Date of Hearing: July 15, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 535 (Richardson) – As Introduced February 20, 2025

**SENATE VOTE**: 28-3

**SUBJECT**: Obesity Treatment Parity Act.

**SUMMARY:** Requires 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 Food and Drug Administration (FDA)-approved anti-obesity medication. Specifically, **this bill**:

1) Requires an individual or group health care service plan contract and health insurance policy that provides coverage for outpatient prescription drug benefits and is issued, amended, or renewed on or after January 1, 2026, to include coverage for all of the following for the treatment of obesity:

    a) Intensive behavioral therapy;

    b) Bariatric surgery; and,

    c) At least one FDA-approved anti-obesity medication.

2) Allows a health plan or health insurer to apply utilization management to determine the medical necessity for treatment of obesity under this bill, 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 or policy.

3) Prohibits coverage criteria for FDA-approved anti-obesity medications from being more restrictive than the FDA-approved indications for those treatments.

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

5) Exempts from the provisions of this bill a specialized health care service plan contract or policy that covers only dental or vision benefits or a Medicare supplement contract or policy.

6) Makes legislative findings and declarations regarding obesity as a serious chronic disease, its linkage to chronic health conditions, its cost and coverage impacts, and the stigma associated with the disease.

**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) and the California Department of Insurance (CDI) to regulate health insurers under the Insurance Code. [Health and Safety Code (HSC) § 1340, *et seq*. and Insurance Code (INS) § 106, *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 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]

4) Allows health 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 health 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, California Code of Regulations (CCR) § 1300.67.24]

5) Requires a health insurance policy that covers outpatient prescription drugs to cover medically necessary drugs. [INS § 10123.201]

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:

i) The Elsevier Gold Standard's Clinical Pharmacology;

ii) The National Comprehensive Cancer Network Drug and Biologics Compendium; and,

iii) The Thomson Micromedex DrugDex; and,

f) 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]

**FISCAL EFFECT**: According to the Senate Appropriations Committee:

1) DMHC estimates costs to be approximately $3,710,000 in 2025-26, $9,848,000 in 2026-27, and $8,988,000 in 2027-28 and annually thereafter for state administration (Managed Care Fund).

2) Unknown costs, likely minor, for CDI for state administration (Insurance Fund).

**COMMENTS**:

**1) PURPOSE OF THIS BILL**. According to the author, obesity and diabetes are serious problems in the United States. More than 1 in 4 adults in California are obese, increasing from 19.3% in 2001 to 28.2% in 2021. Approximately 11.7% of adults in California have Type 2 diabetes. According to Let's Get Healthy California, if adult BMI were reduced by 5%, California could save $81.7 billion in obesity related health care costs by 2030. While diet and exercise are critical components of weight loss, many adults still fail to achieve weigh loss on their own. The United States Preventative Task Force has included weight loss medications as part of their research for future recommendations, stating, "Interventions that combined pharmacotherapy with behavioral interventions reported greater weight loss and weight loss maintenance over 12 to 18 months compared with behavioral interventions alone." FDA approved weight loss medications can be a useful tool in helping people prevent and control diabetes and improve health outcomes by achieving health weight. By including weight loss drugs in combination with a healthy diet and regular exercise, the author concludes we can reduce incidence of diabetes and comorbidities related to obesity and save money on health-related illness.

**2) 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 this bill. Key findings include:

**a)** ***Obesity and treatments***. According to CHBRP, 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 height and weight. Risks of heart disease, diabetes, respiratory issues, musculoskeletal disorders, and certain cancers, as well as reduced life expectancy can be increased because of obesity. 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. There are several methods used to treat obesity but this bill focuses on intensive behavioral therapy, bariatric surgery, and anti-obesity medications.

**b)** Intensive behavioral therapy is a particular form of behavioral intervention that is rigorous, structured, and involves multiple components, and, typically lasts one to two years and provides patients with tools to support weight loss and maintenance of weight loss (e.g., food scales, pedometers).

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

**d)** Anti-obesity medications can be broken into two types of drugs:

**i)** ***Glucagon-like peptide-1 (GLP-1) receptor agonists***. 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. CHBRP notes that not all GLP-1 medications are applicable to this bill because only three out of eight are FDA-approved specifically for the treatment of obesity. Those that are relevant include liraglutide (Saxenda), semaglutide (Wegovy), and tirzepatide (Zepbound).

**ii)** ***Non–GLP-1 medications***. Non–GLP-1 medications treat obesity through a variety of different mechanisms, including blocking fat absorption and deposition, suppressing appetite, and increasing metabolism. There are four non-GLP-1 medications with FDA indications for chronic weight management. Bupropion/naltrexone (Contave), Olistat (Xenical, Alli), Phentermine/Topiramate (Qsymie), and Phentermine (c) (Adipex-P, Lomaira).

**e)** ***Coverage impacts and enrollees covered***. At baseline, nearly all the population with health insurance subject to this bill has coverage for intensive behavioral therapy (99.8% enrollees), bariatric surgery (99.7% enrollees), and at least one FDA-approved anti-obesity medication. Specifically, 93.2% of enrollees have existing coverage for a non-glucagon-like peptide-1 [non-GLP-1] receptor agonist anti-obesity medication. With this

bill, 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 GLP-1 receptor agonist anti-obesity. 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 this bill.

