SENATE COMMITTEE ON HEALTH
Senator Richard Roth, Chair

BILL NO: SB 1008
AUTHOR: Bradford
VERSION: March 14, 2024
HEARING DATE: April 24, 2024
CONSULTANT: Teri Boughton

SUBJECT: Obesity Treatment Parity Act

SUMMARY: Requires health plan contracts and insurance policies to cover obesity treatment, including intensive behavioral therapy, bariatric surgery, and at least one federal Food and Drug Administration (FDA) approved antiobesity medication.

Existing law:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act); California Department of Insurance (CDI) to regulate health and other insurance; and, the Department of Health Care Services (DHCS) to administer the Medi-Cal program. [HSC §1340, et seq., INS §106, et seq., and WIC §14000, et seq.]

2) Establishes, as California's essential health benefits (EHBs) benchmark, the Kaiser Small Group Health Maintenance Organization, existing California mandates (including medically necessary basic health care services), and ten federal Affordable Care Act (ACA) mandated benefits as described below. Requires non-grandfathered individual and small group plan contracts and insurance policies to cover EHBs:
   a) Ambulatory patient services;
   b) Emergency services;
   c) Hospitalization;
   d) Maternity and newborn care;
   e) Mental health and substance use disorder services, including behavioral health treatment;
   f) Prescription drugs;
   g) Rehabilitative and habilitative services and devices;
   h) Laboratory services;
   i) Preventive and wellness services and chronic disease management; and,
   j) Pediatric services, including oral and vision care. [HSC §1367.005 and INS §10112.27]

3) Requires all DMHC regulated health plans and CDI regulated large group health insurance policies to cover medically necessary basic health care services, defined as all of the following:
   a) Physician services, including consultation and referral;
   b) Hospital inpatient services and ambulatory care services;
   c) Diagnostic laboratory and therapeutic radiologic services;
   d) Home health services;
   e) Preventive health services;
   f) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. Basic health care services includes ambulance and ambulance transport services provided through the 911 emergency response system; and,
   g) Hospice care, as specified. [HSC §1345 and INS §10112.281]

4) Requires health plans that provide coverage for prescription drugs to maintain an expeditious process by which the prescribing provider may obtain authorization for a medically necessary, nonformulary prescription drug. [HSC §1367.24]

5) Allows plans that provide coverage for outpatient prescription drug benefits to exclude drugs prescribed solely for the purposes of losing weight, except when medically necessary for the treatment of morbid obesity. Allows plans to require enrollees who are prescribed drugs for morbid obesity to be enrolled in a comprehensive weight loss program, if covered by the plan, for a reasonable time prior to or concurrent with receiving the prescription drug. [Title 28 CCR §1300.67.24]

6) Prohibits a health plan contract or insurance policy that covers prescription drug benefits from limiting or excluding coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA, provided that all of the following conditions have been met:
   a) The drug is approved by the FDA;
   b) The drug is prescribed by a participating licensed health care professional for the treatment of a life-threatening condition; or the drug is prescribed by a participating licensed health care professional for the treatment of a chronic and seriously, debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the plan formulary. Requires, if the drug is not on the plan formulary, the participating subscriber's request to be considered pursuant to the expeditious process, as specified;
   c) The drug has been recognized for treatment of that condition by any of the following:
   d) The American Hospital Formulary Service's Drug Information;
   e) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:
   f) The Elsevier Gold Standard's Clinical Pharmacology;
   g) The National Comprehensive Cancer Network Drug and Biologics Compendium; and,
   h) The Thomson Micromedex DrugDex;
   i) Two articles from major peer reviewed medical journals that present data supporting the proposed Off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal. [HSC §1367.21 and INS §10123.195]

7) Defines "chronic and seriously debilitating" as diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity. [HSC §1367.21 and INS §10123.195]

This bill:

1) Requires an individual or group health plan contract and insurance policy that provides outpatient prescription drug benefits issued, amended, or renewed after January 1, 2025 to include coverage for the treatment of obesity, including coverage for intensive behavioral therapy, bariatric surgery, and at least one FDA-approved antiobesity medication.

