Date of Hearing: June 9, 2026

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 1023 (Laird) – As Amended March 16, 2026

SENATE VOTE: 29-0

SUBJECT: Health care coverage: antiretroviral drugs, drug devices, and drug products.

SUMMARY: Requires a health plan and health insurer that covers non-self-administered drugs, drug devices, or drug products that are approved by the United States Food and Drug Administration (FDA) for the prevention of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) as a medical benefit to also cover those items as an outpatient prescription drug benefit. Specifically, **this bill**:

1) Requires a health plan and health insurer that covers non-self-administered drugs, drug devices, or drug products that are approved by the FDA for the prevention of HIV/AIDS as a medical benefit to also include those non-self-administered antiretroviral drugs, drug devices, or drug products that are approved by the FDA for the prevention of HIV/AIDS as an outpatient prescription drug benefit.

2) Adds drug devices and drug products to existing prior authorization and step therapy exemptions for antiretroviral (ARV) drugs that are medically necessary for the prevention of HIV/AIDS.

3) Exempts specialized health plan contracts or insurance policies that cover only dental, mental health, or vision benefits, and Medicare supplement contracts and policies.

4) Applies the law regardless of whether an antiretroviral drug, drug device, or drug product is self-administered.

5) Authorizes the California Department of Insurance (CDI) to exercise the authority provided in law and the Administrative Procedures Act (APA) as specified, to implement and enforce this bill and the law it amends. Permits a hearing requested by an insurer when a penalty is assessed to be conducted by an administrative law judge or the administrative hearing bureau of CDI under specified procedures. States that this does not impair or restrict the CDI Commissioner's authority pursuant to another provision of the law or the APA.

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 CDI to regulate health and other insurance. [Health & Safety Code (HSC) § 1340, *et seq*. and Insurance Code (INS) § 106, *et seq*.]

2) Establishes California's essential health benefits (EHBs) benchmark under the Patient Protection and Affordable Care Act (ACA) as the Kaiser Small Group Health Maintenance Organization, establishes existing California health insurance mandates, and the 10 ACA

mandated benefits, including prescription drug coverage. [HSC § 1367.005 and INS § 10112.27]

3) Requires health plans and insurers, at a minimum, to provide coverage for and prohibits any cost-sharing requirements for the following:

   a) Evidence-based items or services that had in effect on January 1, 2025 a rating of "A" or "B" in the recommendations of the United States Preventive Services Taskforce (USPSTF);

   b) Immunizations that had a recommendation in effect on January 1, 2025 from the Advisory Committee on Immunization Practices (ACIP) of the Center for Disease Control; and,

   c) With respect to infants, children, adolescents, and women, additional preventive care and screenings provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration (HRSA) as of January 1, 2025. [HSC § 1367.002 and INS § 10112.2]

4) Permits the State Department of Public Health (DPH) to modify or supplement baseline recommendations by the USPSTF, ACIP and HRSA that were in effect on January 1, 2025. Allows DPH to take into consideration guidance and recommendations from additional medical and scientific organizations, including the American Academy of Pediatrics, American College of Obstetricians and Gynecologists, and the American Academy of Family Physicians. [HSC § 120164]

5) Defines "basic health care services" 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]

6) Requires the criteria or guidelines used by health plans and insurers, or any entities with which plans or insurers contract for utilization review (UR) or utilization management (UM) functions, to determine whether to authorize, modify, or deny health care services to:

   a) Be developed with involvement from actively practicing health care providers;

   b) Be consistent with sound clinical principles and processes;

   c) Be evaluated, and updated if necessary, at least annually;

   d) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee or insured in that specified case; and,

   e) Be available to the public upon request. [HSC § 1363.5 and INS § 10123.135]

7) Authorizes a health plan or insurer that provides coverage for prescription drugs to require step therapy if there is more than one drug that is clinically appropriate for the treatment of a medical condition. [HSC § 1367.206 and INS § 10123.201]

