2026, two GLP-1s are approved for use in adolescents ages 12 years or older.
[15] Based on recently identified studies, CHBRP changed the level of evidence from *conflicting evidence*, as shown in previous CHBRP analyses.
[16] One RCT employed lifestyle counseling in addition to both the GLP-1 and placebo treatments, three RCTs employed lifestyle modification, and one RCT employed IBT plus a low-calorie diet.

Impact of FDA-Approved GLP-1 Medications for Weight Management on Other Health Outcomes

Quality of life and physical functioning outcomes for GLP-1 medications

Liraglutide 3.0 mg (Saxenda)

Liraglutide was associated with greater improvements in health status (Atlas et al., 2022), functional outcomes (Jobanputra et al., 2023), and health-related quality of life (Shi et al., 2024) compared to control treatments among adults with overweight or obesity. One study found no significant difference in knee pain relief (Gudbergsen et al., 2021), and one study found no significant difference in depression symptom scores (Shi et al., 2024) between liraglutide and control treatments. Among adolescents, there was no significant difference in weight-related quality of life (Kelly et al., 2020).

Semaglutide 2.4 mg (Wegovy)

Among adults with overweight or obesity, semaglutide was associated with greater improvements in functional outcomes (Davies et al., 2021; Jobanputra et al., 2023; Kosiborod et al., 2024), health status (Lincoff et al., 2023), and health-related quality of life (Qin et al., 2024; Shi et al., 2024) compared to control treatments.

Among adolescents with overweight or obesity, semaglutide was associated with significant improvements in weight-related quality of life overall and in the physical comfort domain of the Impact of Weight on Quality of Life (IWQOL) – Kids questionnaire. There were no significant differences between semaglutide and the control treatment in regard to the body esteem, social life, or family relations domains of the questionnaire (Weghuber et al., 2022).

Tirzepatide (Zepbound)

Tirzepatide was associated with significantly greater improvements in physical functioning (Jastreboff et al., 2022; Liu et al., 2024) and quality of life (Liu et al., 2024) compared to control treatments among adults with overweight or obesity.

Orforglipron (Foundayo)

Orforglipron was associated with statistically significant improvements in cardiometabolic markers such as waist circumference, systolic blood pressure, and cholesterol levels compared to placebo (Wharton et al., 2025c).

Type 2 diabetes risk assessment outcomes for GLP-1 medications

Assessing fasting plasma glucose (FPG) levels (which provide a snapshot of blood sugar at a specific point in time), blood glucose levels, fasting serum insulin levels (which measures insulin levels in the bloodstream), and dyslipidemia (an abnormal distribution of lipids within the bloodstream), aid in the diagnosis of diabetes (Nichols et al., 2008; Schofield et al., 2016).

Liraglutide 3.0 mg (Saxenda)

Among adults with overweight or obesity, six trials indicated greater improvements in blood glucose with liraglutide compared to control treatments. Only three of five trials identified benefits to low-density lipoprotein cholesterol with liraglutide (Atlas et al., 2022).

Semaglutide 2.4 mg (Wegovy)

Among adults with overweight or obesity, semaglutide was associated with greater improvements in FPG levels, fasting serum insulin levels, and lipid profile measures[17] compared to control treatments (Davies et al., 2021; Lincoff et al., 2023; McGowan et al., 2024; Qin et al., 2024; Wadden et al., 2021) and greater improvements in cardiometabolic factors

[17] Lipid profile comprises total cholesterol, high-density lipoprotein cholesterol, low-density lipoprotein cholesterol, very low-density lipoprotein cholesterol, free fatty acids, and triglycerides.

(Wilkinson et al., 2023). A significantly greater proportion of participants with obesity and prediabetes returned to normoglycemia at week 52 with semaglutide control to the control treatment (McGowan et al., 2024).

Among adolescents ages 12 to <18 years, semaglutide resulted in statistically significant reductions in total cholesterol, low-density lipoprotein cholesterol, very-low-density lipoprotein cholesterol, and triglycerides (Weghuber et al., 2022).

Tirzepatide (Zepbound)

Tirzepatide for adults with overweight or obesity was associated with significant improvements in fasting insulin and lipid levels, and higher likelihood of returning to normoglycemia (Jastreboff et al., 2022).

Orforglipron (Foundayo)

Treatment with orforglipron for adults with overweight or obesity resulted in improvements in fasting glucose and fasting insulin. The majority of patients (74.6 to 83.7%) who had prediabetes had returned to normoglycemia at the end of the trial (Wharton et al., 2025c).

Hemoglobin A1c outcomes for GLP-1 medications

The hemoglobin A1c (also known as glycated hemoglobin, glycosylated hemoglobin, HbA1c, or A1c) test measures a person's average level of blood sugar (glucose) over the past 90 days. Higher HbA1c levels suggest poor blood sugar control and increased risk of diabetes-related complications, which contributes to obesity (Eyth and Naik, 2023).

Liraglutide 3.0 mg (Saxenda)

Liraglutide was associated with greater improvements in HbA1c compared to control treatments among adults with overweight or obesity (Alkhezi et al., 2023; Atlas et al., 2022). Among children ages 6 to 12 years (Fox et al., 2025) and adolescents ages 12 to <18 years (Kelly et al., 2020), liraglutide did not result in statistically significant improvements in HbA1c compared with placebo.

Semaglutide 2.4 mg (Wegovy)

Among adults with overweight or obesity, semaglutide was associated with significantly greater reductions in HbA1c (Alkhezi et al., 2023; Davies et al., 2021; McGowan et al., 2024; Qin et al., 2024) and significantly greater improvements in glycated hemoglobin (Lincoff et al., 2023; Wadden et al., 2021) compared to control treatments. In adolescents ages 12 to <18 years, semaglutide was associated with greater reductions in HbA1c compared with placebo (Weghuber et al., 2022).

Tirzepatide (Zepbound)

Tirzepatide was associated with significant reductions in HbA1c compared to control treatments among adults with overweight or obesity (Alkhezi et al., 2023; Liu et al., 2024).

Orforglipron (Foundayo)

In adults with overweight or obesity, treatment with orforglipron resulted around a 0.3% decrease in HbA1c (Wharton et al., 2025c).