2) Permits a plan or insurer to apply utilization management to determine the medical necessity for treatment of obesity 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 the contract or policy.

3) Defines "FDA-approved antiobesity medication" to mean a medication approved by the FDA with an indication for chronic weight management in patients with obesity.

4) Prohibits coverage criteria for FDA-approved antiobesity medications from being more restrictive than the FDA-approved indications for those treatments.

5) Exempts specialized health plan contracts and insurance policies that cover only dental or vision and Medicare supplement contracts.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, today, over 42% of Americans have obesity. Experts predict that half of Americans will have obesity by the end of this decade. Rather than a character flaw or just 'needing to shed a few pounds,' obesity is a serious, chronic medical condition with linkages to many of the top causes of death, including heart disease, stroke, diabetes, and cancer. The costs of obesity are high and growing. A recent study found that healthcare costs for people with obesity are about $3,500 higher each year than those with a healthy weight. When the indirect costs of obesity are included, the total economic costs of obesity are staggering, estimated at nearly $1.4 trillion. Like other chronic diseases, obesity treatment requires a continuum of care, including primary and specialist care, anti-obesity medications, and surgical interventions. This bill would require health plans in California to include comprehensive coverage for the treatment of obesity, including coverage of at least one FDA-approved anti-obesity medication, increasing access to life-altering treatments.

2) *Obesity classification.* According to the Obesity Medical Association (OMA) the diseases of overweight and obesity are classified into increasing BMI levels that typically have increasingly higher levels of health consequences. The following are levels of obesity based on BMI:

   a) Overweight: 25.0-29.9 kg/m²
   b) Class I Obesity: 30.0-34.9 kg/m²
   c) Class II Obesity: 35.0-39.9 kg/m²
   d) Class III Obesity: $\geq$ 40.0 kg/m²

   The medical definition of extreme obesity (formerly referred to as morbid obesity), according to the OMA, is a serious health condition that results from an abnormally high body mass that is diagnosed by having a BMI greater than 40 kg/m², a BMI of greater than 35 kg/m² with at least one serious obesity-related condition, or being more than 100 pounds over ideal body weight. Using BMI is problematic, as it does not assess for obesity because BMI cannot tell if a person's weight is due to muscle or excess fat. A very lean person with a lot of muscle may be labeled as having Class III obesity. There are more accurate tools, such as Body Composition analyzers, but these are not widely available. There is a valid argument that using a waist measurement at the level of the umbilicus or navel is a better way of determining the level of unhealthy fat.

   OMA indicates that problems with obesity come from the strain of carrying excess weight, and include high blood pressure, congestive heart failure, sleep apnea, shortness of breath, nerve pain, arthritis, back pain, heartburn, leg swelling, varicose veins, and physical

disability. Other problems result from disturbances in metabolic function from having dysfunctional fat cells, such as Type 2 Diabetes, high cholesterol, heart disease, fatty liver disease, dementia, increased risk of several cancers, kidney disease, stroke, gout, asthma, erectile dysfunction, infertility, polycystic ovary syndrome, pregnancy complications, and blood clots. Patients with Class III obesity also suffer from discrimination, social bias, depression, anxiety, and low self-esteem.

