Date of Hearing: June 16, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1089 (Richardson) – As Amended May 14, 2026

SENATE VOTE: 39-0

SUBJECT: Preventive Treatment Health Care Act.

SUMMARY: Requires a health benefit plan or contract offered to public employees and annuitants to offer coverage for chronic weight disease management or to treat obesity or overweight persons, including nutritional information and at least one glucagon-like peptide-1 (GLP-1) approved by the United States Food and Drug Administration (FDA). Expands California Health and Human Services Agency (CHHSA) authority under CalRx to enter into partnerships for GLP-1s. Specifically, **this bill**:

1) Requires a health benefit plan or contract that contract with the California Public Employee's Retirement System (CalPERS) board to offer coverage for chronic weight disease management or to treat obesity or overweight persons, including nutritional information and at least one GLP-1 antiobesity medication approved by the FDA.

2) Permits, when determining the cost for weight disease management or treatments for obesity or overweigh persons, the cost to Medi-Cal beneficiaries in the year 2025 or better pricing to be considered.

3) Sunsets 1) and 2) above on January 1, 2032.

4) Expands CHHSA authority under CalRx, subject to appropriation by the Legislature, to enter into partnerships to increase competition, lower prices, and address supply shortages for at least one GLP-1 antiobesity medication approved by the FDA. Requires CHHSA to make its best effort to negotiate pricing at or lower than the cost to Medi-Cal beneficiaries in 2025.

5) Defines GLP-1 antiobesity medication approved by the FDA to include a GLP-1, GLP-1 receptor agonist, glucose-dependent insulinotropic polypeptide plus GLP-1, GLP-1 receptor dual agonist, or tirzepatide.

6) Makes legislative findings and declarations about chronic weight disease and associated conditions and health outcomes.

EXISTING LAW:

1) Establishes the CHHSA, which consists of the following departments and offices: Aging, Child Support Services, Community Services and Development, Developmental Services, Health Care Access and Information (HCAI), Health Care Services, Managed Health Care (DMHC), Public Health, Rehabilitation, Social Services, State Hospitals, the Center for Data Insights and Innovation, the Emergency Medical Services Authority, the Office of Technology and Solutions Integration, the Office of Law Enforcement Support, the Office of the Surgeon General, the Office of Youth and Community Restoration, and the State Council on Developmental Disabilities. [Government Code (GOV) § 12803 and § 12806]

2) Establishes the California Affordable Drug Manufacturing Act of 2020. Requires CHHSA or its departments 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 for public and private purchasers, taxpayers, and consumers, and to increase patient access to affordable drugs. Permits CHHSA and its departments to enter into exclusive or nonexclusive contracts on a bid or negotiated basis. [Health and Safety Code (HSC) § 127690, *et seq.*]

3) Requires CHHSA to enter into partnerships resulting in the 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, and pharmacies. States that CHHSA will only enter into production partnerships at a price that results in savings, targets failures in the market for generic drugs, or improves patient access to affordable medications. Requires CHHSA to prioritize the selection of 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. [HSC § 127693]

4) Permits CHHSA and its departments, including HCAI, to enter into exclusive or nonexclusive contracts on a bid or negotiated basis in accomplishing 2) above. Exempts contracts entered into or amended pursuant to this authority from 7) and 8) of existing law below, and exempts these contracts from the review or approval of any division of the Department of General Services (DGS). [HSC § 127692]

5) Permits 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. [HSC § 127697]

6) Establishes the Public Employees' Medical and Hospital Care Act and the Board of Administration of CalPERS to provide health care, retirement, and other benefits to state and other government employees and retirees. [GOV §§ 22750-22755]

7) 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 DMHC and insurers regulated by the California Department of Insurance (CDI). [GOV § 22853.1, § 22853.3, and § 22853.4]

FISCAL EFFECT: According to the Senate Committee on Appropriations, unknown significant General Fund costs, at least tens of millions annually until January 1, 2032, due to increases in CalPERS plan premiums. HCAI estimates General Fund costs of approximately $450,000 for staffing resources to enter into partnerships (this assumes CHHSA would delegate these responsibilities to HCAI). In addition, HCAI estimates General Fund costs of several million dollars to effectuate partnerships for development, distribution, or procurement.

