Board of Administration

Agenda Item 8c

June 17, 2026

Item Name: Senate Bill 1089 (Richardson) – Preventive Treatment Health Care Act

Program: Legislation

Item Type: Action

Recommendation

Adopt an **OPPOSE** position on Senate Bill (SB) 1089 (Richardson), as amended May 14, 2026. SB 1089 would require California Public Employees' Retirement System (CalPERS) health plans to cover at least one GLP-1 medication for the treatment of overweight and obesity, resulting in significant and ongoing premium increases for members and employers. The bill would mandate coverage of high-cost GLP-1 medications without a mechanism for cost-containment, undermining CalPERS' ability to manage pharmaceutical spending through benefit design and pricing strategies. SB 1089 would therefore increase long-term program expenditures and reduce the Board's ability to maintain affordable and sustainable coverage.

Executive Summary

SB 1089 would amend the Public Employees' Medical and Hospital Care Act to require CalPERS health plans to cover medications to treat overweight and obesity, including at least one United States Food and Drug Administration (FDA)-approved GLP-1 medication, from January 1, 2028, through January 1, 2032.

CalPERS supports efforts to expand access to effective obesity treatment and recognizes the clinical benefits GLP-1 medications can offer. However, mandating coverage without cost controls would create an immediate and significant financial burden on members, employers, and the State General Fund, while undermining CalPERS' ability to manage or contain those costs.

The estimated first-year premium increase is $437.3 million, or $28.09 per member per month (PMPM), with costs expected to grow in subsequent years as utilization rises. The State General Fund share is estimated to be $187.2 million ($30.33 PMPM) in year one. 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.

Although structured as a five-year pilot, the mandate would effectively create a permanent benefit obligation, one that would be difficult to reverse and costly to sustain. States that have moved quickly to expand GLP-1 coverage are already scaling back due to unsustainable costs,

and California's own Medi-Cal program discontinued broad GLP-1 anti-obesity medication coverage in 2026.

Strategic Plan

This item supports the CalPERS Exceptional Health Care Strategic Goal to ensure CalPERS members have access to equitable, high-quality, affordable health care by ensuring the care CalPERS provides is affordable.

Background

Obesity and overweight are chronic medical conditions associated with increased risk of heart disease, stroke, diabetes, and certain cancers. The Centers for Disease Control defines overweight as a body mass index (BMI) between 25 and 30, obesity as a BMI of 30 or higher and severe obesity as a BMI of 40 or higher.[1] More than 40% of the U.S. adults have obesity, and an additional 30% are classified as overweight, together representing a substantial portion of the population and significant driver of health expenditures.[2,3]

GLP-1 medications were initially developed for diabetes treatment but are increasingly prescribed for the treatment of overweight and obesity due to their effects on appetite reduction and weight reduction. Utilization of GLP-1 medications specifically for obesity and overweight treatment has grown significantly in recent years, with products such as Zepbound accounting for a substantial share of prescriptions in the obesity medication class.[4]

GLP-1 anti-obesity medications have an FDA indication for chronic weight management in adults with obesity (BMI ≥ 30 kg/m^2) or overweight (BMI ≥ 27 kg/m^2) with at least one weight-related condition, such as type 2 diabetes, hypertension, or dyslipidemia. These medications are intended to be used alongside diet and exercise.

Current Federal, State, and CalPERS Coverage Requirements for GLP-1 Medications

Under the Affordable Care Act, Public Health Service Act, Section 2713, commercial health plans are required to cover certain obesity-related preventive services, such as counseling and screening; however, federal law does not require coverage of GLP-1 medications for weight loss.[5]

[1] Centers for Disease Control. “Adult BMI Categories.” March 19, 2024. https://www.cdc.gov/bmi/adult-calculator/bmi-categories.html
[2] Centers for Disease Control. “Adult Obesity Facts." May 14, 2024. https://www.cdc.gov/obesity/adult-obesity-facts/index.html
[3] Centers for Disease Control, National Center for Health Statistics. “Obesity and Overweight.” March 6, 2026. https://www.cdc.gov/nchs/fastats/obesity-overweight.htm
[4] Eli Lilly (LLY): Incretin Growth Still Drives the Story. TickerSpark Investor Intelligence. April 2026. https://tickerspark.ai/research/lly
[5] Title 42 United States Code 300gg-13: Coverage of preventive health services. USCode.House.gov. Accessed January 2026. https://uscode.house.gov/view.xhtml?req=(title:42%20section:300gg-13%20edition:prelim)