3) *California Health Benefits Review Program (CHBRP) report.* AB 1996 (Thomson, Chapter 795, Statutes of 2002) requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996, and reviewed SB 839 (Bradford of 2023) as updated by this bill. Key findings include:

   a) *Disparities.* 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 (13%) followed by White adults (23.7%), with American Indian/Alaska Native adults (40.4%), Black adults (39.1%), and Latino adults (39.4%) all reporting the highest rates. Finally, adults residing in urban locations reported lower rates of obesity compared to adults residing in rural locations. People of color have higher rates of obesity, in part, because they are more likely to live in neighborhoods with obesogenic food environments (food deserts, scarcity of nutritious foods). 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 access to antiobesity treatments and outcomes. Specifically, it was found that Black and Hispanic adults with obesity were more likely to have financial barriers to accessing GLP-1s 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 (Washington et al., 2023).

   b) *Societal impacts.* Treatment of obesity-related diseases places a large economic burden on the health care system. 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 — comprised of $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). Within California, Cawley et al. (2021) estimated the total annual medical expenditure related to adult obesity (i.e., BMI >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 2023 dollars, the total medical expenditures attributed to obesity in California is equal to $6.8 billion.

c) *Prevalence in California among privately insured in 2022.*

Age	Overweight BMI 25 to 30	Obese BMI>30
13-17	18.8%	10.9%
18-24	22.8%	15.5%
25-39	32.6%	24.7%
40-64	36.8%	30.3%
18-64	33.7%	26.7%

Source: California Health Benefits Review Program, 2023, analysis of the California Health Interview Survey Data. Analysis limited to respondents with employment-based and privately purchased health insurance.
Note: (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 13% of the overweight population.
(b) Overweight for children under age 18 is defined as having a BMI between the 85th and 95th percentile while obesity is defined as having a BMI in the 95th percentile or above (NIH, 2022). Estimates for teens (aged 13-17) are presented because the data source did not include information on obesity rates for children aged 0 to 12.
(c) In addition, rates for adults >65 are not presented because the vast majority of that population is enrolled in Medicare and thus not enrolled in health insurance subject to SB 839

FDA-Approved Drugs for Weight Management Relevant to SB 839 (Nov 2023)

Drug	FDA Approval Year	Mode of Administration/Dosage	Population Approved/Indicated For
GLP-1			
Liraglutide (Saxenda)	2014 adults; 2020 aged 12+ years	Daily subcutaneous.	Adults with BMI of >30 kg/m² or >27 kg/m² 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/m² for adults by International cut-offs.
Semaglutide (Wegovy)	2021 adults; 2023 aged 12+	Weekly subcutaneous, gradually increase dose every four weeks	Adults with BMI >30 kg/m² or >27 kg/m² in the presence of comorbid condition. 12+ years with BMI at the 95th percentile or greater standardized for age and sex.
Tirzepatide (Zepbound)(a)	2023	Weekly subcutaneous	Adults with BMI >30 kg/m² or >27 kg/m² with comorbid condition.
Non GLP-1			
Bupropion/Naltrexone (Contrave)	2014	Daily orally. Dose is increased weekly until target dosage of two tables twice daily.	Adults with an initial BMI of >30 kg/m² or >27 kg/m² with weight-related comorbid condition.
Orlistat (Xenical)	1999	Daily orally	Adults with BMI of >30 kg/m² or a BMI of >27 kg/m² in the presence of other comorbidities.
Phentermine/Topiramate (Qsymia)	2012	Daily orally	Adults with BMI of >30 kg/m² or >27 kg/m² with weight-related comorbid condition. Pediatric patients aged 12 years and older with BMI in the 95th percentile or greater.
Setmelanotide (Imcivree)	2020	Daily subcutaneous	Age 6+ years for people living with Bardet-Biedl syndrome, or POMC, PCSK1, or LEPR deficiency.
Phentermine (Adipex-P, Lomaira)	1959	Daily orally; approved by the FDA for short-term use (three months)	Age 16+ years with BMI of 30 kg/m² or greater or 27 kg/m² or greater) in the presence of at least one weight-related comorbid condition.