8) Requires a health plan or insurer to expeditiously grant a request for a step therapy exception within the applicable time limit if a prescribing provider submits necessary justification and supporting clinical documentation that the required prescription drug is inconsistent with good professional practice for provision of medically necessary covered services, taking into consideration the enrollee's or insured's needs and medical history. Permits the basis of the provider's determination to include, but not be limited to, any of the following criteria:

   a) The prescription drug required by the plan or insurer is contraindicated or is likely, or expected, to cause an adverse reaction or physical or mental harm in comparison to the requested prescription drug;

   b) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the enrollee or insured and the known characteristics and history of the enrollee's or insured's prescription drug regimen;

   c) The enrollee or insured has tried the required prescription drug while covered by their current or previous health coverage or Medicaid, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse reaction. Permits the plan or insurer to require the submission of documentation demonstrating that the enrollee or insured tried the required prescription drug before it was discontinued;

   d) The required prescription drug is not clinically appropriate for the enrollee or insured because the required drug is expected to do any of the following, as determined by the prescribing provider:

      i) Worsen a comorbid condition;

      ii) Decrease the capacity to maintain a reasonable functional ability in performing daily activities; or,

      iii) Pose a significant barrier to adherence to, or compliance with, the enrollee or insured's drug regimen or plan of care.

   e) The enrollee or insured is stable on a prescription drug selected by the prescribing provider for the medical condition under consideration while covered by their current or previous health coverage or Medicaid. [HSC § 1367.206 and INS § 10123.201]

9) Authorizes a health care provider or prescribing provider, enrollee, insured, or their designee or guardian to appeal a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request consistent with the plan's or insurer's current UM process. [HSC § 1367.206 and INS § 10123.201]

10) Prohibits a health plan or insurer from subjecting antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, including preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP), to prior authorization or step therapy. Permits a health plan or insurer not to cover all of the therapeutically equivalent versions without prior authorization or step therapy, if at least one therapeutically equivalent version is covered without prior authorization or step therapy, if the FDA has approved one or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV. [HSC § 1342.74 and INS § 10123.1933]

11) Prohibits health plans and insurers or their designated pharmacy benefit manager from prohibiting, a pharmacy provider from dispensing PrEP or PEP. Requires health plans and insurers to cover PrEP and PEP that has been furnished by a pharmacist, as authorized in the law, including the pharmacist's services and related testing ordered by the pharmacist. Requires plans and insurers to pay or reimburse, consistent with the law, the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the health plan has an out-of-network pharmacy benefit. [*Ibid.*]

12) Exempts health plans and insurers from covering PrEP and PEP furnished by a pharmacist at an out-of-network pharmacy, unless the health plan or insurer has an out-of-network pharmacy benefit. [*Ibid.*]

13) Prohibits, for specified plans and insurers, the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription from exceeding $250 for a supply of up to 30 days or $500 for bronze products. [HSC § 1342.73 and INS § 10123.1932]

FISCAL EFFECT: According to the Senate Appropriation Committee, DMHC estimates costs of approximately $288,000 in 2027-28, and $276,000 in 2028-29 and annually thereafter for state administration (Managed Care Fund) and unknown costs, likely minor, for CDI for state administration (Insurance Fund).

COMMENTS:

1) **PURPOSE OF THIS BILL**. According to the author, this bill increases access to HIV PrEP by requiring health plans that already cover the medication to offer reimbursement through their outpatient prescription drug benefit pathway. The author continues that PrEP is a highly effective clinical strategy that uses ARV medication to prevent HIV-negative individuals from acquiring the virus. The author notes that plans may currently restrict reimbursement for PrEP to the medical benefit pathway. The author argues that medical benefit billing is often unsustainable for smaller healthcare providers due to administrative and financial barriers. The author states that this bill allows healthcare providers to secure timely reimbursement, increasing access to HIV PrEP for patients who receive care at small local clinics. The author concludes that given the current volatility of federal grants, structural adjustments to the reimbursement process are necessary to ensure California's public health infrastructure supports HIV prevention efforts.

