SENATE COMMITTEE ON LABOR, PUBLIC EMPLOYMENT AND RETIREMENT
Senator Lola Smallwood-Cuevas, Chair
2025 - 2026 Regular

Bill No:	SB 1089	**Hearing Date:**	April 22, 2026
Author:	Richardson		
Version:	March 24, 2026		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Glenn Miles		

SUBJECT: Preventive Treatment Health Care Act

KEY ISSUE

This bill requires, commencing January 1, 2027, a health benefit plan or contract that contracts with the California Public Employees' Retirement System (CalPERS), to offer optional coverage for chronic weight disease management, including nutritional information and at least one Glucagon-like peptide-1 (GLP-1) anti-obesity medication (AOM) approved by the U.S. Food and Drug Administration (FDA).

ANALYSIS

Existing law:

1) Establishes the Public Employees' Medical and Hospital Care Act (PEMHCA) and tasks the CalPERS board of directors to contract with carriers for health benefit plans or approve health benefit plans offered by employee organizations, with the purpose of providing public employees with health plan benefits similar to those available in private industry and promoting and preserving public employee health. (Government Code § 22750 et seq.)

2) Requires a health benefit plan or contract to provide coverage for an FDA-approved vaccine for AIDS, contraceptives and related services, and vasectomies and related services, consistent with laws that apply to health plans regulated by the California Department of Managed Health Care (DMHC) and insurers regulated by the California Department of Insurance (CDI). (Government Code § 22853.1, § 22853.3, and § 22853.4)

3) Sets minimum standards for public employees' health benefits plans; minimum standards for health carriers; and minimum scope and content of basic health benefits plans, as specified. (2 C.C.R. §§ 599.508 – 599.510).

4) Provides state regulation of health plans, as defined, through DMHC's licensing authority under the Knox-Keene Act and regulates health insurance policies, as defined, through the California Department of Insurance (CDI). (Health and Safety Code § 1340 et seq. and Insurance Code § 106 et seq.)

5) Establishes the California Health and Human Services Agency (CHHSA) consisting of several departments and offices including DMHC, Health Care Access and Information (HCAI), and the Center for Data Insights and Innovation. (Government Code § 12803 and § 12806)

6) Requires CHHSA or its departments, under the California Affordable Drug Manufacturing Act of 2020, to enter into partnerships to increase competition, lower prices, and address shortages in the market for generic prescription drugs, to reduce the cost of prescription drugs, as specified, and to increase patient access to affordable drugs. This program is referred to as CalRx. (Health and Safety Code § 127692(a))

7) Requires CalRx to enter into partnerships resulting in the production, procurement or distribution of generic drugs, with the intent that these drugs be made widely available to public and private purchasers, providers and suppliers, and pharmacies. Requires the generic drugs to be produced or distributed by a drug company or generic drug manufacturer that is registered with the FDA. Requires CalRx to only enter into partnerships to produce generic drugs at a price that results in savings, targets failures in the market for generic drugs, and improves patient access to affordable medications. (Health and Safety Code § 127693(a) and § 127693(b))

8) Requires, in identifying generic prescription drugs to be produced, CHHSA to consider reports on prescription drug costs published by DMHC and CDI, and pharmacy spending data from Medi-Cal and other entities for which the state pays the cost of generic prescription drugs. Requires the partnerships to include the production of at least one form of insulin, provided that a viable pathway for manufacturing a more affordable form of insulin exists. (Health and Safety Code § 127693(c)(1) and (2))

9) Authorizes CalRx, subject to appropriation, to enter into partnerships to increase competition, lower prices, and address supply shortages for: over-the-counter naloxone products; generic or brand name drugs to address emerging health concerns, including reproductive health care or gender affirming health care; development, production, procurement, or distribution of vaccines, as specified; and, the manufacture, purchase, or distribution of medical supplies or medication devices. (Health and Safety Code HSC § 127697)

This bill:

1) Establishes the Preventive Treatment Health Care Act to promote access to affordable AOM for Californians. [1]

2) Makes legislative findings and declarations related to among other issues: the state of chronic weight disease in California and its contributing role in other serious diseases, including cancer and heart disease; its impact on employee productivity and economic contributions; and costs to the state exceeding $1 billion in disability and health care.