Source: California Health Benefits Review Program, 2023; FDA, 2023. Note: (a) Tirzepatide (Zepbound) is a dual glucose-dependent insulinotropic polypeptide (GIP)/GLP-1

a) *Coverage impacts and enrollees covered*. Nearly three million Californians with obesity are enrolled in health insurance subject to this bill, and an additional 500,000 overweight Californians with comorbidities. This is based on adolescents and adults up to age 64 that have BMIs that would categorize them as having obesity, and, overweight Californians with BMI ≥ 27 and <30 with comorbidities.

b) *Medical effectiveness.* While CHBRP included reviews of medical effectiveness of IBT and bariatric surgery, this bill analysis is focusing on the medical effectiveness of weight management drugs, as IBT and bariatric surgery are already widely covered by California health plans and insurers.

i) *Summary of findings regarding FDA-approved weight management drugs for adults:* There is clear and convincing evidence that both FDA approved GLP-1 and non–GLP-1 drugs (liraglutide, semaglutide, tirzepatide, bupropion/naltrexone, and phentermine/topiramate) for weight loss are effective when used as adjuncts to usual care (which includes standard diet and activity and lifestyle recommendations). Use of these drugs increase the amount of weight lost and percent of body weight lost, and reduces BMI compared to placebo or usual care alone. A recent study by the Institute for Clinical and Economic Review (ICER) concluded that compared to placebo, the weight management drugs demonstrated 4.6% to 13.7% mean greater weight loss. Liraglutide, semaglutide, and tirzepatide also improved blood sugar, blood pressure, and physical function compared to usual care. Comparisons across the drugs as well as direct evidence for three drugs (liraglutide, semaglutide, liraglutide) suggest that semaglutide and phentermine/topiramate achieve greater weight loss than liraglutide and bupropion-naltrexone and that tirzepatide is more effective than semaglutide and liraglutide. There is limited evidence from one network meta-analysis that some GLP-1s are more effective than non-GLP-1s. The network meta-analysis found that people with obesity (without diabetes mellitus) who received semaglutide (a GLP-1) experienced statistically greater weight loss than people who received phentermine/topiramate (high dose) or bupropion/naltrexone (both non-GLP-1s) and had the greatest odds of achieving 5% and 10% weight loss at 1 year following initiation of treatment (Atlas et al., 2022). However, this network meta-analysis also reported that phentermine/topiramate (high dose) demonstrated statistically greater weight loss than liraglutide (a GLP-1) among people with obesity (without diabetes mellitus). Among participants with obesity and diabetes mellitus, people who received GLP-1s experienced greater percentage weight loss than people who received non-GP-1s, but the differences were not statistically significant. CHBRP did not identify any studies that compared the effect of tirazepatide on weight to the effects of non-GLP-1s on weight loss.

ii) *Summary of findings regarding FDA-approved weight management drugs for children and adolescents*: There is limited evidence that weight management drugs improve weight loss in adolescents. Two randomized controlled trials (RCTs) reported that adolescents who received semaglutide had a greater reduction in mean body weight and BMI than adolescents who received a placebo. One RCT evaluating phentermine/topiramate in adolescents with obesity reported significant weight loss compared to placebo. Two systematic reviews reported mixed results on the effects of orlistat on bodyweight and BMI. For liraglutide, one meta-analysis reported that there was no statistically significant difference in weight loss or reduction in BMI, compared to placebo. Bupropion/naltrexone and tirzepatide are not approved for use in adolescents.

iii) *When data are available, CHBRP estimates the marginal change in relevant harms associated with interventions affected by the proposed mandate*. In the case of this bill, there is evidence to suggest that an increase in the use of obesity treatments could result in harm. Potential harms associated with the use of FDA-approved drugs for

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

c) *Utilization*. There would be no material change in utilization of IBT or bariatric surgery postmandate due to the existing 99.9% compliant benefit coverage at baseline. At base line 64% of enrollees do not have coverage for a non-GLP-1 or a GLP 1. *This bill would be likely to impact benefit coverage for 64% or less of enrollees, rather than the nearly 90% of commercial/CalPERS enrollees for whom changes in benefit coverage were expected for SB 839.* CHBRP assumed that compliance would principally be through coverage of Non-GLP-1 rather than coverage of GLP-1s. Therefore, while SB 839 assumed an increase in enrollees using GLP-1s of 951%, CHBRP would estimate a 0% increase based on this bill. GLP-1 medications typically have higher costs than non-GLP-1 medications. As a result of less change in benefit coverage, utilization projections would be less for this bill. The number of new users of the treatments would be approximately 29,000 or less, rather than the 124,000 that was projected for SB 839. The impact of this bill on utilization would be 23% of what was projected for SB 839.