Blood pressure outcomes for GLP-1 medications

Systolic blood pressure (SBP) measures the pressure in the circulatory system when the heart beats and pumps blood. Diastolic blood pressure (DBP) measures the pressure in the circulatory system when the heart is resting between beats. Obesity is a significant risk factor for hypertension (high blood pressure). Obesity-related hypertension is often a precursor for coronary artery disease, heart failure, and chronic kidney disease (Jung and Ihm, 2023).

Liraglutide 3.0 mg (Saxenda)

Liraglutide was associated with greater improvements in SBP compared to control treatments among adults with overweight or obesity (Atlas et al., 2022). Among children ages 6 to 12 years (Fox et al., 2025) and adolescents ages 12 to <18 years (Kelly et al., 2020), liraglutide did not result in statistically significant improvements in DBP and SBP compared with placebo.

Semaglutide 2.4 mg (Wegovy)

Semaglutide resulted in significant improvements in SBP (Davies et al., 2021; Lincoff et al., 2023; McGowan et al., 2024; Qin et al., 2024; Wadden et al., 2021) and DBP (Lincoff et al., 2023; Qin et al., 2024; Wadden et al., 2021) compared to control treatments among adults with overweight or obesity. In adolescents ages 12 to <18 years, semaglutide did not result in statistically significant reductions in DBP and SBP compared with placebo (Weghuber et al., 2022).

Tirzepatide (Zepbound)

Tirzepatide was linked to significant improvements in SBP and DBP compared to control treatments among adults with overweight or obesity (Jastreboff et al., 2022; Liu et al., 2024).

Orforglipron (Foundayo)

Treatment with orforglipron resulted in decreases of around 6 mm Hg of SBP and 2.5 mm Hg of DBP, compared with less than 1 mm Hg for the placebo group for both SBP and DBP (Wharton et al., 2025c).

C-reactive protein level outcomes for GLP-1 medications

C-reactive protein (CRP) levels are a marker of inflammation in the body. Higher BMI is associated with higher CRP concentrations, suggesting low-grade systemic inflammation in people with overweight or obesity. Elevated CRP levels in people with overweight or obesity are associated with increased risk for health issues such as cardiovascular disease, type 2 diabetes, and other inflammatory conditions (Visser et al., 1999).

Liraglutide 3.0 mg (Saxenda)

CRP levels significantly decreased with the combination of liraglutide and exercise, but not with placebo, exercise alone, or liraglutide alone (Sandsdal et al., 2023).

Semaglutide 2.4 mg (Wegovy)

Semaglutide was associated with significant improvements in CRP levels compared to control treatments (Davies et al., 2021; Lincoff et al., 2023; Qin et al., 2024; Wadden et al., 2021).

Orforglipron (Foundayo)

Orforglipron was associated with decreases in the high sensitivity CRP levels compared with placebo. (Wharton et al., 2025c).

Very strong evidence of improvement in health related quality of life, physical functioning, cardiometabolic health, blood pressure, and HbA1c with GLP-1s in adults.

In children and adolescents, there is *conflicting evidence* that GLP-1s have an impact on other health outcomes. There is *some evidence* that semaglutide improves health related quality of life, physical functioning, and cholesterol, and HbA1c levels. Conversely, there is *some 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 3. Level of Evidence of Effectiveness of FDA-Approved GLP-1 Medications on Other Health Outcomes for Adults

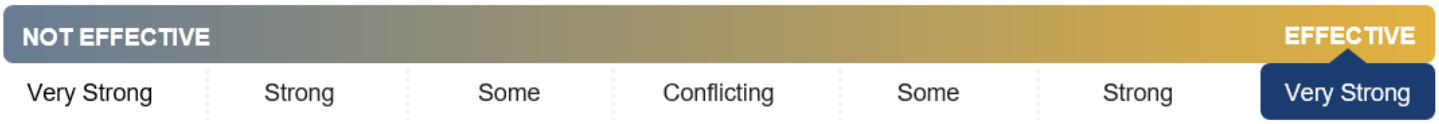


Figure 4. Level of Evidence of Effectiveness of FDA-Approved GLP-1 Medications on Other Health Outcomes for Children and Adolescents

Harms of GLP-1 Medications

Liraglutide 3.0 mg (Saxenda)

Harms of liraglutide in adults: Gastrointestinal adverse events (AEs) such as nausea, vomiting, indigestion, loss of appetite, constipation, and diarrhea were more commonly experienced by liraglutide groups than control groups (Alkhezi et al., 2023; Atlas et al., 2022; Gudbergsen et al., 2021; Shi et al., 2024). The odds of study withdrawal due to AEs were higher with liraglutide (Alkhezi et al., 2023; Shi et al., 2024). Liraglutide was also associated with higher rates of gallbladder-related and pancreatic AEs (Atlas et al., 2022).

A meta-analysis of 26 trials reported that GLP-1 treatments were associated with a significant increase in the risk of overall thyroid cancer compared to placebo; however, when isolating the meta-analysis to only include the six studies that involved liraglutide or semaglutide for the treatment of obesity in adults, the increased risk for overall thyroid cancer was not statistically significant (Silverii et al., 2024).

Harms of liraglutide in children and adolescents: Adverse events were similar for participants taking liraglutide and taking placebo (Fox et al., 2025; Kelly et al., 2020). Most events were mild or moderate in severity and resolved without long-term complications. The most common side effects were gastrointestinal disorders including nausea, vomiting, and diarrhea and were more common within the treatment group. Approximately 12% of participants ages 6 to 12 years taking liraglutide (seven participants) experienced serious adverse events, three of these events were considered to be possibly or probably linked to liraglutide (Fox et al., 2025). Among adolescents ages 12 to <18 years, serious adverse events were reported among three participants taking liraglutide and five participants taking the placebo.

Semaglutide 2.4 mg (Wegovy)

Harms of semaglutide in adults: The proportions of AEs (Qin et al., 2024; Wadden et al., 2021) and serious AEs (McGowan et al., 2024; Qin et al., 2024) were similar in both the semaglutide and control groups. Another study reported that serious AEs were more likely to be reported by the control group than the semaglutide group (Lincoff et al., 2023).