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, chronic weight disease is a serious problem in the United States. The author states that there are approximately 24.5 million adults between the ages of 18-64 years living in California. The author continues that according to UCLA's California Health Interview Survey, nearly 61% of California adults fall into the combined overweight/obese category, which is associated with 200 morbid conditions, including 13 types of cancer. The author states that chronic weight management can be related to a reduced labor participation, earnings, increased early mortality, absenteeism, disability, and healthcare costs exceeding $1 billion and a 2.6% reduction in the California Gross Domestic Product. The author notes that CalPERS health insurance covers more than 1.5 million public employees. The author continues that as the largest purchaser of public employee health benefits in California, the program provides coverage for over 1,200 public agencies and schools. The author concludes that this bill will require CalPERS to offer GLP-1s as an optional benefit through their health plan to reduce chronic weight management and reduce overall employer costs.

2) **BACKGROUND**. Obesity is a chronic health condition characterized by an increase in the size and amount of fat cells in the body. 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. Causes of obesity are multi-faceted and can include lifestyle habits, environment, stress, health conditions and certain medications, socioeconomic factors, and individual characteristics such as genetics and metabolism. Overall, it is estimated that 15.2% of adolescents aged 12 to 17 years and 27.8% of adults aged 18 to 64 years with private health insurance in California have BMIs that categorize them as having obesity. According to CalPERS, within their Basic and Medicare population of approximately 1,282,000 members, an estimated 360,000 (28%) have obesity or severe obesity and an additional 240,000 (19%) are overweight, together representing more than 600,000 potentially eligible members, or nearly half the Basic and Medicare population.

   a) **California Health Benefits Review Program (CHBRP)**. CHBRP was created in response to AB 1996 (Thomson), Chapter 795, Statutes of 2002, which 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. SB 125 (Hernandez), Chapter 9, Statutes of 2015, added an impact assessment on essential health benefits (EHBs), and legislation that impacts health insurance benefit designs, cost-sharing, premiums, and other health insurance topics to CHBRP's purview. CHBRP reviewed this bill and included the following impact estimates in their analysis:

      i) **Baseline coverage**. CHBRP estimates that at baseline, 187,000 CalPERS enrollees (15.3%) with state-regulated insurance subject to the mandate are enrolled in a plan that covers GLP-1 medications for weight management – specifically, Blue Shield HMO, which added this coverage as of January 1, 2026. The remaining 1,037,000

enrollees (84.7%) are in plans that do not cover GLP-1 medications for weight management.

ii) **Medical effectiveness.** CHBRP found that there is very strong evidence for adults and strong evidence for children and adolescents that GLP-1s result in weight loss.

iii) **Public health impacts.** CHBRP found that enrollees newly using GLP-1s would experience an average of 4.8% to 17.8% reduction in body weight and improvements in related health improvements over time. However, because this bill would not impact coverage for commercial or Medi-Cal enrollees, CHBRP found that this bill could exacerbate existing disparities in obesity and treatment.

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

v) **Premium and enrollee impacts.** At the time of the publication of this analysis, CHBRP's estimated premium impacts are outdated due to amendments taken in the Senate. However, CalPERS recently released an analysis of the current version of this bill with projected premium impacts, covered in the paragraph below.

b) **CalPERS premium impact.** According to an analysis of this bill published for their upcoming June 17 board meeting, CalPERS estimates that in the first-year premiums would increase by increase $437.3 million, or $28.09 per member per month (PMPM), with costs expected to grow by tens of millions of dollars annually in subsequent years as utilization rises. The state's General Fund share is estimated to be $187.2 million ($30.33 PMPM) in year one. CalPERS notes that these figures likely underestimate the true fiscal impact, as they do not account for the loss of CalPERS' negotiating leverage or the costs of managing side effects. CalPERS notes that CHBRP's analysis projected medical costs savings of approximately $454 per GLP-1 medication user annually after five or more years. However, this will only offset a fraction of the cost of the drugs. CalPERS states that these findings highlight the significant cost impact associated with GLP-1 coverage, with all members experiencing a higher premium, while projected long-term medical savings remain comparatively minimal.

c) **Recent elimination of GLP-1 coverage in Medi-Cal.** California's Medi-Cal program had previously opted to cover GLP-1 medications with an FDA indication for weight management, with quantity limits and labeler restrictions. However, this coverage was eliminated as of December 31, 2025. In 2024, the state reimbursed more than $1.6 billion for two GLP-1 drugs, representing approximately 10% of Medi-Cal's total pharmacy spending. Coverage for GLP-1 medications for Medi-Cal beneficiaries with other FDA-approved indications for GLP-1 medications (e.g., diabetes) remains intact.

