SENATE BILL No. 523

Introduced by Senator Leyva

February 17, 2021

An act to add Section 22856 to the Government Code, to amend Section 1367.25 of the Health and Safety Code, to amend Section 10123.196 of the Insurance Code, and to add Section 10509.5 to the Public Contract Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 523, as introduced, Leyva. Health care coverage: contraceptives.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law provides for the regulation of health insurers by the Department of Insurance. Existing law establishes health care coverage requirements for contraceptives, including, but not limited to, requiring a health care service plan, including a Medi-Cal managed care plan, or a health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, to cover up to a 12-month supply of federal Food and Drug Administration approved, self-administered hormonal contraceptives when dispensed at one time for an enrollee or insured by a provider or pharmacist, or at a location licensed or authorized to dispense drugs or supplies.

This bill, the Contraceptive Equity Act of 2021, would make various changes to expand coverage of contraceptives by a health care service plan contract or health insurance policy issued, amended, renewed, or delivered on and after January 1, 2022, including requiring a health care service plan or health insurer to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost-sharing or medical

management restrictions and to reimburse enrollees and insureds for out-of-pocket costs for over-the-counter birth control methods purchased at any out-of-network pharmacy in California, without medical management restrictions. The bill would also require coverage for clinical services related to the provision or use of contraception, as specified. The bill would revise provisions applicable when a covered, therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by deferring to the attending provider, as specified.

With respect to religious employers, this bill would authorize an enrollee or insured to submit a request to the health care service plan or health insurer if the employer elects not to purchase coverage for contraceptive methods, as required by existing law. The bill would require the applicable department to reimburse a religious employer for the contraceptive care and related products provided to the employee, as specified. The bill would prohibit the employer from discriminating or retaliating against the employee for independently obtaining contraceptives outside of the employer's plan under this authorization.

This bill would prohibit the Board of Public Relations of the Public Employees' Retirement System and the University of California from approving or renewing a health benefit plan that does not comply with the contraceptive coverage requirements of the bill and existing law described above, on and after January 1, 2022.

Because a willful violation of the bill's requirements by a health care service plan would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. This act shall be known, and may be cited, as the Contraceptive Equity Act of 2021.

SEC. 2. The Legislature finds and declares all of the following:

(a) California has a long history of expanding timely access to birth control to prevent unintended pregnancy. Thanks to a

combination of innovative policies and programs enacted statewide, unintended pregnancy rates are at a 30-year low.

(b) Despite the progress made, health disparities in reproductive health outcomes persist among Black, Indigenous and People of Color, including disproportionate unintended pregnancy, infant and maternal mortality, and (STD) rates. The legislature must take action to ensure that all Californians have equitable access to preventive contraceptive care.

(c) The federal Patient Protection and Affordable Care Act (Public Law 111-148) included a mandate that most health insurance plans cover contraception without out-of-pocket costs for patients.

(d) California's Contraceptive Coverage Equity Act of 2014 and the Annual Supply of Contraceptives Act of 2016, built on this federal policy and existing state law to be the first state in the country to require coverage of birth control methods approved by the federal Food and Drug Administration for women without cost-sharing or restrictions and a 12-month supply of self-administered birth control dispensed at one time for individuals enrolled in health insurance plans and policies regulated by the Keene Health Care Service Act of 1975.

(e) Since 2014, several other states have expanded on California's model legislation to create more equitable contraceptive coverage and access by requiring most health insurance plans and policies to cover voluntary sterilization services and all birth control methods available over-the-counter without a prescription for all beneficiaries, regardless of gender.

(f) A report by the Guttmacher Institute shows that vasectomy is among the most effective – and cost-effective contraceptive methods available.

(g) Trump-era attacks on birth control access have underscored the need to codify the expansion of contraceptive coverage for as many Californians as possible under state law.

(h) The COVID-19 public health emergency has also further illuminated the structural inequities that disproportionately affect youth, low-income people and communities of color in accessing birth control services. A report by the Guttmacher Institute revealed that 29 percent of White women, 38 percent of Black women and 45 percent of Latinas now face difficulties accessing birth control as a result of the pandemic.