California law requires coverage of GLP-1 medications for diabetes and morbid obesity (BMI ≥ 40 kg/m^2) in health plans regulated under the Knox-Keene Health Care Service Plan Act of 1975.[6]

CalPERS' Knox-Keene regulated plans that manage their own pharmacy benefit, including HMO plans offered by Blue Shield of California and Kaiser Permanente, cover GLP-1 medications for morbid obesity (BMI ≥ 40 kg/m^2), subject to prior authorization requirements. CalPERS' self-insured pharmacy benefit manager covers non-GLP-1 anti-obesity medications for the treatment of overweight and obesity, including Phentermine, Qsymia and Contrave.

All CalPERS health plans currently cover GLP-1 medications for diabetes and certain obesity-related conditions, including obstructive sleep apnea, cardiovascular risk factors, and Metabolic Dysfunction-Associated Steatohepatitis. Coverage varies by health plan and clinical indication.

Analysis

Specifically, SB 1089:

- Requires, starting on January 1, 2028, and ending on January 1, 2032, a health benefit plan or contract offered to public employees and annuitants that contracts with the 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 anti-obesity medication approved by the FDA.
- Specifies that GLP-1 includes GLP-1, GLP-1 receptor agonist, glucose-dependent insulinotropic polypeptide plus GP-1, GLP-1 receptor dual agonist, or tirzepatide.
- Specifies that when determining the cost for weight disease management or treatments for obesity or overweight persons, CalPERS health plans may consider the cost previously provided to Medi-Cal beneficiaries in the year 2025 or better pricing.
- Requires chronic weight disease management or treatments for obesity or overweight persons to follow the indications for use in the label approved by the FDA.
- Allows California Health and Human Services Agency (CalHHS), subject to an appropriation by the Legislature, to enter into partnerships to increase competition, lower prices, and address supply shortages for at least one FDA approved GLP-1 anti-obesity medication, as specified.
- Requires CalHHS to make its best effort to negotiate pricing at or lower than the cost to Medi-Cal beneficiaries in the year 2025.

<u>Clinical Effectiveness Evidence</u>

GLP-1 medications have demonstrated significant effectiveness in weight reduction and may improve long-term health outcomes, including reduced risks in cardiovascular disease and chronic kidney disease.[7,8] Evidence reviews have found these therapies to be cost-effective on a per-patient basis under standard economic measures that evaluate outcomes and quality of life. However, cost-effectiveness is dependent on long-term adherence due to the high likelihood of weight regain after discontinuation. Additionally, at current prices and at population

[6] Cal. Health and Safety Code §1367.51. California Legislative Information. January 2026. https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=HSC&sectionNum=1367.51.&article=5.&highlight=true&keyword=glucagon+GLP-1

[7] Lifetime Health Effects and Cost-Effectiveness of Tirzepatide and Semaglutide in US Adults

[8] Fiscal Impact of Expanded Medicare Coverage for GLP-1 Receptor Agonists to Treat Obesity

scale, broad coverage is expected to substantially increase overall pharmacy spending, and current evidence indicates that medical savings would offset only a fraction of the cost of the drugs.[9]

Common adverse effects, including nausea, vomiting, diarrhea, and gastrointestinal complications, may drive increased utilization of primary care, specialist consultations, emergency care, and medication adjustments.[10] For a population the size of CalPERS, even relatively modest rates of side effect-related utilization could translate into substantial aggregate expenditures, materially increasing total program costs beyond current pharmacy projections.[11,12] At the same time, improved management of obesity and related chronic conditions could reduce other forms of medical utilization over the longer term.