[1] The bill alternatively references chronic weight disease management, chronic weight disease management medications, Glucagon-like peptide-1 (GLP-1) anti-obesity medications, and anti-obesity medications throughout its provisions. We understand these references to generally mean the same thing, coverage for chronic weight disease management, including nutritional information and at least one Glucagon-like peptide-1 (GLP-1) anti-obesity medication. In this analysis, we opt to use the acronym AOM (anti-obesity medication) for all versions of these references.

3) Requires a health benefit plan or contract that contracts with CalPERS, commencing January 1, 2027, to offer optional coverage for chronic weight disease management, including nutritional information and at least one FDA-approved AOM as one if its health plan options.

4) Requires CalPERS-contracted plans to offer AOM at the cost previously provided to Medi-Cal beneficiaries in 2025 or at the most favored nation pricing, as set forth in federal Executive Order No. 14297 on May 12, 2025, or better pricing.

5) Requires the AOM to follow FDA label indications for usage.

6) Requires the California Health and Human Services Agency (CHHSA) to do the following:

   a. Make AOM available to state and local government employers;
   b. Determine if the state shall make AOM available to all Californians, including enrollees and insureds of licensed health care service plan contracts and health insurance policies;
   c. Determine if such availability shall be at the cost previously provided to Medi-Cal beneficiaries in 2025 or at most favored nation pricing, as set forth in federal Executive Order No. 14297 on May 12, 2025, or better pricing.
   d. Expand its existing partnerships for the acquisition or production of specified medicines to include the acquisition of certain brand name prescription drugs including AOM and AOM related supplies. [2]

7) Provides that the bill's provisions related to CalPERS and CHHSA making AOM available, as specified, shall remain in effect only until January 1, 2032, and as of that date are repealed.

8) Requires CalRx to do the following:

   a. Enter into partnerships resulting in the acquisition of brand name prescription drugs and requires CalRx to include the acquisition or production of pens, vial injections, pills, and patches of GLP-1 semaglutide, GLP-1RA, GIP+GLP-1 tirzepatide, and future chronic weight disease products.
   b. Requires CalRx to consider the cost previously provided to Medi-Cal beneficiaries in 2025 or a lower cost, and the cost previously provided at the most favored nation pricing as set forth in a May 12, 2025, federal Executive Order, or better pricing.
   c. Requires any CalRx partnerships to consider guaranteeing access to supply of pens, vial injections, pills, and patches of GLP-1 semaglutide, GLP-1RA, GIP-GLP-1 tirzepatide, and future chronic weight disease products, and creating a state brand of those same products. [3]

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[2] The author agreed to accept Senate Health Committee amendments to remove the bill's provisions related to CHHSA. Due to time limitations to hear the bill in both committees, those amendments will be taken in Senate LPER Committee.

[3] The agreed upon Senate Health Committee amendments referenced in Footnote 2 (FN2) also revise the bill's requirements on CalRx to instead provide that CalRx is authorized to include at least one AOM in the list of medications CalRx may, subject to an appropriation, enter into partnerships, as specified.

COMMENTS

1. Background

This bill, following Senate Health Committee amendments that are to be adopted in this committee (see FN 2 above and Section 6 below), seeks to promote access to life-altering AOMs by requiring CalPERS to offer AOMs as an option in at least one of its plans and by authorizing CalRx to include AOMs in those pharmaceuticals for which it can enter into specified partnerships to develop and offer medicines. Please see the Senate Health Committee's April 15, 2026, Policy Analysis of this bill for information regarding its provisions related to CHSSA and CalRx.[4] Our analysis relates to the provisions applicable to CalPERS.

CalPERS' Role in Providing Health Coverage

Pursuant to existing law, CalPERS negotiates with insurance carriers and health plans to purchase and administer healthcare benefits coverage for approximately 1.5 million public employees and retirees.[5] (The California Department of Human Resources (CalHR) negotiates for other benefits for state employees such as dental and eyewear coverage.) In addition to the state, approximately 1,149 public agencies contract with CalPERS for health coverage.

CalPERS provides health coverage to public employees through Health Maintenance Organizations (HMOs), Exclusive Provider Organizations (EPOs), Preferred Provider Organizations (PPOs), fully funded insurance plans, and self-insured plans. These different organizations fall within multiple, overlapping regulatory frameworks. DMHC (Knox-Keene) regulates CalPERS' HMO and EPO plans. CDI regulates CalPERS' fully insured PPO plans. Additionally, CalPERS has adopted regulations on its self-insured PPO plans that generally follow federal Employee Retirement Income Security Act (ERISA) practices. Lastly, CalPERS also sets minimum plan standards and minimum coverage benefits that generally exceed regulatory requirements.