(i) The COVID-19 pandemic has exacerbated rates of sexually transmitted diseases STDs in California and across the country that were already skyrocketing to epidemic proportions prior to the public health emergency. Condoms are the only birth control method that also reduce STD transmission rates.

(j) The Legislature intends to reduce sexual and reproductive health disparities and ensure greater health equity by providing a pathway for more Californians to get the contraceptive care they want, when they need it – without inequitable delays or cost barriers. This includes a pathway to no-cost coverage for Californians whose employer-based health insurance plan may exclude contraceptive care under existing California law.

(k) The Legislature intends for the relevant California departments and agencies to work in concert to ensure compliance with these provisions.

SEC. 3. Section 22856 is added to the Government Code, to read:

22856. Notwithstanding any other law, commencing January 1, 2022, the board shall not approve a health benefit plan contract for employees that does not comply with the contraceptive coverage requirements of Section 1367.25 of the Health and Safety Code, Section 10123.196 of the Insurance Code, and Senate Bill No. 999 (Ch. 499, Stats. 2016).

SEC. 4. Section 1367.25 of the Health and Safety Code is amended to read:

1367.25. (a) A group health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2000, to December 31, 2015, inclusive, and an individual health care service plan contract that is amended, renewed, or delivered on or after January 1, 2000, to December 31, 2015, inclusive, except for a specialized health care service plan contract, shall provide coverage for the following, under general terms and conditions applicable to all benefits:

(1) A health care service plan contract that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration (FDA)-approved prescription contraceptive methods designated by the plan. In the event the patient's participating provider, acting within ~~his or her~~ *the provider's* scope of practice, determines that none of the

methods designated by the plan is medically appropriate for the patient's medical or personal history, the plan shall also provide coverage for another FDA-approved, medically appropriate prescription contraceptive method prescribed by the patient's provider.

(2) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(b) (1) A health care service plan contract, except for a specialized health care service plan contract, that is issued, amended, renewed, or delivered on or after January 1, 2016, shall provide coverage for all of the following services and contraceptive methods for ~~women:~~ *all subscribers and enrollees:*

(A) Except as provided in subparagraphs (B) and (C) of paragraph (2), all FDA-approved contraceptive drugs, devices, and other ~~products for women,~~ *products,* including all FDA-approved contraceptive drugs, devices, and products available over the ~~counter, as prescribed by the enrollee's provider.~~ *counter without a prescription, as follows:*

(i) A health care service plan shall not require a prescription to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products.

(ii) A health care service plan is required to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost-sharing or medical management restrictions and reimburse enrollees for out-of-pocket costs for over-the-counter birth control methods purchased at any out-of-network pharmacy in California without medical management restrictions.

(iii) A health care service plan may limit the frequency and define quantities with which the coverage required under this subparagraph is provided.

(B) Voluntary sterilization procedures.

~~(C) Patient education and counseling on contraception.~~

(C) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education, and counseling.

(D) Followup services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not

limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(2) (A) ~~Except for a grandfathered health plan, a~~ *A* health care service plan subject to this subdivision shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this ~~subdivision.~~ *subdivision, except for a grandfathered health plan or a qualifying health plan for a health savings account. For a qualifying health plan for a health savings account, the carrier shall establish the plan's cost-sharing for the coverage required pursuant to this subdivision at the minimum level necessary to preserve the enrollee's ability to claim tax-exempt contributions and withdrawals from the enrollee's health savings account under Internal Revenue Service laws and regulations.* Cost sharing shall not be imposed on any Medi-Cal beneficiary.