Semaglutide was more likely to cause gastrointestinal AEs such as nausea, vomiting, diarrhea, constipation, headache, loss of appetite, indigestion, and abdominal pain compared to control treatments (Alkhezi et al., 2023; McGowan et al., 2024; Qin et al., 2024; Shi et al., 2024; Wadden et al., 2021). Semaglutide had higher rates of AEs leading to discontinuation (Lincoff et al., 2023; Qin et al., 2024; McGowan et al., 2024; Shi et al., 2024).

Rates of cardiovascular disorders were significantly lower with semaglutide compared to control treatments (Qin et al., 2024). Semaglutide was the only GLP-1 associated with higher odds of causing headache and abdominal pain (Alkhezi et al., 2023).

A meta-analysis of 26 trials reported that GLP-1 treatments were associated with a significant increase in the risk of overall thyroid cancer compared to placebo; however, when isolating the meta-analysis to only include the six studies that involved liraglutide or semaglutide for the treatment of obesity in adults, the increased risk for overall thyroid cancer was not statistically significant (Silverii et al., 2024).

Harms of semaglutide in children and adolescents: The control group was more likely to report AEs than the semaglutide group; however, gastrointestinal AEs (primarily nausea, vomiting, and diarrhea) and serious AEs were more frequently reported by the semaglutide group (Weghuber et al., 2022).

Tirzepatide (Zepbound)

Harms of tirzepatide in adults: Tirzepatide participants were more like to report AEs (but not serious AEs) than control treatment participants – the most commonly reported AEs were gastrointestinal, and withdrawal rates due to AEs were higher with tirzepatide (Jastreboff et al., 2022; Liu et al., 2024). Tirzepatide was more likely to cause nausea, vomiting, and loss of appetite than placebo – tirzepatide 10 mg was significantly more likely to cause constipation and tirzepatide 15 mg was more likely to cause diarrhea and indigestion (Alkhezi et al., 2023).

Harms of tirzepatide in children and adolescents: Tirzepatide is not approved for use in children and adolescents.

Orforglipron (Foundayo)

Harms of orforglipron in adults: The most commonly reported AEs were gastrointestinal in nature, including nausea, constipation, diarrhea, vomiting, and dyspepsia. Most AEs were mild; treatment discontinuation due to gastrointestinal adverse events occurred in 3.5% to 7% of patients), Serious adverse events were few and occurred in around 4% to 5% of participants in the clinical trial. Of note, there were five cases of pancreatitis but no cases of medullary thyroid cancer during the clinical trial (Wharton et al., 2025c).

Harms of orforglipron in children and adolescents: Orforglipron is not approved for use in children and adolescents.

There is *very strong evidence* that, 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.

For children and adolescents, there is *very strong evidence* that gastrointestinal events such as nausea, vomiting, and diarrhea are common while serious events are rare.

Cost Impact Analysis: Data Sources, Caveats, and Assumptions

Key Uncertainties and Considerations

- The implementation of SB 1089 brings uncertainty in terms of decisions made to ensure consistency of coverage across CalPERS enrollees. It is possible that if required to cover GLP-1 medications for weight loss for one plan option, CalPERS may choose to uniformly offer GLP-1 medications to all plan options. The impact on premiums would be orders of magnitude higher if GLP-1 medications for weight loss were available for all plan options.
- CHBRP has assumed that SB 1089 would allow CalPERS to access Most Favored Nation pricing for the PERS Platinum PPO option. If such unit costs were not achieved, the impact on premiums would be orders of magnitude higher.
- The financial impact of SB 1089 also depends on the timing of implementation, communication with CalPERS enrollees, and individual decision making by enrollees who may choose to switch plans to obtain GLP-1 medication coverage for weight loss. As such, SB 1089 would change the premiums and risk profiles of all plan options. Furthermore, public entities participating in CalPERS have varied approaches towards contributing to overall premiums, and therefore, the impact on enrollee premiums would vary as well. Lastly, CalPERS open enrollment usually occurs in September and October for plan years beginning shortly thereafter. Therefore, an implementation date of January 1, 2027, may not be feasible if this legislation is signed in September 2026.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Administrative and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

State Health Care Spending Target

In 2024, in an effort to slow health care spending growth and improve health care affordability for California families, California's Office of Health Care Affordability (OHCA) under the Department of Health Care Access and Information approved a statewide target for maximum annual growth in health care spending for certain health care entities. The targets apply to per capita spending to specific entities, including health plans and insurers, provider organizations with at least 25 physicians, and hospitals (HCAI, 2022). The state is implementing this target with a phased-in approach, with a spending target of 3.5% for 2026, lowered to 3.2% in 2027 and 2028, and will be at 3% for 2029 and beyond (HCAI, 2025). Since health insurance benefit mandates may increase health care spending, such as increases to insurance premiums, administrative costs, and out-of-pocket costs, OHCA spending targets may be relevant considerations in benefit mandate policy decisions.

Postmandate Changes in the Number of Uninsured Persons

CHBRP assumes that if premiums increase by more than 1.7% in the small- or large-group market segments or 0.6% in the individual market, some enrollees will lapse their coverage. Because the change in average premiums does not exceed 1.7% in the small- or large-group market segments or 0.6% in the individual market (see Table 3, Table 5, and Table 6 in the Analysis of SB 1089), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 1089.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

At baseline, CalPERS enrollees without coverage for GLP-1 anti-obesity medications who wish to use them must pay the full cost out of pocket (estimated at $274/month for self-pay). An estimated 9,237 enrollees do so at baseline, representing $30,371,000 in annual out-of-pocket spending. Postmandate, these enrollees would shift to covered benefits with a $20 copay, transferring the cost from enrollee self-pay to plan-covered benefits (and thus to premiums shared by all enrollees and the CalPERS employer contribution).

Cost Impact Analysis: Data Sources, Caveats, and Assumptions

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc., the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[18] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses, are available on CHBRP's website.[19]

This section describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Baseline coverage was determined by market research on CalPERS plan formularies. No carrier survey was conducted, as CalPERS coverage status for GLP-1 anti-obesity medications was already known.

Health Cost Guidelines

The Health Cost Guidelines (HCGs) are a health care pricing tool used by actuaries in many of the major health plans in the United States. The HCGs provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. It is likely that these organizations use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, we believe the HCG-based values are also good estimates of the premium impact as estimated by the HMOs and insurance companies.