d) **Growing consumer premiums and affordability concerns.** Over the last two decades, significant federal policy changes have reshaped the health insurance landscape in California, expanding coverage, increasing affordability, and strengthening consumer

protections for millions of residents. These policies drove historic reductions in the uninsured rate and provided greater stability for families, providers, and health systems across the state. These gains, however, are under threat as the expiration and rollback of key federal supports, combined with broader economic uncertainty and rising health care costs, risk reversing hard-won progress and increasing the number of Californians who are struggling to access affordable health care. According to the California Health Care Foundation 2026 Health Policy Survey (CHCF Survey), half of Californians (51%) reported that their health care expenses have increased faster than their incomes, and a vast majority (71%) are experiencing financial strain due to health care costs. About 6 in 10 Californians overall (59%), and 70% of Californians with low incomes, say they skipped or postponed care due to cost in the past year. Nearly half of Californians (47%) say it is "very" or "somewhat" difficult to afford health care.

i) **Employer coverage**. For those on employer-based individual and family plans, the California Health Benefits Survey found that the average total premium for family coverage in California has increased by 24% since 2022 – rapidly outpacing the national rates of inflation (12%) and wages (14%). This continues a 20-year trend: according to the UC Labor Center, family health care premiums for private-sector workers have grown by 129% since 2005, faster than the state's median household income (94%) and the inflation rate (69%). Because health insurance is part of an employee's total compensation plan, higher premiums cut into employee wage increases and other benefits.

e) **CalRx.** To help reduce the cost of prescription drugs in state programs and to consumers, the state recently created the CalRx program at HCAI. Established by SB 852 (Pan), Chapter 207, Statutes of 2020, the program aims to reduce the cost of drugs by expanding the availability of low-cost generics in the market. According to the Legislative Analyst's Office (LAO), CalRx accomplishes this objective by entering into partnerships with private entities to distribute or manufacture generic drugs. Before entering into these partnerships, HCAI must ensure they result in savings, address market failures, improve patient access, and are viable. The Legislature has directed HCAI to work on two key drug initiatives through CalRx, insulin and naloxone. CalRx has executed contracts for both drugs, offering an over-the-counter naloxone nasal spray product at $24 for each twin pack and a biosimilar insulin pen at $55 for a five-pack of 3mL pens.

3) **SUPPORT**. California Life Sciences (CLS) supports this bill, stating that it is an important step toward ensuring that the transformative GLP-1 therapies California's biopharmaceutical industry has helped develop can reach the patients who need them most. CLS continues that the development of GLP-1 receptor agonists and related therapies represents one of the most significant breakthroughs in metabolic medicine in decades, yet cost and access remain the primary barriers preventing Californians from benefiting from these innovations. CLS argues that this bill closes this access gap by mandating coverage for evidence-based chronic weight disease management within the CalPERS system, with pricing benchmarked to 2025 Medi-Cal rates or better. CLS notes that for life sciences companies, this is consequential in two ways. First, CLS states that it ensures that FDA approval and clinical validation translate into real patient access, fulfilling the promise of the regulatory pathway and supporting the commercial viability of treatments that required enormous scientific and financial investment to bring to market. Second, CLS continues that it positions California as a state where breakthrough therapies reach patients equitably — reinforcing the case for continued

innovation investment in metabolic and preventive medicine and signaling to the broader industry that California rewards scientific progress with meaningful policy.

4) PREVIOUS LEGISLATION.

a) AB 575 (Arambula) of 2025 would have required an individual or group health plan contract or health insurance policy that provides coverage for outpatient prescription drug benefits to include coverage for at least one FDA-approved GLP-1 receptor agonist and intensive behavioral therapy for the treatment of obesity without prior authorization. AB 575 was held in the Assembly Health Committee.

b) SB 535 (Richardson) of 2025 would have required health plans and health insurers that provide coverage for outpatient prescription drug benefits to include coverage intensive behavioral therapy, bariatric surgery, and at least one FDA-approved anti-obesity medication.

c) SB 1008 (Bradford) of 2024 was substantially similar to SB 535 (Richardson). SB 1008 was held in the Senate Appropriations Committee.

d) SB 839 (Bradford) of 2023 was substantially similar to AB 575, except that SB 839 did not prohibit prior authorization and prohibited cost-sharing from being different or separate from other illnesses, conditions, or disorders. SB 839 was not heard in the Senate Health Committee at the author's request.

e) AB 116 (Committee on Budget), Chapter 21, Statutes of 2025, expands authority for CalRx to enter into partnerships to increase competition, lower prices, and address supply shortages for generic or brand name drugs to address emerging health concerns including reproductive health care, gender affirming health care, vaccines, medical supplies, and medical devices.