(B) If the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, a health care service plan is not required to cover all of those therapeutically equivalent versions in accordance with this subdivision, as long as at least one is covered without cost sharing in accordance with this subdivision. *If there is no therapeutically equivalent generic substitute available in the market, a health care service plan is required to provide coverage without cost sharing for the original, brand name contraceptive.*

(C) If a covered therapeutic equivalent of a drug, device, or product ~~is not available, or~~ is deemed medically inadvisable by the enrollee's provider, a health care service plan ~~shall provide coverage, subject to a plan's utilization management procedures, for the prescribed contraceptive drug, device, or product without cost sharing. Any~~ *shall defer to the determination and judgment of the attending provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost-sharing requirements. Medical inadvisability may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider. The department shall promulgate regulations establishing an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome, including timeframes, for an enrollee, an enrollee's*

designee, or an enrollee's provider to request coverage of an alternative prescribed contraceptive. A request by a contracting provider shall be responded to by the health care service plan in compliance with the Knox-Keene Health Care Service Plan Act of 1975, as set forth in this chapter and, as applicable, with the plan's Medi-Cal managed care contract.

(3) Except as otherwise authorized under this section, a health care service plan *shall not infringe upon an enrollee's choice of contraceptive drug, device, or product and* shall not impose any restrictions or delays on the coverage required under this ~~subdivision.~~ *subdivision, including prior authorization, step therapy, or other utilization control techniques.*

(4) Benefits for an enrollee under this subdivision shall be the same for an enrollee's covered spouse and covered nonspouse dependents.

(5) For purposes of ~~paragraphs (2) and (3) of this subdivision, and subdivision (d),~~ *this subdivision,* "health care service plan" shall include Medi-Cal managed care plans that contract with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(c) Notwithstanding any other provision of this section, a religious employer may request a health care service plan contract without coverage for FDA-approved contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a health care service plan contract shall be provided without coverage for contraceptive methods. *The exclusion from coverage under this provision shall not apply to a contraceptive drug, device, procedure, or other product that is used for purposes other than contraception.*

(1) For purposes of this section, a "religious employer" is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization as described in Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

~~(2) Every religious employer that invokes the exemption provided under this section shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.~~

(2) If a religious employer makes an election under this section not to purchase coverage for contraceptive methods, all of the following shall apply:

(A) The religious employer shall provide written notice to prospective enrollees prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.

(B) An employee may submit a request for no-cost contraceptive care coverage to the health care service plan, drugs, devices, products, and procedures. If a request is received, the health care service plan shall provide no-cost contraceptive coverage following the requirements of this section and provisions outlined in Senate Bill No. 999 (Ch. 499, Stats. 2016).

(C) The health care service plan shall be reimbursed by the state for contraceptive care, services, drugs, devices, products, and procedures provided to employees under this provision. This subparagraph shall cease to be implemented on July 1, 2023, unless the department determines that date may be extended based on utilization demand and need, and subject to an appropriation by the Legislature for that purpose.

(D) A religious employer that invokes the exemption under this subparagraph may not discriminate, fire, or enforce other workplace punishment against an employee based on the employee's decision to independently obtain contraceptive coverage, care, or prescriptions outside of the employer-based plan.

(d) (1) Every health care service plan contract that is issued, amended, renewed, or delivered on or after January 1, 2017, shall cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an enrollee by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

(2) ~~Nothing in this~~ *This* subdivision shall *not* be construed to require a health care service plan contract to cover contraceptives provided by an out-of-network provider, pharmacy, or location licensed or otherwise authorized to dispense drugs or supplies, except as may be otherwise authorized by state or federal law or by the plan's policies governing out-of-network coverage.

(3) ~~Nothing in this~~ *This* subdivision shall *not* be construed to require a provider to prescribe, furnish, or dispense 12 months of self-administered hormonal contraceptives at one time.

(4) A health care service plan subject to this subdivision, in the absence of clinical contraindications, shall not impose utilization controls or other forms of medical management limiting the supply of FDA-approved, self-administered hormonal contraceptives that may be dispensed or furnished by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply.

(e) This section shall not be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within ~~his or her~~ *the provider's* scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an enrollee.

(f) This section shall not be construed to deny or restrict ~~in any way~~ the department's authority to ensure plan compliance with this chapter when a plan provides coverage for contraceptive drugs, devices, and products.

(g) This section shall not be construed to require an individual or group health care service plan contract to cover experimental or investigational treatments.

(h) For purposes of this section, the following definitions apply:

(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(3) With respect to health care service plan contracts issued, amended, or renewed on or after January 1, 2016, "provider" means an individual who is certified or licensed pursuant to Division 2

(commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, or Division 2.5 (commencing with Section 1797) of this code.