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.
- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing EHBs and mandated benefits, experience rating, and individual and small group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures – inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.

[18] CHBRP's authorizing statute requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[19] See CHBRP's Cost Impact Analysis landing page; in particular, see *Cost Impact Analyses: Data Sources, Caveats, and Assumptions*.

- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.
- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.
- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.
- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.

GLP-1 Medications and Estimated 2027 Utilization

CHBRP identified SAXENDA, WEGOVY (injectable and oral), and ZEPBOUND as the GLP-1 medications approved for weight loss as of March 2026 that may be covered under SB 1089. At baseline, utilization also includes compounded GLP-1 medications.

CHBRP's typical data source does not contain information related to whether GLP-1 medications are on a health plan's formulary. CHBRP estimated utilization as follows:

- CHBRP estimated that in any given month 11.5% of enrollees with obesity and full coverage by their health plan would use these medications in 2027 based on internal Milliman research. The results of this research also estimate GLP-1 utilization rates in the distant future (Rogers et al., 2025). These figures were assessed for reasonableness by comparing December 2025 utilization rates from Milliman's MyRxConsultant. The comparison was for national self-insured employers covering GLP-1s for weight loss.

- CHBRP estimates that 3.9% of individuals with obesity and without coverage would self-pay for these medications premandate. This information is based upon CHBRP's interpretation of the 2024 KFF Survey (Montero et al., 2024). This is also consistent with CHBRP's analysis of AB 575 where CHBRP assumed that the proportion of obese individuals purchasing GLP-1s for weight loss through self-pay was 25% that of full coverage.

- Estimated utilization is consistent with high observed trends for these medications and an assumption that supply chain issues are and remain fully resolved at baseline.

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable. Prior CHBRP analyses of obesity treatment bills included changes in cost-sharing parity and differences in prescription drug coverage. Other mandates focused on changes in cost due only to changes in coverage and did not assume that all plans would cover other non-GLP-1RA anti-obesity medications. The methodology and results of SB 1089 cost analysis are not comparable to the results of prior obesity bills. The results of this analysis may be sensitive to the behavior of plan sponsors in response to the mandate, such as utilization management of GLP-1RA.

Methodology and Assumptions for Baseline Benefit Coverage

As discussed above, we only included the CalPERS Basic population in our analysis of SB 1089. We reviewed formularies and plan documents to understand current coverage for GLP-1RAs for weight loss.

Methodology and Assumptions for Baseline Cost Sharing

CHBRP assumed that cost sharing would be similar to cost sharing for a typical plan design for CalPERS, namely that GLP-1s for weight loss would be placed on a brand tier with a $20 copay.

Methodology and Assumptions for Postmandate Cost Sharing

Postmandate, CHBRP assumed that cost sharing would be similar to cost sharing for a typical plan design, namely that GLP-1s for weight loss would be placed on a brand tier with a $20 copay.

Methodology and Assumptions for Offsets

CHBRP takes a run rate approach to cost offsets. Therefore, estimates of cost savings are based upon a long term view of the clinical benefits of mandated benefits which may reduce health care expenditure. CHBRP assumed that medical costs will be reduced by $454 per GLP-1 user per year. This figure accounts for discontinuance at constant rate of 20% per year.

The rate at which enrollees who initiate GLP-1 therapy continue treatment year over year is not well established; CHBRP's model assumes 20% annual discontinuance, but real-world persistence may differ substantially, and both the cost of therapy and the magnitude of cost offsets scale directly with continuation rates. Current evidence suggests that persistent use yields more substantial health benefits, meaning that actual continuation rates will significantly affect whether the projected cost offsets materialize.

See the table below for a build-up of cost offsets. These estimates reflect long-term cost savings (or run-rate cost savings) if GLP-1s had been covered for many years. Savings are lower than average in earlier years and higher than average in later years. Full savings for GLP-1RAs would not be anticipated to be achieved until 2032 at the earliest.

	Percentage of Members Continuing Treatment at End of Year	*Percentage of Members (1)*	*Savings Assuming Full Adherence (PMPY) (2)*
Year 1	80.0%	20.0%	-$109
Year 2	64.0%	16.0%	$282
Year 3	51.2%	12.8%	$445
Year 4	41.0%	10.2%	$604
Year 5	32.8%	8.2%	$760
Year 6+	N/A	32.8%	$760
Total		100.0%	$454

(1) These figures reflect the distribution of members after many years, assuming discontinuing members are replaced by new starts.

(2) The estimated savings are based upon the ICER Interactive Modeler for tirzepatide (ICER, 2025) averaged with semaglutide under the following assumptions:

- 100% utilization among 1,000 enrollees
- Unit cost $0 for GLP-1s and lifestyle modification
- No discontinuation for GLP-1s or lifestyle modification (discontinuance is addressed by (1) above).

- Offsets selected (direct impact on CVD events, ESKD, cirrhosis, OSA, knee replacement, hip replacement, and unrelated medical costs)
- Adverse event costs (model populates $9,147 for one-off G3-4 gastrointestinal costs)

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by the DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. CalPERS PPOs do not currently provide coverage for GLP-1 anti-obesity medications for weight management. Blue Shield HMO (a fully insured CalPERS option) began covering semaglutide for weight loss as of January 1, 2026, suggesting emerging demand for this benefit among CalPERS enrollees.

Among self-insured employers nationally, Milliman internal research indicates that employers who offer GLP-1 coverage would observe 11.5% utilization in 2027 among obese or overweight enrollees, consistent with substantial demand. The 2025 KFF Health Tracking Poll found that 27% of individuals paid the full cost themselves (an increase from 19% in 2024), indicating meaningful demand even absent employer coverage (Montero et al., 2024; Montero et al., 2025).

References

Aboueid S, Bourgeault I, Giroux I. Nutrition care practices of primary care providers for weight management in multidisciplinary primary care settings in Ontario, Canada - a qualitative study. *BMC Family Practice*. 2018;19(1):69. doi:10.1186/s12875-018-0760-3

Albers L, Logan J. Improving Health Outcomes and Equity: A Population Health Approach. CalPERS. 2023. Available at: https://www.calpers.ca.gov/documents/202307-full-day-2-improving-health-outcomes-and-equity-a-population-health-approach/download. Accessed March 15, 2026.

