KEY FINDINGS

Analysis of California Senate Bill 535:

Obesity Treatment Parity Act

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

CHBRP

Summary

The version of California Senate Bill 535 analyzed by California Health Benefits Review Program (CHBRP) would require coverage for intensive behavioral therapy (IBT), bariatric surgery, and at least one U.S. Food and Drug and Administration-(FDA)-approved anti-obesity medication (AOM) indicated for chronic weight management in patients with obesity.

In 2026, of the 22.2 million Californians enrolled in state-regulated health insurance, approximately 13.6 million of them would have insurance subject to SB 535.

Benefit Coverage

At baseline, nearly all the population with health insurance subject to SB 535 has coverage for IBT (99.8% enrollees), bariatric surgery (99.7% enrollees), and at least one FDA-approved AOM. Specifically, 93.2% of enrollees have existing coverage for a non-glucagon-like peptide-1 [non-GLP-1] receptor agonist AOM. Postmandate, 100% of these enrollees would have coverage for all three obesity treatments. At baseline, 17.4% of enrollees have coverage for at least one FDA-approved glucagon-like peptide-1 [GLP-1] receptor agonist AOM. However, it is likely that 100% of enrollees would obtain coverage for a non–GLP-1 medication and that GLP-1 medications would not be fully adopted by plans complying with SB 535. SB 535 would likely not exceed essential health benefits (EHB)s.

Medical Effectiveness

CHBRP found *very strong evidence* that IBT is effective in reducing weight and improving related health outcomes in adults, adolescents, and children. There is *very strong evidence* that bariatric surgery is effective in reducing weight in adults, and *some evidence* it is effective in adolescents and children. There is *very strong evidence* that FDA-approved AOMs are effective in reducing weight in adults, and *conflicting evidence* they are effective in reducing weight in children and adolescents.

Cost and Public Health Impacts

In 2026, CHBRP estimates SB 535 would result in an increase in utilization of obesity treatments, including an additional: 35 enrollees receiving IBT; 4 receiving bariatric surgery; and 4,047 utilizing AOMs (all non–GLP-1). As a result, these enrollees would experience a 3% to 14% reduction in body weight and related health improvements. CHBRP estimates SB 535 would increase total premiums by approximately $530,000 and increase cost sharing by $98,000 each year. Noncovered expenses for enrollees would be reduced by $219,000.

Context

Obesity is a chronic health condition characterized by an increase in the size and amount of fat cells in the body.[1] Health care providers screen for obesity by calculating patients' body mass index (BMI), which takes into account an individual's height and weight. Adults with a BMI of 25 to ≤30 are categorized as overweight and those with a BMI of 30 or higher are categorized as obese.

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

There are several methods used to treat obesity. SB 535 focuses on three treatment types: intensive behavioral therapy (IBT), bariatric surgery, and anti-obesity medications (AOMs).

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

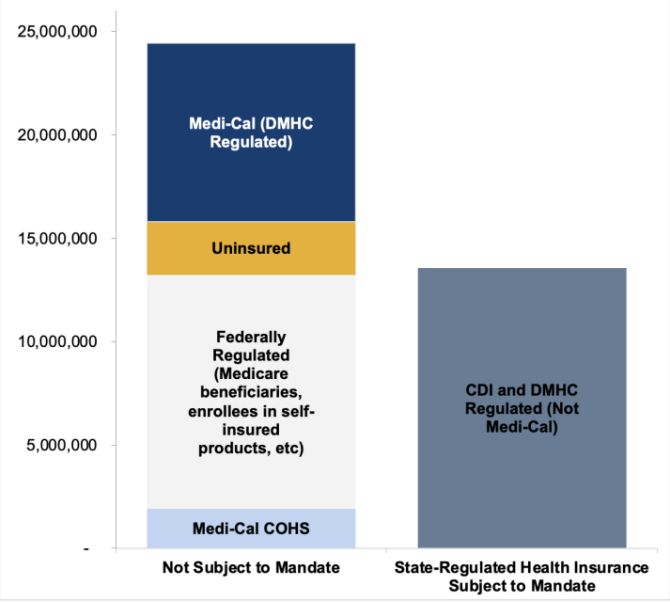
[1] Refer to CHBRP's full report for full citations and references.

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

- **Bariatric surgery** is a procedure conducted on the stomach or intestines to induce weight loss.