**f)** ***Medical effectiveness***. CHBRP found very strong evidence that intensive behavioral health 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 anti-obesity medications are effective in reducing weight in adults, and conflicting evidence they are effective in reducing weight in children and adolescents.

**g)** ***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 intensive behavioral therapy and bariatric surgery without coverage; 42,813 enrollees use GLP-1s without coverage; and 2,023 use non–GLP-1 anti-obesity medications without coverage. In 2026, CHBRP estimates this bill would result in an increase in utilization of obesity treatments, including an additional: 35 enrollees receiving intensive behavioral therapy; four receiving bariatric surgery; and 4,047 utilizing anti-obesity medications (all non–GLP-1). As a result, these enrollees would experience a 3% to 14% reduction in body weight and related health improvements.

**h)** ***Medi-Cal and CalPERS***. No impact.

**i)** ***Impact on expenditures***. CHBRP estimates this bill 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.

**j)** ***Long-term impacts***. CHBRP estimates approximately 4,086 enrollees would newly use treatments for obesity within one year. Public health impacts would be likely to accrue to these individuals outside of the one-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.

**k)** ***Essential health benefits***. This bill is unlikely to result in an expansion of EHBs.

**3)** **SUPPORT**. This bill is sponsored by the Chronic Obesity Prevention and Education (cHOPE) Alliance, a program of the California Chronic Care Coalition, to ensure access to options for the treatment of obesity. The cHOPE Alliance describes itself as made up of more than fifteen patient advocacy groups and health care provider associations, including the Alliance for Patient Access, American Diabetes Association, California Chronic Care Coalition, California Pharmacists Association, California Access Coalition, among many others, that was formed on the belief that obesity must be addressed holistically, like any other chronic disease, and without shame or stigma. The sponsor states that it knows know

that addressing obesity will save lives, drive down health care costs, and lead to numerous societal benefits, including increased productivity and a better quality of life for millions of Californians. The sponsor states obesity has been recognized as a chronic, pervasive, and relapsing disease by the American Medical Association for the last decade, and 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 by helping Californians achieve healthy weight levels. Additionally, the sponsor states it would be remiss to not mention the substantial equity issue at play in the obesity space, citing numerous historically disadvantaged groups by race and income show numbers far higher. The sponsor concludes that, as California strives to address historic wrongs, it must prioritize the health of Californians who have been marginalized by ensuring access to the best that health care innovations have to offer, and this bill will ensure that Californians have a full range of treatment options available for the chronic disease of obesity.

4) **OPPOSITION**. This bill is opposed by the California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) which state that health plans and insurers in California currently offer a comprehensive array of weight management tools and interventions designed to promote sustainable, healthy lifestyle changes that effectively lower the risk for long-term health complications. Specifically, CAHP and ACLHIC state that they are troubled that this bill will inadvertently mandate health plans and insurers cover glucagon-like peptide 1 receptor agonists (GLP-1) for weight loss. CAHP and ACLHIC state this comes at a critical juncture when California is actively re-evaluating and, in some instances, eliminating coverage of these very drugs for weight loss due to their enormous cost. Health care leaders and nonpartisan budget experts across the state are already sounding the alarm about the unsustainable financial burden these drugs represent, especially as California faces unprecedented challenges with rising health care costs. CAHP and ACLHIC states the current pricing of these medications is prohibitively expensive, and argues their cost-effectiveness for broad population-level weight loss, particularly in the context of a state mandate, is highly questionable. CAHP and ACLHIC conclude that mandating coverage for these high-cost drugs would ultimately impact premiums and access to other essential health services, and it urges the Assembly Health Committee to consider the broader implications of this mandate on the affordability and accessibility of health care, stating it believes that a balanced approach, focusing on a range of evidence-based, cost-effective weight management strategies, is in the best interest of patients and the health care system.

5) **RELATED LEGISLATION**. AB 575 (Arambula) would require 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 glucagon-like peptide-1 receptor agonist and intensive behavioral therapy for the treatment of obesity without prior authorization. AB 575 is pending in the Assembly Health Committee.

6) **PREVIOUS LEGISLATION**.

   **a)** SB 1008 (Bradford) of 2024 was substantially similar to this bill. SB 1008 was held in the Senate Appropriations Committee.

**b)** 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.

**7) AMENDMENTS**. Following discussions with the author, this bill will be amended to narrow its provisions. The existing legislative findings and declarations will be re-worded, the provisions affecting health insurers in the Insurance Code will be deleted, the provision requiring coverage in the Knox-Keene Act of intensive outpatient therapy will be deleted, and the requirement for coverage for at least one FDA-approved anti-obesity medication will be clarified so that the requirement in this bill does not limit existing prescription drug coverage requirements, including the requirement in existing DMHC regulation requiring coverage of prescription drugs when medically necessary for the treatment of "morbid obesity."

**REGISTERED SUPPORT / OPPOSITION**:

**Support**

The Chronic Obesity Prevention and Education Alliance (sponsor)
Aids Healthcare Foundation
Alliance for Patient Access
American Diabetes Association
Biocom California
California Access Coalition
California Black Health Network
California Chapter American College of Cardiology
California Chronic Care Coalition
California Life Sciences Association
California Pharmacists Association
California Rheumatology Alliance
Looms for Lupus
Nevada Chronic Care Collaborative
Obesity Action Coalition
The L for Lupus Community Foundation
Western Center on Law & Poverty

**Oppose**

Association of California Life & Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce

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