Alkhezi OS, Alahmed AA, Alfayez OM, Alzuman OA, Almutairi AR, Almohammed OA. Comparative effectiveness of glucagon-like peptide-1 receptor agonists for the management of obesity in adults without diabetes: a network meta-analysis of randomized clinical trials. *Obesity Reviews*. 2023;24(3):e13543. doi:10.1111/obr.13543

Ard J, Fitch A, Fruh S, Herman L. Weight loss and maintenance related to the mechanism of action of glucagon-like peptide 1 receptor agonists. *Advances in Therapy*. 2021;38(6):2821-2839. doi:10.1007/s12325-021-01710-0

Aronne LJ, Horn DB, le Roux CW, et al.; SURMOUNT-5 Trial Investigators. Tirzepatide as compared with semaglutide for the treatment of obesity. *New England Journal of Medicine*. 2025;393(1):26-36. doi:10.1056/NEJMoa2416394

Atlas SJ, Kim K, Beinfeld M, et al. Medications for Obesity Management: Effectiveness and Value; Final Evidence Report. Institute for Clinical and Economic Review; October 20, 2022. Available at: https://icer.org/assessment/obesity-management-2022/. Accessed March 2025.

California Department of Health Care Access and Information (HCAI). Get the Facts About the Office of Health Care Affordability. 2022. Available at: https://hcai.ca.gov/get-the-facts-about-the-office-of-health-care-affordability/. Accessed November 3, 2025.

California Department of Health Care Access and Information (HCAI). Slow Spending Growth. 2025. Available at: https://hcai.ca.gov/affordability/ohca/slow-spending-growth/. Accessed November 3, 2025.

California Health Interview Survey (CHIS). AskCHIS Dashboard. University of California, Los Angeles, Center for Health Policy Research. 2024. Available at: https://healthpolicy.ucla.edu/our-work/california-health-interview-survey-chis. Accessed February 25, 2026.

Cawley J, Biener A, Meyerhoefer C, et al. Direct medical costs of obesity in the United States and the most populous states. *Journal of Managed Care & Specialty Pharmacy*. 2021;27(3):354-366. doi:10.18553/jmcp.2021.20410

Centers for Disease Control and Prevention (CDC). Adult BMI Categories. March 19, 2024a. Available at: https://www.cdc.gov/bmi/adult-calculator/bmi-categories.html. Accessed March 2025.

Centers for Disease Control and Prevention (CDC). Child and Teen BMI Categories. June 28, 2024b. Available at: https://www.cdc.gov/bmi/child-teen-calculator/bmi-categories.html. Accessed March 2025.

Centers for Medicare & Medicaid Services (CMS). Medicaid Drug Rebate Program (MDRP). Last updated February 21, 2025. Available at: https://www.medicaid.gov/medicaid/prescription-drugs/medicaid-drug-rebate-program/index.html. Accessed March 11, 2025.

Centers for Medicare & Medicaid Services (CMS). Medicare GLP-1 Bridge. March 2026. Available at: https://www.cms.gov/medicare/coverage/prescription-drug-coverage/medicare-glp-1-bridge. Accessed March 7, 2026.

Ciardullo S, Morieri ML, Daniel G, et al. GLP1-GIP receptor co-agonists: a promising evolution in the treatment of type 2 diabetes. *Acta Diabetologica*. 2024;61(8):941-950. doi:10.1007/s00592-024-02300-6

Cleveland Clinic. Metabolic Dysfunction-Associated Steatohepatitis (MASH). May 2025. Available at: https://my.clevelandclinic.org/health/diseases/22988-nonalcoholic-steatohepatitis. Accessed March 15, 2026.

Collins L, Costello RA. Glucagon-Like Peptide-1 Receptor Agonists. In: *StatPearls*. Treasure Island, FL: StatPearls Publishing; February 29, 2024.

Davies M, Færch L, Jeppesen OK, et al. Semaglutide 2.4 mg once a week in adults with overweight or obesity, and type 2 diabetes (STEP 2): a randomised, double-blind, double-dummy, placebo-controlled, phase 3 trial. *Lancet*. 2021;397(10278):971-984. doi:10.1016/S0140-6736(21)00213-0

Eisenberg D, Shikora SA, Aarts E, et al. 2022 American Society of Metabolic and Bariatric Surgery (ASMBS) and International Federation for the Surgery of Obesity and Metabolic Disorders (IFSO) indications for metabolic and bariatric surgery. *Obesity Surgery*. 2023;33(1);3-14. doi:10.1007/s11695-022-06332-1

Eyth E, Naik R. Hemoglobin A1C. In: *StatPearls*. Treasure Island, FL: StatPearls Publishing; March 13, 2023.

Fox CK, Barrientos-Pérez M, Bomberg EM, et al.; SCALE Kids Trial Group. Liraglutide for children 6 to <12 years of age with obesity - a randomized trial. *New England Journal of Medicine*. 2025;392(6):555-565. doi:10.1056/NEJMoa2407379

Gasoyan H, Pfoh ER, Schulte R, Sullivan E, Le P, Rothberg MB. Association of patient characteristics and insurance type with anti-obesity medications prescribing and fills. *Diabetes, Obesity & Metabolism*. 2024;26(5):1687-1696. doi:10.1111/dom.15473

Grunvald E, Shah R, Hernaez R, et al.; AGA Clinical Guidelines Committee. AGA clinical practice guideline on pharmacological interventions for adults with obesity. *Gastroenterology*. 2022;163(5):1198-1225. doi:10.1053/j.gastro.2022.08.045

Gudbergsen H, Overgaard A, Henriksen M, et al. Liraglutide after diet-induced weight loss for pain and weight control in knee osteoarthritis: a randomized controlled trial. *American Journal of Clinical Nutrition*. 2021;113(2):314-323. doi:10.1093/ajcn/nqaa328

Hampl SE, Hassink SG, Skinner AC, et al. Clinical practice guideline for the evaluation and treatment of children and adolescents with obesity. *Pediatrics*. 2023;151(2):e2022060640. doi:10.1542/peds.2022-060640

Henderson J, Ehlers AP, Lee JM, et al. Weight loss treatment and longitudinal weight change among primary care patients with obesity. *JAMA Network Open.* 2024;7(2):e2356183. doi:10.1001/jamanetworkopen.2023.56183

Hersch DE, Uy MJ, Ngaw SM, Loth KA. Primary care providers' perspectives on initiating childhood obesity conversations: a qualitative study. *Family Practice.* 2021;38(4):460-467. doi:10.1093/fampra/cmaa144

Institute for Clinical and Economic Review (ICER). ICER Model for Semaglutide and Tirzepatide for Obesity: Effectiveness and Value. Version December 16, 2025. Accessed March 4, 2026 via ICER Analytics.