- **AOMs** are drugs used for chronic weight management. AOMs can be broken into two types of drugs: glucagon-like peptide-1 (GLP-1) receptor agonists, and non–GLP-1 medications. GLP-1 medications are a class of drugs that activate the body's GLP-1 receptors. This activation triggers several downstream effects, including lowering glucose (sugar) levels within the bloodstream, reducing digestion rate, and increasing the sensation of fullness for longer. GLP-1 medications are indicated for type 2 diabetes and obesity, among other conditions. Non–GLP-1 AOMs treat obesity through a variety of different mechanisms, including blocking fat absorption and deposition, suppressing appetite, and increasing metabolism.

Figure A. Health Insurance in CA and SB 535



Source: California Health Benefits Review Program, 2025.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[2]
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

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

Bill Summary

SB 535 would require coverage for IBT, bariatric surgery, and at least one U.S. Food and Drug and Administration (FDA)-approved AOM indicated for chronic weight management in patients with obesity. In addition, the bill would prohibit coverage criteria from being more restrictive than the FDA-approved indications for those treatments.

If enacted, SB 535 would apply to the health insurance of approximately 13.6 million enrollees (35.8% of all Californians). Figure A notes how many Californians have health insurance that would be subject to SB 535.

Impacts

AOMs have several FDA-approved indications. Based on the language of the bill, CHBRP assumed that SB 535 would apply only to those indicated for chronic weight management, which would include both GLP-1 and non–GLP-1 medications. CHBRP assumed that due to the cost of GLP-1 medications, health plans and policies not yet in compliance with SB 535 at baseline would become compliant by offering a non–GLP-1 medication due to the lower cost.

In addition, within the population of enrollees with overweight or obesity, some enrollees are diagnosed with comorbidities, such as type 2 diabetes. CHBRP assumed that the enrollees diagnosed with overweight or obesity in addition to a comorbidity for which there is an AOM indicated would be able to access an AOM specific to the comorbidity rather than to one indicated for chronic weight management. As a result, CHBRP did not assume any change in utilization for AOMs indicated for other conditions.

Benefit Coverage

CHBRP estimates that at baseline, nearly all of the 13.6 million Californians with health insurance subject to SB 535 has coverage for IBT (99.8% enrollees), bariatric surgery (99.7% enrollees), and at least one FDA-approved AOM. Specifically, 93.2% of enrollees have existing coverage for a non-GLP-1 AOM. Postmandate,

100% of these enrollees would have coverage for all three obesity treatments.

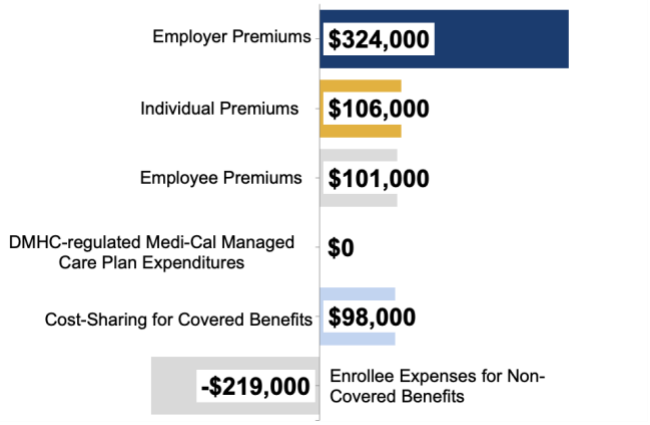
Utilization

At baseline, CHBRP estimates there are approximately 3.1 million enrollees with obesity and about 756,000 enrollees with overweight and comorbidities. CHBRP estimates zero enrollees utilize IBT and bariatric surgery without coverage; 42,813 enrollees use GLP-1s without coverage; and 2,023 use non–GLP-1 AOMs without coverage. Postmandate, CHBRP assumes there would be an additional 35 enrollees receiving IBT, and 4 undergoing bariatric surgery. There would be no increase in utilization of GLP-1 AOMs, but an additional 4,047 enrollees would use non–GLP-1 AOMs.

Expenditures

SB 535 would increase total premiums by approximately $530,000 and increase cost sharing by $98,000 each year. Noncovered expenses for enrollees would be reduced by about $220,000. No measurable offsets are projected.

