SENATE THIRD READING
SB 1023 (Laird)
As Amended August 18, 2026
Majority vote

SUMMARY

Requires a health plan *or* insurer *to cover* 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 both a medical benefit and a prescription drug benefit. *Requires, if obtained under the prescription drug benefit, the drug, device or product to be dispensed and administered by a health care provider acting within the scope of their license.*

Major Provisions

COMMENTS

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 antiretroviral (ARV) therapy.

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.

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.

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.

Arguments in Support
The Los Angeles (Lesbian Gay Bisexual and Transgender) 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.

Arguments in 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.

FISCAL COMMENTS

According to the Assembly Committee on Appropriations:

1) General Fund costs to the California Public Employees Retirement System of an unknown amount, likely exceeding $150,000 per year, by increasing access to ARV treatment.

2) The Department of Managed Health Care and California Department of Insurance estimate minor and absorbable costs.

VOTES

SENATE FLOOR: 29-0-11
YES: Allen, Archuleta, Arreguín, Ashby, Becker, Blakespear, Cabaldon, Caballero, Cervantes, Cortese, Durazo, Gonzalez, Grayson, Hurtado, Laird, Limón, McGuire, McNerney, Menjivar, Pérez, Reyes, Richardson, Rubio, Smallwood-Cuevas, Stern, Umberg, Wahab, Weber Pierson, Wiener
ABS, ABST OR NV: Alvarado-Gil, Choi, Dahle, Grove, Jones, Niello, Ochoa Bogh, Padilla, Seyarto, Strickland, Valladares

ASM HEALTH: 11-0-5
YES: Bonta, Addis, Aguiar-Curry, Ahrens, Caloza, Carrillo, Elhawary, Patel, Celeste Rodriguez, Sharp-Collins, Stefani
ABS, ABST OR NV: Chen, Johnson, Patterson, Sanchez, Schiavo

ASM APPROPRIATIONS: 11-1-3
YES: Wicks, Arambula, Calderon, Caloza, Fong, Mark González, Krell, Pacheco, Pellerin, Sharp-Collins, Solache
NO: Tangipa
ABS, ABST OR NV: Hoover, Dixon, Ta

UPDATED

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