Jastreboff AM, Aronne LJ, Ahmad NN, et al. Tirzepatide once weekly for the treatment of obesity. *New England Journal of Medicine*. 2022;387(3):205-216. doi:10.1056/NEJMoa2206038

Jobanputra R, Sargeant JA, Almaqhawi A, et al. The effects of weight-lowering pharmacotherapies on physical activity, function and fitness: a systematic review and meta-analysis of randomized controlled trials. *Obesity Reviews*. 2023;24(4):e13553. doi:10.1111/obr.13553

Jung M-H, Ihm S-H. Obesity-related hypertension and chronic kidney disease: from evaluation to management. *Kidney Research and Clinical Practice*. 2023;42(4):431-444. doi:10.23876/j.krcp.23.072

Kelly AS, Arslanian S, Hesse D, et al. Reducing BMI below the obesity threshold in adolescents treated with once-weekly subcutaneous semaglutide 2.4 mg. *Obesity (Silver Spring).* 2023;31(8):2139-2149. doi:10.1002/oby.23808

Kelly AS, Auerbach P, Barrientos-Perez M, et al.; NN8022-4180 Trial Investigators. A randomized, controlled trial of liraglutide for adolescents with obesity. *New England Journal of Medicine*. 2020;382(22):2117-2128. doi:10.1056/NEJMoa1916038

Kosiborod MN, Petrie MC, Borlaug BA, et al. Semaglutide in Patients with Obesity-Related Heart Failure and Type 2 Diabetes. *New England Journal of Medicine*. 2024;390(15):1394-1407. doi:10.1056/NEJMoa2313917.

LeBlanc EL, Patnode CD, Webber EM, Redmond N, Rushkin M, O'Connor EA. *Behavioral and Pharmacotherapy Weight Loss Interventions to Prevent Obesity-Related Morbidity and Mortality in Adults: An Updated Systematic Review for the U.S. Preventive Services Task Force.* Evidence Synthesis, No. 168. Rockville, MD: Agency for Healthcare Research and Quality; 2018. Available at: https://www.ncbi.nlm.nih.gov/books/NBK532379/. Accessed March 17, 2025.

Levi J, Wang J, Venter F, Hill A. Estimated minimum prices and lowest available national prices for antiobesity medications: improving affordability and access to treatment. *Obesity*. 2023;31(5):1270-1279. doi:10.1002/oby.23725

Lincoff AM, Brown-Frandsen K, Colhoun HM, et al. Semaglutide and cardiovascular outcomes in obesity without diabetes. *New England Journal of Medicine*. 2023;389(24):2221-2232. doi:10.1056/NEJMoa2307563

Liu L, Shi H, Xie M, Sun Y, Nahata MC. Efficacy and safety of tirzepatide versus placebo in overweight or obese adults without diabetes: a systematic review and meta-analysis of randomized controlled trials. *International Journal of Clinical Pharmacy*. 2024;46(6):1268-1280. doi:10.1007/s11096-024-01779-x

Lu Y, Liu Y, Krumholz HM. Racial and ethnic disparities in financial barriers among overweight and obese adults eligible for semaglutide in the United States. *Journal of the American Heart Association*. 2022;11(19):e025545. doi:10.1161/JAHA.121.025545

McGowan BM, Bruun JM, Capehorn M, et al. Efficacy and safety of once-weekly semaglutide 2.4 mg versus placebo in people with obesity and prediabetes (STEP 10): a randomised, double-blind, placebo-controlled, multicentre phase 3 trial. *Lancet Diabetes & Endocrinology*. 2024;12(9):631-642. doi:10.1016/S2213-8587(24)00182-7

McGough M, Lo J, Tevis D, Rae M, Cox C. How Many Adults With Private Health Insurance Could Use GLP-1 Drugs? Peterson-KFF Health System Tracker September 5, 2024. Available at: https://www.healthsystemtracker.org/brief/how-many-adults-with-private-health-insurance-could-use-glp-1-drugs. Accessed March 2025.

Mekonnen A, Vasilevski V, Chapman A, et al. Barriers and enablers to effective weight management for people living with overweight and obesity: a rapid scoping review. *Obesity Reviews.* 2024;26(3):e13858. doi:10.1111/obr.13858

Montero A, Sparks G, Presiado M, Hamel L. KFF Health Tracking Poll May 2024: The Public's Use and Views of GLP-1 Drugs. May 10, 2024. Available at: https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-may-2024-the-publics-use-and-views-of-glp-1-drugs/. Accessed March, 2025.

Montero A, Kearney A, Mulugeta M, Kirzinger A, Hamel L. KFF Health Tracking Poll: Prescription Drug Costs, Views on Trump Administration Actions, and GLP-1 Use. November 14, 2025. Available at: https://www.kff.org/public-opinion/kff-health-tracking-poll-prescription-drug-costs-views-on-trump-administration-actions-and-glp-1-use/. Accessed March 4, 2026.

Narain K, Scannell C. Exploring racial and ethnic differences in utilization of medications for obesity management in a nationally representative survey. *Journal of Racial and Ethnic Health Disparities*. 2026;13(1):329-339. doi:10.1007/s40615-024-02248-x

National Conference of State Legislators (NCSL). 'Compounded" Weight-Loss Drugs Are a Growing Problem for State Regulators. July 15, 2024. Available at: https://www.ncsl.org/state-legislatures-news/details/compounded-weight-loss-drugs-are-a-growing-problem-for-state-regulators. Accessed March 2025.

National Institutes of Health (NIH), Office of Research on Women's Health. Sex and Gender. 2019. Available at: https://orwh.od.nih.gov/sex-gender. Accessed March 2023.

National Institutes of Health (NIH). What Are Overweight and Obesity? 2022. Available at: https://www.nhlbi.nih.gov/health/overweight-and-obesity. Accessed March 2025.