d) *Medi-Cal.* This bill does not include requirements on Medi-Cal. However, CHBRP indicates that Medi-Cal enrollees already have coverage for drugs with FDA indication for weight management, bariatric surgery, and IBT for weight loss.

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

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

g) *Essential health benefits*. CHBRP does not believe this bill would meet the definition of a state benefit mandate that would exceed EHBs (which would require under the ACA, California to defray the costs).

2) *ICER.* ICER is an independent nonprofit research institute that produces reports analyzing the evidence on the effectiveness and value of drugs and other medical services. ICER's reports include evidence-based calculations of prices for new drugs compared to expected long-term patient outcomes, and cost growth for the overall health care system. In October of 2022, ICER issued an access and affordability alert for one of the weight management drugs,

semaglutide, indicating that the amount of added health care costs may be difficult for the health system to absorb in the short term without displacing other needed services, creating pressure on payers to restrict access, or causing rapid growth in health care insurance costs that would threaten access to high-value care for patients. Final ICER policy recommendations prepared for the New England Comparative Effectiveness Public Advisory Council include recommendations to include coverage of weight loss medications in the Medicare and Medicaid programs. With regard to states, it indicates if narrowing coverage is necessary, coverage can be framed to ensure access to lower cost and generic drugs for individuals with clinical characteristics that have the most to benefit. As an example, the National Health System in England has set a higher threshold for treatment with semaglutide using a BMI of greater than or equal to 35 kg/m² or 27 kg/m² with at least one weight related comorbid condition. There is also a recommendation that U.S. payers should ensure efficient systems to process exceptions based on racial and ethnic groups for whom BMI thresholds do not identify risks for future obesity complications, and that higher thresholds should be developed in conjunction with clinical experts.

Congressional Budget Office (CBO). An October 5, 2023 CBO blog calling for new research in the area of obesity indicates that at present evidence does not support that there is enough potential savings on cardiac care and other health care to offset federal costs of Medicare coverage for antiobesity medication with increased use of antiobesity medication by people with obesity who are not diabetic. The blog indicates that Medicare coverage of these medications would lead to an overall increase in the deficit over the next ten years but that could change depending on the future prices of these medications and their longer-term effects on the use of other health care services. A March 2024 Kaiser Family Foundation post indicates that Medicare Part D plans can cover GLP-1s for medically-accepted indications that are not just for weight loss, such as diabetes and now cardiovascular risk according to a CMS memo.

4) *Related legislation.* SB 839 (Bradford of 2023) would have required an individual or group health plan contract or health insurance policy to include comprehensive coverage for the treatment of obesity, including coverage for intensive behavioral therapy, bariatric surgery, and federal FDA-approved antiobesity medication. SB 839 would have prohibited coverage criteria for FDA-approved antiobesity medications from being more restrictive than the FDA-approved indications for those treatments, and cost-sharing from being different or separate from other illnesses, conditions, or disorders. *SB 839 was not heard in the Senate Committee on Health at the author's request.*