Long-term adherence to GLP-1 therapy remains a significant concern, with a recent analysis finding that less than 25% to 35% of patients remain on treatment after one year.[13,14] Discontinuation is commonly driven by gastrointestinal side effects, such as nausea, vomiting, and diarrhea. Evidence also shows that patients who discontinue therapy regain much of the lost weight, while improvements in metabolic risk markers dimmish after cessation, meaning sustained benefits require chronic use.[15]

Clinical trials have demonstrated the short-term efficacy and safety of GLP-1 medications; however, long-term outcomes and cost impacts remain under evaluation. As a result, projections of meaningful long-term savings are difficult to rely on with confidence. Continued assessment of the effectiveness, durability, and tolerability of these medications over extended use will be important for informing future clinical and coverage policy decisions.[16]

Budget and Fiscal Impacts

Clinical Promise and Fiscal Considerations

According to the Institute for Clinical and Economic Review (ICER), these medications for the treatment of overweight and obesity may be cost-effective for some people over a lifetime, but broad coverage would strain health care resources due to the sheer scale of the eligible

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[9] *Final Evidence Report on Treatments for Obesity.* Institute for Clinical and Economic Review. December 16, 2025. https://icer.org/pressreleases/institute-for-clinical-and-economic-review-publishes-final-evidence-report-on-treatments-for-obesity/

[10] *Clinical Recommendations to Manage Gastrointestinal Adverse Events in Patients Treated with Glp-1 Receptor Agonists: A Multidisciplinary Expert Consensus.* Journal of Clinical Medicine. December 24, 2022. https://pmc.ncbi.nlm.nih.gov/articles/PMC9821052/

[11] *GLP-1 Side Effects Have a Side Effect on Pharmacy Costs| AMCP Annual 2025.* Managed Healthcare Executive. April 2, 2025. https://www.managedhealthcareexecutive.com/view/glp-1-side-effects-have-a-side-effect-on-pharmacy-costs-amcp-annual-2025

[12] *GLP-1s in Employee Health Plans: Cost Forecasts & Mitigation Tactics.* Inside Rx. November 25, 2025. https://insiderx.com/blog/glp-1s-in-employee-health-plans-cost-forecasts-mitigation-tactics

[13] *Glucagon-Like Peptide-1 Receptor Agonist Switching and Treatment Persistence in Adults Without Diabetes.* JAMA Network, Open. March 10, 2026. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2846157

[14] *Discontinuation and Reinitiation of Dual-Labeled GLP-1 Receptor Agonists Among US Adults With Overweight or Obesity.* JAMA Network, Open. January 31, 2025. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2829779

[15] *Metabolic rebound after GLP-1 receptor agonist discontinuation: a systematic review and meta-analysis.* eClinical Medicine. November 28, 2025. https://pmc.ncbi.nlm.nih.gov/articles/PMC12702299/

[16] *Weight Loss That Lasts: Reviewing the Long-Term Impact of GLP-1 Receptor Agonists*. Cureus. July 19, 2025. https://pmc.ncbi.nlm.nih.gov/articles/PMC12361690/

population.[17] Real-world data reinforces this concern as studies of total cost of care in the commercial market consistently show that GLP-1 coverage increases overall spending because added costs far exceed any savings from reduced healthcare utilization.[18]

Scale of Potential Eligibility

Within the CalPERS Basic and Medicare population of approximately 1,282,000 members, an estimated 360,000 (28%) have obesity or severe obesity (BMI ≥ 30 kg/m^2) and an additional 240,000 (19%) are overweight (BMI ≥ 27 and < 30 kg/m^2), together representing more than 600,000 potentially eligible members, or nearly half the Basic and Medicare population.

Projected Cost Increase

SB 1089 is estimated to increase total premiums for all CalPERS members by approximately $437.3 million ($28.09 PMPM) in year one. Costs are expected to grow by tens of millions of dollars annually in subsequent years.

For state members, SB 1089 is estimated to increase premiums by $226.6 million ($30.33 PMPM) in year one. The State General Fund impact is estimated to be $187.2 million ($30.33 PMPM), representing the state employer's share of CalPERS coverage. Costs are projected to increase in subsequent years consistent with broader utilization trends.

The California Health Benefits Review Program (CHBRP) analysis, using the ICER Interactive Modeler, 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. CHBRP projected that premiums would increase the first year following implementation of the mandate, with further increases expected over time.[19] 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.

Mandated Health Benefits Raise Costs

By mandating GLP-1 coverage, the bill removes all leverage that CalPERS has to negotiate prices, giving drug manufacturers unrestricted pricing power. While the bill references Medi-Cal 2025 pricing as a benchmark, it does not include an enforceable mechanism to ensure those prices would be available in the commercial market or preserve CalPERS' ability to secure more favorable terms. Beyond pricing, the mandate would limit CalPERS' flexibility to manage which members are served, restricting utilization management tools beyond verifying basic clinical eligibility criteria such as BMI thresholds.