Nichols GA, Hillier TA, Brown JB. Normal fasting plasma glucose and risk of type 2 diabetes diagnosis. *American Journal of Medicine*. 2008;121(6):519-524. doi:10.1016/j.amjmed.2008.02.026

Qin W, Yang J, Deng C, Ruan Q, Duan K. Efficacy and safety of semaglutide 2.4 mg for weight loss in overweight or obese adults without diabetes: an updated systematic review and meta-analysis including the 2-year STEP 5 trial. *Diabetes, Obesity & Metabolism*. 2024;26(3):911-923. doi:10.1111/dom.15386

Rogers J, Kussman L, Anderson B, Sarich J, Marshall A. Building a Long-Range GLP-1 Forecast: When Could Commercial Health Plans See a Plateau? Milliman. 2025. Available at: https://www.milliman.com/en/insight/long-range-glp-1-forecast-health-plans. Accessed March 15, 2026.

Sandsdal RM, Juhl CR, Jensen SBK, et al. Combination of exercise and GLP-1 receptor agonist treatment reduces severity of metabolic syndrome, abdominal obesity, and inflammation: a randomized controlled trial. *Cardiovascular Diabetology*. 2023;22(1):41. doi:10.1186/s12933-023-01765-z

Schofield JD, Liu Y, Rao-Balakrishna P, Malik RA, Soran H. Diabetes dyslipidemia. *Diabetes Therapy*. 2016;7(2):203-219. doi:10.1007/s13300-016-0167-x

Seino Y, Fukushima M, Yabe D. GIP and GLP-1, the two incretin hormones: similarities and differences. *Journal of Diabetes Investigation.* 2010;1(1-2):8-23. doi:10.1111/j.2040-1124.2010.00022.x

Shi Q, Wang Y, Hao Q, et al. Pharmacotherapy for adults with overweight and obesity: a systematic review and network meta-analysis of randomised controlled trials. *Lancet*. 2024;403(10434):e21-e31. doi:10.1016/S0140-6736(24)00351-9

Silverii GA, Monami M, Gallo M, et al. Glucagon-like peptide-1 receptor agonists and risk of thyroid cancer: A systematic review and meta-analysis of randomized controlled trials. *Diabetes Obesity & Metabolism*. 2024;26(3):891-900. doi:10.1111/dom.15382

Stokes A, Collins JM, Grant BF, et al. Prevalence and determinants of engagement with obesity care in the United States. *Obesity (Silver Spring)*. 2018;26(5):814-818. doi:10.1002/oby.22173

U.S. Food and Drug Administration (FDA). Human Drug Compounding. December 18, 2024. Available at: https://www.fda.gov/drugs/guidance-compliance-regulatory-information/human-drug-compounding. Accessed March 2025.

U.S. Food and Drug Administration (FDA). Drugs@FDA. Available at: https://www.accessdata.fda.gov/scripts/cder/daf/index.cfm. Accessed March 2025a.

U.S. Food and Drug Administration (FDA). FDA Clarifies Policies for Compounders as National GLP-1 Supply Begins to Stabilize. March 10, 2025b. Available at: https://www.fda.gov/drugs/drug-safety-and-availability/fda-clarifies-policies-compounders-national-glp-1-supply-begins-stabilize. Accessed March 2025.

U.S. Preventive Services Task Force (USPSTF), Curry SJ, Krist AH, Owens DK, et al. Behavioral weight loss interventions to prevent obesity-related morbidity and mortality in adults: U.S. Preventive Services Task Force Recommendation Statement. *JAMA*. 2018;320(11):1163-1171. doi:10.1001/jama.2018.13022

Visser M, Bouter LM, McQuillan GM, Wener MH, Harris TB. Elevated C-reactive protein levels in overweight and obese adults. *JAMA*. 1999;282(22):2131-2135. doi:10.1001/jama.282.22.2131

Wadden TA, Bailey TS, Billings LK, et al. Effect of subcutaneous semaglutide vs placebo as an adjunct to intensive behavioral therapy on body weight in adults with overweight or obesity: the STEP 3 randomized clinical trial. *JAMA*. 2021;325(14):1403-1413. doi:10.1001/jama.2021.1831

Washington TB, Johnson VR, Kendrick K, et al. Disparities in access and quality of obesity care. *Gastroenterology Clinics*. 2023;52(2):429-441. doi:10.1016/j.gtc.2023.02.003

Waters H, Graf M. America's Obesity Crisis: The Health and Economic Costs of Excess Weight. Santa Monica, CA: Milken Institute; 2018. Available at: https://milkeninstitute.org/sites/default/files/reports-pdf/Mi-Americas-Obesity-Crisis-WEB_2.pdf. Accessed April 21, 2025.

Weghuber D, Barrett T, Barrientos-Pérez M, et al.; STEP TEENS Investigators. Once-weekly semaglutide in adolescents with obesity. *New England Journal of Medicine*. 2022;387(24):2245-2257. doi:10.1056/NEJMoa2208601

Wharton S, Freitas P, Hjelmesæth J, et al.; STEP UP trial group. Once-weekly semaglutide 7·2 mg in adults with obesity (STEP UP): a randomised, controlled, phase 3b trial. *Lancet Diabetes & Endocrinology*. 2025a;13(11):949-963. doi:10.1016/S2213-8587(25)00226-8

Wharton S, Lingvay I, Bogdanski P, et al.; OASIS 4 Study Group. Oral semaglutide at a dose of 25 mg in adults with overweight or obesity. *New England Journal of Medicine*. 2025b;393(11):1077-1087. doi:10.1056/NEJMoa2500969

Wharton S, Aronne LJ, Stefanski A, et al.; ATTAIN-1 Trial Investigators. Orforglipron, an oral small-molecule GLP-1 receptor agonist for obesity treatment. *New England Journal of Medicine*. 2025c;393(18):1796-1806. doi:10.1056/NEJMoa2511774

Williams E. Medicaid Coverage of and Spending on GLP-1s. KFF. January 16, 2026. Available at: https://www.kff.org/medicaid/medicaid-coverage-of-and-spending-on-glp-1s/. Accessed March 16, 2026.