(i) The changes made to this section by the act that added this subdivision apply only to a health care service plan contract that is issued, amended, renewed, or delivered on or after January 1, 2022.

SEC. 5. Section 10123.196 of the Insurance Code is amended to read:

10123.196. (a) An individual or group policy of disability insurance issued, amended, renewed, or delivered on or after January 1, 2000, through December 31, 2015, inclusive, that provides coverage for hospital, medical, or surgical expenses, shall provide coverage for the following, under the same terms and conditions as applicable to all benefits:

(1) A disability insurance policy that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration (FDA)-approved prescription contraceptive methods, as designated by the insurer. If an insured's health care provider determines that none of the methods designated by the disability insurer is medically appropriate for the insured's medical or personal history, the insurer shall, in the alternative, provide coverage for some other FDA-approved prescription contraceptive method prescribed by the patient's health care provider.

(2) Coverage with respect to an insured under this subdivision shall be identical for an insured's covered spouse and covered nonspouse dependents.

(b) (1) A group or individual policy of disability insurance, except for a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2016, shall provide coverage for all of the following services and contraceptive methods for ~~women:~~ *all policyholders and insureds:*

(A) Except as provided in subparagraphs (B) and (C) of paragraph (2), all FDA-approved, contraceptive drugs, devices, and other ~~products for women,~~ *products,* including all FDA-approved, contraceptive drugs, devices, and products available over the ~~counter, as prescribed by the insured's provider.~~ *counter without a prescription, as follows:*

(i) A health insurer shall not require a prescription to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products.

(ii) A health insurer is required to provide point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products at in-network pharmacies without cost-sharing or medical management restrictions and reimburse insureds for out-of-pocket costs for over-the-counter birth control methods purchased at any out-of-network pharmacy in California without medical management restrictions.

(iii) A health care insurer may limit the frequency and define quantities with which the coverage required under this subparagraph is provided.

(B) Voluntary sterilization procedures.

~~(C) Patient education and counseling on contraception.~~

(C) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, ultrasound, anesthesia, patient education, and counseling.

(D) Followup services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not limited to, management of side effects, counseling for continued adherence, and device insertion and removal.

(2) (A) ~~Except for a grandfathered health plan, a~~ *A* disability insurer subject to this subdivision shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this ~~subdivision.~~ *subdivision, except for a grandfathered health plan or a qualifying health plan for a health savings account. For a qualifying health plan for a health savings account, the carrier shall establish the plan's cost-sharing for the coverage required pursuant to this subdivision at the minimum level necessary to preserve the insured's ability to claim tax exempt contributions and withdrawals from the insured's health savings account under Internal Revenue Service laws and regulations.*

(B) If the FDA has approved one or more therapeutic equivalents of a contraceptive drug, device, or product, a disability insurer is not required to cover all of those therapeutically equivalent versions in accordance with this subdivision, as long as at least one is covered without cost sharing in accordance with this subdivision. *If there is no therapeutically equivalent generic substitute available*

in the market, a health care service plan is required to provide coverage without cost sharing for the original, brand name contraceptive.

(C) If a covered therapeutic equivalent of a drug, device, or product ~~is not available, or~~ is deemed medically inadvisable by the insured's provider, a disability insurer shall ~~provide coverage, subject to an insurer's utilization management procedures, for the prescribed contraceptive drug, device, or product without cost sharing. Any~~ *defer to the determination and judgment of the attending provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost-sharing requirements. Medical inadvisability may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives and ability to adhere to the appropriate use of the drug or item, as determined by the attending provider. The department shall promulgate regulations establishing an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome, including timeframes, for an insured, an insured's designee or an insured's provider to request coverage of an alternative prescribed contraceptive. A* request by a contracting provider shall be responded to by the disability insurer in compliance with Section 10123.191.

(3) Except as otherwise authorized under this section, an insurer *shall not infringe upon an insured's choice of contraceptive drug, device, or product and* shall not impose any restrictions or delays on the coverage required under this ~~subdivision.~~ *subdivision, including prior authorization, step therapy, or other utilization control techniques.*

(4) Coverage with respect to an insured under this subdivision shall be identical for an insured's covered spouse and covered nonspouse dependents.