CalPERS' Core Beliefs

CalPERS adheres to board-established core beliefs as part of its mission and values. One of its core beliefs is *Health Program Sustainability* which states, "The sustainability of the Health Program is the foremost consideration when reviewing proposed changes to benefits, coverage areas, and costs."[6] Another CalPERS core belief, *Affordability,* holds that, "Health premiums and out-of-pocket costs must be affordable and sustainable for members and employers."[7]

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[4] CA Senate Committee on Health, SB 1089 Policy Bill Analysis https://leginfo.legislature.ca.gov/faces/billAnalysisClient.xhtml?bill_id=202520260SB1089

[5] CalPERS Facts at a Glance, Calendar Year 2024 Health benefits Program (PDF) https://www.calpers.ca.gov/about/organization/facts-at-a-glance

[6] CalPERS Mission and Vision, CalPERS Beliefs, Health Benefits, Theme: Health Program Sustainability: https://www.calpers.ca.gov/about/organization/calpers-story/our-mission-vision

[7] Ibid., CalPERS Beliefs, Health Benefits, Theme: Affordability

CalPERS' Negotiation and Rate Development Process

CalPERS determines health premiums annually through its rate development process by which it negotiates methodically with health carriers to achieve the most competitive premiums possible for CalPERS members and employers. It compares each plan's premium proposal against actual cost and utilizations trends using data from CalPERS' Health Care Decision Support System (data warehouse) to create baseline premium projections for each plan.[8]

In July 2025, CalPERS announced that the overall weighted premium rate for its health plan premiums would increase in calendar year 2026 by 8.21%, with Medicare plans (i.e., plans available to CalPERS retirees) set to see an average increase of 10.78%.[9]

CalPERS noted that "Pharmacy costs continue to drive rate changes across plans as utilization and unit costs increase, particularly with specialty and brand name drugs. For Medicare premiums, revenue changes from the Centers for Medicare and Medicaid Services (CMS) and increased utilization of medical services further impact costs for both Medicare Advantage and Medicare Supplemental plans."[10]

Committee Concerns

- *Increased State Employee and Retiree Health Costs*

  This bill may result in increased health care premiums for public employees and retirees. Retirees are particularly vulnerable and highly sensitive to increased premium costs since they live on fixed income. Public employees faced with increased health care premium costs are likely to increase wage demands or demands for higher employer premium contributions in collective bargaining. Such demands are likely to increase pressure on the General Fund to subsidize those increases.

  CalPERS healthcare premiums are paid by contributions from both the employer and the employee. For state employees, the employer premium contribution is based on a formula that is driven in part by employee plan utilization. In short, the formula generally provides that the state cover 80% of the weighted average premium for active employees and 80% of the average additional premium for their family members (80/80 formula). Actual contributions are based on collective bargaining agreements. Health care inflation for existing health plan premiums already substantially exceeds the Consumer Price Index (CPI) upon which the state generally bases increases to employee compensation.

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[8] How CalPERS Sets Health Premiums, https://www.calpers.ca.gov/members/health-benefits/plans-and-rates/how-calpers-sets-health-premiums

[9] CalPERS News, "CalPERS Announces Health Plan Premiums for 2026", July 15, 2025, https://www.calpers.ca.gov/newsroom/calpers-news/2025/calpers-announces-health-plan-premiums-for-2026

[10] Ibid.

Any premium increases attributable to this bill will likely exacerbate employee and retiree dissatisfaction with current compensation levels.

- *SB 1089's Timeline for Implementation Conflicts with CalPERS Plan Design and Rate Setting Process*

  CalPERS begins its plan design negotiations approximately one and a half years in advance of new plan implementation. SB 1089 requires CalPERS contracting health plans to offer optional AOM coverage commencing January 1, 2027. However, CalPERS is in the middle of its process to adopt 2027 premium rates for 2027 plan changes that were negotiated in September 2027. Amending the bill's timeline to January 1, 2028, would avoid substantially disrupting existing plan and rate negotiations.