Figure B. Expenditure Impacts of SB 535



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

Medi-Cal

There would be no impact on Medi-Cal expenditures as SB 535 only applies to group and individual health plans and policies; therefore, it does not apply to the health insurance of any Medi-Cal beneficiaries, including those in managed care plans regulated by DMHC.

CalPERS

For enrollees associated with California Public Employees' Retirement System (CalPERS) in DMHC-regulated plans, CHBRP estimates premiums would have no change.

Covered California – Individually Purchased

CHBRP estimates that premiums for DMHC-regulated individual market plans available through Covered California would increase by 0.0006%, whereas mirror plans available outside of Covered California would increase by 0.0002%.

Number of Uninsured in California

Because the change in average premiums does not exceed 1% for any market segment, CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 535.

Medical Effectiveness

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

Measurable health outcomes relevant to SB 535 include primary outcomes such as change in body weight of 5%, 10%, 15%, or 20%, waist circumference, and mean BMI change. Additional health-related outcomes included diabetes risk, hemoglobin, systolic and diastolic blood pressure, and functional quality of life. CHBRP also reviewed literature on potential harms of FDA-approved AOMs and complications from bariatric surgery. The results of the literature review are as follows:

- Bariatric surgery:
  - *Very strong evidence*[3] that bariatric surgery is effective in reducing weight and improving related health outcomes compared to nonsurgical interventions in adults.
  - *Some evidence*[4] that bariatric surgery is effective in reducing weight in adolescents compared to similar adolescents who do not have surgery.
- FDA-approved AOMs:
  - *Very strong evidence* that use of both GLP-1 and non–GLP-1 AOMs combined with usual care (including diet and activity and lifestyle recommendations) results in greater weight loss than usual care alone in adults.
  - *Conflicting evidence* that GLP-1 and non-GLP-1 AOMs improve weight loss in children and adolescents.
- IBT:
  - *Very strong evidence* that IBT is effective in reducing weight and the risk of developing type 2 diabetes in adults.
  - *Very strong evidence* that IBT is effective for weight management and is associated with greater improvements in diabetes and blood pressure control in adolescents and children.

There are potential harms associated with bariatric surgery, including site infections, cholecystitis with pancreatitis, pouch dilations (requiring repositioning), pneumonia, severe headaches, hernias, bowel obstructions, and other gastrointestinal issues.

The potential harms associated with the use of FDA-approved AOMs include gastrointestinal-related symptoms, such as nausea, constipation, diarrhea, and dyspepsia (i.e., discomfort or pain in the upper abdomen); paresthesia (i.e., burning or prickling sensation often occurring in the hands, arms, legs, or feet); dry mouth; insomnia; irritability; anxiety; headache; and increased blood pressure and heart rate. Adverse events may contribute to discontinuation of the drug, which can impact the overall medical effectiveness of the treatment. It is unclear if long-term use is associated with more severe and persistent harms.

There are no serious harms associated with IBT.

Public Health

It is estimated that as a result of SB 535, utilization of obesity treatments would increase by 4,086 enrollees (4,047 utilizing FDA-approved AOMs; 4 receiving bariatric surgery; 35 receiving IBT for weight loss). As a result, these enrollees would experience a 3% to 14% reduction in body weight by and related health improvements, which is supported by evidence that obesity treatments are medically effective.

Long-Term Impacts

In the case of SB 535 CHBRP estimates approximately 4,086 enrollees would newly use treatments for obesity within 1-year postmandate. Public health impacts would be likely to accrue to these individuals outside of the 1-year time frame as they continue to lose and maintain their weight loss. CHBRP found limited evidence to evaluate the long-term benefits of obesity treatments. Therefore, although this limited evidence suggests that there would continue to be a reduction in the overall prevalence of obesity and obesity-related chronic disease, including a reduction in cardiovascular disease, hypertension (i.e., high blood pressure), type 2 diabetes, and certain types of cancer, the magnitude of these benefits is unknown.

Essential Health Benefits and the Affordable Care Act

The obesity treatments that are the subject of SB 535 are regularly covered under California's essential health benefit (EHB) benchmark plan, it seems unlikely that SB 535 would exceed the definition of EHBs in California.

[3] *Very strong evidence* indicates that there are multiple studies of a treatment, and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.

[4] *Some 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.