(c) This section shall not be construed to deny or restrict in any way any existing right or benefit provided under law or by contract. *The exclusion from coverage under this provision shall not apply to a contraceptive drug, device, procedure, or other product that is used for purposes other than contraception.*

(d) This section shall not be construed to require an individual or group disability insurance policy to cover experimental or investigational treatments.

(e) Notwithstanding any other provision of this section, a religious employer may request a disability insurance policy without coverage for contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a disability insurance policy shall be provided without coverage for contraceptive methods.

(1) For purposes of this section, a "religious employer" is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization pursuant to Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

~~(2) Every religious employer that invokes the exemption provided under this section shall provide written notice to any prospective employee once an offer of employment has been made, and prior to that person commencing that employment, listing the contraceptive health care services the employer refuses to cover for religious reasons.~~

(2) If a religious employer makes an election under this section not to purchase coverage for contraceptive methods, all of the following shall apply:

(A) The religious employer shall provide written notice to prospective insured prior to enrollment with the plan, listing the contraceptive health care services the employer refuses to cover for religious reasons.

(B) An employee may submit a request for no-cost contraceptive care coverage to the disability insurer, drugs, devices, products, and procedures. If a request is received, the health care service plan shall provide no-cost contraceptive coverage following the requirements of this section and provisions outlined in Senate Bill No. 999 (Ch. 499, Stats. 2016).

(C) The health care service plan shall be reimbursed by the state for contraceptive care, services, drugs, devices, products, and procedures provided to employees under this provision. This subparagraph shall cease to be implemented on July 1, 2023,

unless the department determines that date may be extended based on utilization demand and need, and subject to an appropriation by the Legislature for that purpose.

(D) A religious employer that invokes the exemption under this subparagraph may not discriminate, fire, or enforce other workplace punishment against an employee based on the employee's decision to independently obtain contraceptive coverage, care, or prescriptions outside of the employer-based plan.

(f) (1) A group or individual policy of disability insurance, except for a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2017, shall cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an insured by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

(2) ~~Nothing in this subdivision shall~~ *This subdivision shall not* be construed to require a policy to cover contraceptives provided by an out-of-network provider, pharmacy, or location licensed or otherwise authorized to dispense drugs or supplies, except as may be otherwise authorized by state or federal law or by the insurer's policies governing out-of-network coverage.

(3) ~~Nothing in this subdivision shall~~ *This subdivision shall not* be construed to require a provider to prescribe, furnish, or dispense 12 months of self-administered hormonal contraceptives at one time.

(4) A health insurer subject to this subdivision, in the absence of clinical contraindications, shall not impose utilization controls or other forms of medical management limiting the supply of FDA-approved, self-administered hormonal contraceptives that may be dispensed or furnished by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply.

(g) This section shall not be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within ~~his or her~~ *the provider's* scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an insured.

(h) This section only applies to disability insurance policies or contracts that are defined as health benefit plans pursuant to subdivision (a) of Section 10198.6, except that for accident only, specified disease, or hospital indemnity coverage, coverage for benefits under this section applies to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy or contract. This section shall not be construed as imposing a new benefit mandate on accident only, specified disease, or hospital indemnity insurance.

(i) For purposes of this section, the following definitions apply:

(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(3) With respect to policies of disability insurance issued, amended, or renewed on or after January 1, 2016, "health care provider" means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, or Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

(j) The changes made to this section by the act that added this subdivision apply only to a health insurance policy that is issued, amended, renewed, or delivered on or after January 1, 2022.

SEC. 6. Section 10509.5 is added to the Public Contract Code, to read:

10509.5. Notwithstanding any other law, commencing January 1, 2022, the University of California shall not approve a health benefit plan contract for employees that does not comply with the contraceptive coverage requirements of Section 1367.25 of the Health and Safety Code, Section 10123.196 of the Insurance Code, and Senate Bill No. 999 (Ch. 499, Stats. 2016).

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty

for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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