Although the bill is structured as a five-year pilot program, establishing broad coverage for GLP-1 anti-obesity medications will likely create strong member expectations for continued access. As a result, discontinuing coverage at the end of the pilot period could be operationally

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[17] *Final Evidence Report on Treatments for Obesity.* Institute for Clinical and Economic Review. December 16, 2025. https://icer.org/pressreleases/institute-for-clinical-and-economic-review-publishes-final-evidence-report-on-treatments-for-obesity/

[18] *Employer Approaches to GLP-1 Coverage: Market Trend Report.* Peterson Health Technology Institute. December 2025. https://phti.org/wp-content/uploads/sites/3/2025/12/PHTI-Employer-Approaches-to-GLP-1-Coverage-Market-Trend-Report.pdf

[19] *Bill Analysis Report: California Senate Bill 1089 Preventive Treatment Health Care Act.* California Health Benefits Review Program, University of California, Berkeley. April 14, 2026. https://www.chbrp.org/sites/default/files/bill-documents/SB1089/SB%201089%20Preventive%20Treatment%20Care%20Act_Analysis_Final.pdf

and politically challenging, with potential member care disruption and increased pressure to maintain the benefit beyond the statutory timeframe. Additionally, discontinuation of coverage will result in members stopping treatment, which clinical evidence indicates leads to weight regain and may negate long-term health benefits and cost effectiveness.

These cost increases would flow through to the State General Fund, contracting agencies, and 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.

Finally, the mandate also undermines CalPERS' pharmacy cost trend guarantee with CVS Caremark, a critical cost control mechanism designed to ensure financial predictability and long-term sustainability to the CalPERS health program. The trend guarantee reflects a meaningful shift towards aligning CVS' financial interests with CalPERS' concern for quality and financial sustainability, which has been lacking in the pharmacy benefits industry. Unforeseen mandates of expensive treatments without cost controls upend CVS' ability to meet agreed upon trend targets.

Impact of GLP-1 Medications on Other State Health Plans

Rising utilization and pharmacy costs have led many state employee health plans to reevaluate obesity-related GLP-1 coverage. Several states initially expanded coverage of GLP-1 medications for weight loss for state employees but later discontinued or scaled back that coverage due to unstainable cost growth and budget pressures. This includes Colorado, Massachusetts, North Carolina, and West Virginia. California's Medi-Cal program discontinued broad coverage for obesity treatment using GLP-1 medications in 2026. 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 and prompting cost-containment measures.[20] These trends reflect increasing concern regarding long-term affordability and sustainability of broad coverage mandates.

Future Pricing Outlook

While recent federal actions, including Most Favored Nation pricing agreements with Eli Lilly and Novo Nordisk and Medicare drug price negotiations, may place some downward pressure on GLP-1 costs over time, these reductions apply primarily to government programs and are unlikely to materially lower commercial market prices within the bill's 2028 to 2032 timeframe.

Benefits and Risks

Benefits:

- GLP-1 medications have demonstrated meaningful effectiveness in weight reduction and may improve long-term health outcomes.
- Members currently paying out-of-pocket for GLP-1 anti-obesity medications may gain improved access and reduced personal costs.

[20] *Weight Loss That Lasts: Reviewing the Long-Term Impact of GLP-1 Receptor Agonists*. Cureus. July 19, 2025. https://pmc.ncbi.nlm.nih.gov/articles/PMC12361690/

Risks:

- GLP-1 anti-obesity medications are a high-cost and rapidly growing pharmaceutical category, with very high first-year premium increase, leading to unsustainable cost growth over time as utilization rises.
- Although structured as a five-year pilot, the mandate would create strong member expectations for continued access, making it difficult to discontinue coverage in 2032, effectively locking in long-term spending growth.
- All members and employers would bear higher premiums regardless of individual utilization, reducing financial stability for retirees on fixed incomes and take-home pay for active employees, with particularly large impacts on employees of school and public agencies with lower employer contributions.

Attachments

Attachment 1 – Support and Opposition

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