2) **BACKGROUND.** HIV attacks the body's CD4 and/or T-cells (i.e., a type of white blood cell), which are integral to the body's immune function. If undiagnosed and left untreated, HIV invades and effectively destroys CD4 cells during the virus replication process, leading to opportunistic infections, opportunistic cancers, and death. Without initial treatment and routine adherence to treatment, HIV typically progresses through three stages of disease: acute HIV infection; chronic HIV infection; and AIDS. There is no cure for HIV/AIDS; however, with routine care and proper treatment, HIV-related morbidity and mortality can be prevented through ARV therapy.

   a) **ARVs for prevention of HIV/AIDs.** Preventing the transmission of HIV to the HIV-negative population has been the focus of a concerted U.S. public health effort for more than 30 years. According to the California Health Benefits Review Program (CHBRP), ARV therapy is the use of HIV medicines — also referred to as an HIV regimen — to treat or prevent HIV. There are more than 30 FDA-approved ARV drugs from eight drug classes that may be used to prevent initial HIV infection (PREP or PEP) or treat HIV infection, prevent HIV transmission to other people, and prevent progression to AIDS. Given the availability of ARV drugs, it is possible for people living with HIV to achieve a life expectancy similar to that of the general population.

   b) **Medical vs. pharmacy benefit coverage for ARVs.** In general, drugs that are physician-ordered and administered under the supervision of a physician (such as in a hospital, a provider's office, infusion center, or similar medical facility), along with the hospital stay or office visit, are covered through the medical benefit. Pharmacy benefits typically cover outpatient prescription drugs by covering prescriptions that are filled at a retail pharmacy, a mail-order pharmacy, or a specialty pharmacy. According to CHBRP, the majority of ARV drugs are covered under the pharmacy benefit. However, long-acting injectable ARV drugs, such as cabotegravir and lenacapavir, are typically covered under the medical benefit. This bill would require health plans and insurers that cover FDA approved drugs for the prevention of HIV/AIDS as a medical benefit to also cover those drugs as a pharmacy benefit.

3) **SUPPORT.** The Los Angeles LGBT Center (the Center), a cosponsor of this bill, writes that PrEP is an essential tool in curbing the spread of HIV and keeping health care costs down. The Center notes that there has been significant innovation in the field of biomedical HIV prevention since Truvada, the first oral formulation of HIV PrEP, was approved by the FDA in 2012. The Center continues that today, two injectable formulations (one administered every two months and another every six months) are available, offering improved adherence and greater clinical effectiveness for many patients. The Center argues that investing in effective HIV prevention yields significant health care savings over the lifespan. The San Francisco Aids Foundation (SFAF), another cosponsor of this bill, notes that despite PrEP's proven clinical effectiveness and ample insurance coverage, uptake remains low, particularly among Black and Latine gay, bisexual, and same-gender loving cisgender men. SFAF cites that approximately 71% of the nation's white men with a PrEP indication initiate a regimen, whereas Black and Latine men trail far behind in PrEP uptake at 15% and 18%, respectively. SFAF argues that when injectable PrEP is only covered under the medical benefit, many providers are unable to offer it—particularly those that lack the resources to purchase medications upfront and seek reimbursement. SFAF continues that as a result, patients are left with fewer options to access the modality that works best for them. SFAF states that supporting providers by enabling them to choose the best billing pathway for their

operations, and thus their patients' needs, can help reduce these disparities in HIV diagnoses and inequities in health care delivery.