- *SB 1089's Optional and Singular Plan Option design conflicts with CalPERS Plan Design Process*

  SB 1089 requires a CalPERS-contracted plan to offer "optional coverage…as part of one of its health plan options." However, this conflicts with how CalPERS negotiates with plans and insurers for the greatest coverage for the best price. CalPERS essentially designs its plans to offer substantially the same coverage to all its participants and bids its design "wish list" to health plans and insurers for costs proposals to cover those benefits. This economy-of-scale and standardization approach is what gives CalPERS its negotiating power with health plan carriers and makes cross-comparison plan analysis effective. Plan individualization and optionalization undermines CalPERS negotiating ability and could likely result in increased health premium and administrative costs. Moreover, the resulting optional plan would likely experience adverse selection, high costs, and utilization that would make it unaffordable to public employees.

2. Need for this bill?

According to the author:

"Chronic weight management can be related to a reduced labor participation, earnings, increased early mortality, absenteeism, disability and healthcare costs exceeding $1 Billion dollars and a 2.6% reduction in the California Gross Domestic Product (GDP). Barriers to the reduction, maintenance, or elimination of chronic weight disease come down to access and cost."

"SB 1089 will create a five-year pilot program under CalPERS to require GLP-1 medications to be provided as part of CalPERS health plan. It would also add GLP-1 to the group of medications produced by CalRx."

3. Proponent Arguments

According to the California Academy of Family Physicians (CAFP):

"CAFP views this bill as an important step in the right direction toward expanding access to chronic weight disease treatment. While we strongly support the bill's focus on public employees and annuitants, we believe these policies should ultimately be extended to all

Californians across all insurance markets. Limiting coverage to a subset of patients risks perpetuating inequities in access to effective treatment. Expanding coverage requirements to all health plans would promote more consistent, equitable care statewide."

According to CPCA Advocates:

"SB 1089 is particularly important for community health centers and their patients. CHCs serve populations with disproportionately high rates of diabetes, obesity, and related chronic conditions. While newer treatments such as GLP-1 receptor agonists have shown significant clinical effectiveness, their high cost has placed them out of reach for many patients, especially those who are uninsured or underinsured."

4. **Opponent Arguments:** None received.

5. **Dual Referral:** The Senate Rules Committee referred this bill to the Senate Health Committee (1) and the Senate Labor, Public Employment and Retirement Committee (2).

6. **Senate Health Committee Amendments**

The author agreed to accept amendments from the Senate Health Committee, which will be taken in the Senate Labor Public Employees and Retirement Committee (see FN 2) due to time and legislative calendar constraints related to hearing the bill in two committees so close together. Those amendments remove requirements on CHSSA, as specified, and leave the mandate on CalPERS health plans and the authorization for CalRx to include AOM in its partnership activities to source and/ or produce specified medicines.

7. **Senate Labor, Public Employees and Retirement Committee Recommended Amendments:**

To address some committee concerns outlined above, the committee recommends the following amendments:

- Delay implementation until January 1, 2028, to coincide with CalPERS' regular plan design and rate determination process.

- Eliminate references to "optional coverage" of AOM and references to AOM coverage "as part of one of its health care options".

SEC. 3. Section 22853.5 is added to the Government Code, to read:

22853.5. (a) Commencing ~~January 1, 2027~~, ***January 1, 2028,*** 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 at least one glucagon-like peptide-1 (GLP-1) antiobesity medication approved by the United States Food and Drug Administration~~, as part of one of its health plan options~~.…

8. Prior Legislation:

SB 535 (Richardson, 2025) would have required health plans and health insurers that provide coverage for outpatient prescription drug benefits to include coverage for intensive behavioral therapy, bariatric surgery, and at least one FDA-approved anti-obesity medication. SB 535 was held on the Assembly Appropriations Suspense File.
SB 839 (Bradford, 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 FDA-approved AOM. This bill died in the Senate Health Committee.

SB 523 (Leyva, Chapter 630, Statutes of 2022) prohibits employment-related discrimination on the basis of reproductive health decision-making, and, beginning in 2024, modifies several aspects of the laws governing health benefits plans and health insurance policies in order to expand coverage, reduce costs, and lower barriers to reproductive health services, including requiring coverage for contraceptives and vasectomies.

SUPPORT

American Diabetes Association
California Academy of Family Physicians
California Black Health Network
California Orthopedic Association
CPCA Advocates, Subsidiary of the California Primary Care Association

OPPOSITION

None received

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