f) AB 118 (Committee on Budget), Chapter 42, Statutes of 2023, clarifies and provides additional flexibility for CalRx to procure various pharmaceutical drugs in addition to its existing efforts to manufacture generic forms of insulin.

g) SB 184 (Committee on Budget and Fiscal Review), Chapter 47, Statutes of 2022, permits, until December 31, 2027, CHHSA and its departments to enter into contracts on a bid or negotiated basis and exempts these contracts from review or approval by the DGS for purposes of implementing CalRx.

h) SB 154 (Skinner), Chapter 43, Statutes of 2022, known as the Budget Act of 2022, appropriated $100 million to support the development of three low-cost biosimilar insulin products and a California-based insulin manufacturing facility, and required expenditures for construction or acquisition of the facility to result in full or partial ownership of the facility by the state.

i) SB 838 (Pan), Chapter 603, Statutes of 2022, requires CalRx to enter into a partnership to manufacture at least one form of insulin, to be made available at production and dispensing costs; requires this partnership to include representation and involvement with the governance of the contractor entity; and, requires CalRx, upon appropriation by the

Legislature, to develop a California-based manufacturing facility for generic drugs, as specified.

j) SB 852 (Pan) Chapter 207, Statutes of 2020, establishes CalRx.

5) DOUBLE REFERRAL. This bill is double referred. Should this bill pass out of this committee, it will be referred to the Assembly Committee on Public Employment and Retirement.

6) POLICY COMMENTS.

a) Exacerbating existing 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 (11.1%), followed by white adults (24.8%), Black adults (37.1%), Latino adults (39.4%), and American Indian/Alaska Native adults (45.6%). CHBRP notes that in addition to disparities in obesity rates by race and ethnicity, there are also disparities in use of anti-obesity medications. Specifically, it was found that Black and Latino adults with obesity were more likely to have financial barriers to accessing GLP-1 medications and were less likely to receive prescriptions compared to white adults. CHBRP notes that research also shows that the high cost of some obesity treatments, including GLP-1 medications, makes them inaccessible for patients with lower incomes.

This bill only expands GLP-1 coverage for CalPERS enrollees but would not provide coverage for enrollees of Medi-Cal, commercial CDI-regulated policies and commercial (non-CalPERS) DMHC-regulated plans. Therefore, this bill would contribute to increasing disparities coverage for GLP-1 medications for weight management and could further exacerbate racial and socioeconomic disparities in obesity rates overall. The Legislature must weigh if prioritizing GLP-1 coverage for public employees is worth the risk of increasing health access and outcome disparities, especially just one year after such coverage was eliminated for the lowest-income Californians under Medi-Cal.

b) Priorities in the midst of an affordability crisis. As detailed in the background section of this analysis, health insurance premiums are skyrocketing due to federal policy changes and disinvestments. These increasing costs are putting immense pressure on the pockets of millions of Californians and pushing many to abandon coverage altogether. This committee has held two informational hearings on this topic this year where firsthand stories of these impacts were shared. For example, a retired veteran from Colusa County testified about premiums for himself and his wife jumping from $540 a month to nearly $4,000 a month from 2025 to 2026. A cost that is more than double his monthly mortgage, and one he simply cannot afford on his fixed income. Stories like this represent the current reality for millions of people across the state, and public employees aren't exempt from these affordability pressures. In their analysis of this bill, CalPERS cautions that the cost of expanding GLP-1 coverage will directly impact members in the form of higher premiums. For retirees on fixed incomes, higher premiums may reduce financial stability. For active employees, higher premiums reduce take-home pay and increase pressure on wages and employer contributions, with broader implications for the state budget. This Legislature must thoroughly consider the impact of policies, such as those under this bill, that will significantly impact premiums at a time when there isn't room for consumers to bear more monthly costs.

7) **PROPOSED AMENDMENTS.** To address the concerns detailed above, the committee may wish to strike the CalPERS provisions of this bill and maintain the language expanding CalRx's authority to enter into partnerships to lower costs for GLP-1s. This will give the state the opportunity to make meaningful progress to reduce the cost of these drugs without increasing health care costs for consumers.

REGISTERED SUPPORT / OPPOSITION:

Support

American Diabetes Association
California Academy of Family Physicians
California Life Sciences Association
California Orthopedic Association
California Rheumatology Alliance
CPCA Advocates, Subsidiary of the California Primary Care Association
Los Angeles County Medical Association
Los Angeles LGBT Center

Opposition

None on file

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