4) **OPPOSITION**. The California Association of Health Plans and Association of California Life and Health Insurance Companies oppose this bill, stating that health plans are already required to cover antiretroviral drugs used for the prevention of HIV/AIDS without step therapy or prior authorization. The opposition continues that legislative mandates that change how plans structure their benefit design – without any clear nexus to consumer access – is not only costly, but creates confusion, reduces flexibility, and undermines the ability of plans to design benefits in a manner that is clinically appropriate and responsive to patient needs. The opposition argues that this bill establishes a troubling precedent by directing how health plans/insurers must structure their benefit designs, an area that has traditionally been within their purview based on clinical care guidelines, actuarial considerations, and regulatory standards. The opposition notes that health plans/insurers distinguish between medical and pharmacy benefits primarily based on the method and setting of administration. The opposition continues that this bill would require plans to categorize certain provider-administered drugs as outpatient prescription drug benefits, despite the fact that these medications are, by definition, not self-administered and are delivered in clinical settings. The opposition concludes that reclassifying these drugs in this manner is inconsistent with longstanding industry standards and could create operational and administrative challenges.

5) **PREVIOUS LEGISLATION**.

   a) AB 554 (Mark González) of 2025, would have required a nongrandfathered health plan contract or health insurance policy to provide coverage, without any cost-sharing, for ARV drugs, devices, or products that are approved by the FDA for PrEP. Would have prohibited a health plan or health insurer from subjecting ARV drug devices or drug products that are medically necessary for the prevention HIV/AIDS to prior authorization or step therapy, but authorizes prior authorization or step therapy if at least one therapeutically equivalent version is covered without prior authorization or step therapy. Would have prohibited a health plan or insurer from imposing cost sharing on a nonformulary ARV drug, drug device, or drug product covered pursuant to an exception request if the nonformulary ARV drug, drug device, or drug product is therapeutically equivalent to a formulary ARV drug, drug device, or drug product that is covered by the health plan or insurer without cost sharing. AB 554 was vetoed by Governor Newsom, who stated in part:

   > I wholeheartedly support efforts to ensure affordable and accessible prevention and treatment of HIV/AIDS, and I share the author's desire to address politically motivated changes to long-standing preventive services requirements by the current hostile federal administration…However, certain components of this measure raise concerns about affordability. By exceeding the cost-sharing provisions under the ACA, this bill would result in increased costs to health plans, which would then be passed on to consumers. At a time when individuals are facing double-digit rate increases in their health care premiums across the nation, the state must weigh the potential benefits of all new mandates against the comprehensive costs to the entire health care delivery system.

b) SB 339 (Weiner), Chapter 1, Statutes of 2024, requires health plans and insurers to cover HIV PrEP and PEP furnished by a pharmacist, including costs for the pharmacist's services and related testing ordered by the pharmacist. Permits a pharmacist to furnish up to a 90-day course of PrEP, or beyond 90-days if specified conditions are met.

c) SB 427 (Portantino) of 2024 was substantially similar to AB 554. SB 427 was held at the Assembly Desk.

d) SB 159 (Wiener), Chapter 532, Statutes of 2019, permits pharmacists to furnish a 60-day supply of PrEP and PEP; prohibits health plans and insurers from requiring prior authorization or step therapy for PrEP or PEP; requires coverage of pharmacist-prescribed PrEP and PEP; and, permits Medi-Cal reimbursement for pharmacists prescribing PrEP and PEP.

REGISTERED SUPPORT / OPPOSITION:

Support

APLA Health (sponsor)
Insurance Commissioner Ricardo Lara / California Department of Insurance (sponsor)
Los Angeles LGBT Center (sponsor)
San Francisco AIDs Foundation (sponsor)
Aids Healthcare Foundation
American Academy of HIV Medicine California/Hawaii Chapter
Biocom
California Federation of Teachers
California LGBTQ Health and Human Services Network
California Life Sciences Association
California Medical Association
California STD/HIV Controller's Association
County Health Executives Association of California
Drug Policy Alliance
Essential Access Health
Glide
Health Access California
Healthright 360
National Health Law Program
Planned Parenthood Affiliates of California
Sunburst Projects
ViiV Healthcare

Opposition

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

Analysis Prepared by: Riana King / HEALTH / (916) 319-2097