5) *Support.* According to this bill's sponsor, the California Chronic Care Coalition on behalf of the Chronic Obesity Prevention and Education Alliance, obesity is the mother of all chronic disease and is associated with more than 200 comorbidities, including diabetes, high blood pressure, heart disease and multiple types of cancer. This bill will help address these rampant health issues, while driving down costs within California's health care system. In fact, according to Let's Get Healthy California, a program within California's Department of Public Health, if adult BMI were reduced by 5%, California could save $81.7 billion in obesity-related health care costs by 2030. The incredible savings that will be realized through effective obesity management dwarfs the relatively minor initial investment. Furthermore, a 2015 study found that adult obesity raised annual medical care costs by $3,508 per obese individual, for a nationwide total of $315.8 billion (year 2010 values), with per-patient costs rising exponentially along with higher BMI scores. The same study found that reductions in BMI lead to significant reductions in annual prescription drug expenditures. Similarly, a

2022 study found that "The presence of ORCs [obesity related complications] increases over time in people with obesity, and this increase is more pronounced in individuals in higher obesity classes. Finally, we would be remiss to not mention the substantial equity issue at play in the obesity space. According to Let's Get Healthy California, obesity rates in our state rose from 22.7% in 2009 to 27.1 in 2018. However, numerous historically disadvantaged groups show numbers far higher. This bill would ensure that Californians have a full range of treatment options available for the chronic disease of obesity. The American Diabetes Association writes there is strong and consistent evidence that obesity management can delay the progression from prediabetes to type 2 diabetes and is highly beneficial in the treatment of type 2 diabetes. In patients with type 2 diabetes who also have overweight or obesity, modest and sustained weight loss has been shown to improve glycemic control and reduce the need for glucose-lowering medications. As a result, medical intervention strategies by physicians may include dietary changes, physical activity, behavioral therapy, pharmacologic therapy, medical devices, and metabolic surgery. The ADA supports legislation aimed at increasing access to the full spectrum of obesity treatments to both help prevent the development of type 2 diabetes, as well as in the treatment of type 2 diabetes. By requiring health care coverage of obesity treatments, this bill will help to ensure that Californians and their physicians will have the ability to utilize the full spectrum of medical interventions in the treatment of their disease.

6) *Support if amended.* The California Chapter of the American College of Cardiology believes it is critical to have this bill apply to Medi-Cal recipients.

7) *Opposition.* The California Association of Health Plans, Association of California Life and Health Insurance Companies, and America's Health Insurance Plans write to oppose this bill because it is one of 14 health insurance mandate bills that will increase costs, reduce choice and competition, and further incent some employers and individuals to avoid state regulation by seeking alternative coverage options. Benefit mandates impose a one-size-fits-all approach to medical care and benefit design driven by the legislature rather than consumer choice. These bills will lead to higher premiums, harming affordability and access for small businesses and individual market consumers. These opponents urge legislators to also consider the cumulative impacts of these mandates on premiums and access to coverage. All of these bills will increase costs and limit employer flexibility. The legislature created the Office of Health Care Affordability to contain cost drivers. With this office in place and the state budget deficit, the legislature should take a wait-and-see approach when considering costly mandates. The health plans have continued to be engaged and look forward to the work ahead. The California Chamber of Commerce writes CHBRP analyzed the cost impact of this bill, and concluded that if the mandate went into effect, total expenditures would be approximately $136 million. This would translate to increased premiums for employers and employees. When looking at health care cost increases in isolation they seem tolerable, however, this bill must be considered in context. Premiums for employers and enrollees consistently increase year after year due to a number of issues including benefit mandates. Furthermore, the 2023 Kaiser Family Foundation Employer Health Benefits Survey indicated that the average annual premiums for employer-sponsored family health coverage reached $23,968 in 2023, with workers on average paying $6,575 toward the cost of their coverage. On average, covered workers contribute 17% of the premium for single coverage and 28% of the premium for family coverage. California should not increase health care coverage costs for employers and employees with another mandate.

SUPPORT AND OPPOSITION:

Support: Chronic Care Coalition (sponsor)
American Diabetes Association
California Chronic Care Coalition
California Life Sciences
California Pharmacists Association
California Rheumatology Alliance
City of La Quinta, Mayor Linda Evans
Obesity Action Coalition
Western Center on Law & Poverty
One individual

Oppose: America's Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce

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