Wilkinson L, Holst-Hansen T, Laursen PN, Rinnov AR, Batterham RL, Garvey WT. Effect of semaglutide 2.4 mg once weekly on 10-year type 2 diabetes risk in adults with overweight or obesity. *Obesity (Silver Spring)*. 2023;31(9):2249-2259. doi:10.1002/oby.23842

Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, MA: Institute for Healthcare Improvement; 2016.

CHBRP Committees and Staff

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.

CHBRP Staff

Garen Corbett, MS, Director
Adara Citron, MPH, Associate Director
An-Chi Tsou, PhD, Principal Policy Analyst
Anna Pickrell, MPH Principal Policy Analyst
Karen Shore, PhD, Contractor*
Nisha Kurani, MPP, Contractor*
*Independent Contractor who supports CHBRP analyses and projects.

Task Force

Faculty Vice Chairs

Janet Coffman, MA, MPP, PhD, *Vice Chair for Medical Effectiveness,* University of California, San Francisco
Elizabeth Magnan, MD, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, Davis
Sara McMenamin, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, San Diego
Nadereh Pourat, PhD, *Vice Chair for Cost*, University of California, Los Angeles

Peer Faculty and Senior Cost Reviewers

Mark Bounthavong, PharmD, PhD, MPH, University of California, San Diego
Kimberly Buss, MD, MS, MPH, University of California, San Francisco
Todd Gilmer, PhD, University of California, San Diego
Sylvia Guendelman, PhD, LCSW, University of California, Berkeley
Grace Lin, MD, MAS, University of California, San Francisco
Jack Needleman, PhD, University of California, Los Angeles
Mark A. Peterson, PhD, University of California, Los Angeles
Alejandro Schuler, PhD, University of California, Berkeley
Marilyn Stebbins, PharmD, University of California, San Francisco
Jonathan Watanabe, PharmD, MS, PhD, University of California, San Francisco

Leads and Analysts

Khadijah Ameen, PhD, MPH, University of California, Berkeley
Bethney Bonilla-Herrera, MA, University of California, Davis
Paul Brown, PhD, University of California, Merced
Timothy T. Brown, PhD, University of California, Berkeley
Danielle Casteel, MA, University of California, San Diego
Margaret Fix, MPH, University of California, San Francisco
Brent Fulton, PhD, MBA, University of California, Berkeley
Carlos Gould, PhD, University of California, San Diego
Alein Haro-Ramos, PhD, MPH, University of California, Irvine
Julia Huerta, BSN, RN, MPH, University of California, Davis
Michelle Keller, PhD, MPH, University of California, Los Angeles, and University of Southern California
Thet Nwe Myo Khin, MPH, University of California, San Diego
Joy Melnikow, MD, MPH, University of California, Davis
Jacqueline Miller, University of California, San Francisco
Marykate Miller, MS, University of California, Davis
Aimee Moulin, MD, University of California, Davis
Katrine Padilla, MPP, University of California, Davis
Jonathan Palisoc, MPP, University of Michigan
Denise Payán, PhD, MPP, University of California, Irvine
Kyoko Peterson, MPH, University of California, San Francisco
Amy Quan, MPH, University of California, San Francisco
Dominique Ritley, MPH, University of California, Davis
Dylan Roby, PhD, University of California, Irvine
Neil Sehgal, PhD, MPH, University of Washington
Mienah Sharif, PhD, MPH, University of California, Berkeley
Riti Shimkhada, PhD, University of California, Los Angeles
Meghan Soulsby Weyrich, MPH, University of California, Davis
Steven Tally, PhD, University of California, San Diego
Dan Zeltzer, PhD, University of California, Berkeley

National Advisory Council

Lauren LeRoy, PhD, Strategic Advisor, L. LeRoy Strategies, *Chair*
Deborah Chollet, PhD, (Retired) Senior Fellow, Mathematica Policy Research, Washington, DC
Allen D. Feezor, Former Deputy Secretary for Health Services, North Carolina Department of Health and Human Services, Raleigh, NC
Charles "Chip" Kahn, MPH, President and CEO, Federation of American Hospitals, Washington, DC
Jeffrey Lerner, PhD, President Emeritus, ECRI Institute Headquarters, Plymouth Meeting, PA; Adjunct Senior Fellow, Leonard Davis Institute of Health Economics, University of Pennsylvania
Donald E. Metz, Executive Editor, *Health Affairs,* Washington, DC
Dolores Mitchell, (Retired) Executive Director, Group Insurance Commission, Boston, MA
Marilyn Moon, PhD, (Retired) Senior Fellow, American Institutes for Research, Washington, DC
Rachel Nuzum, MPH, Senior Vice President for Federal and State Health Policy, The Commonwealth Fund, New York, NY
Carolyn Pare, (Retired) President and CEO, Minnesota Health Action Group, Bloomington, MN
Osula Evadne Rushing, MPH, Senior Vice President for Strategic Engagement, KFF, Washington, DC
Ruchika Talwar, MD, MMHC, Assistant Professor Department of Urology and Medical Director Episodes of Care, Population Health, Vanderbilt University Medical Center
Alan Weil, JD, MPP, Senior Vice President for Public Policy, AARP, Washington, DC

Acknowledgments

CHBRP gratefully acknowledges the efforts of the team contributing to this analysis:

Dan Zeltzer, PhD, of the University of California, Berkeley and Todd Gilmer, PhD, of the University of California, San Diego, prepared the cost impact analysis. John Rogers, ASA, MAAA, MS, and Matthew Ulrich, FSA, MAAA, of Milliman provided actuarial analysis. Adara Citron, MPH, of CHBRP staff prepared the Overview and Policy Context, updated the *Background* section, prepared the public health analysis, and synthesized the individual sections into a single report. Zachary Blundell, MPH, CHBRP Contractor, assisted with the public health impacts section. Abby Choy, Project Assistant with CHBRP, prepared the infographic. A subcommittee of CHBRP's National Advisory Council (see previous page of this report) and a member of the CHBRP Faculty Task Force, Grace Lin, PhD, MAS, of the University of California, San Francisco, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

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.

Disclaimer

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.

Suggested Citation

California Health Benefits Review Program (CHBRP). (2026). *Analysis of California Senate Bill 1089 Preventive Treatment Health Care Act.* Berkeley, CA.