

AMENDED IN ASSEMBLY JULY 17, 2025

AMENDED IN ASSEMBLY JULY 3, 2025

**SENATE BILL**

**No. 257**

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**Introduced by Senator Wahab**  
**(Coauthors: Senators Ashby, Cabaldon, Cervantes, Laird, Limón,**  
**Rubio, and Wiener)**

February 3, 2025

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An act to amend Section 1399.849 of, and to add Section 1374.54 to, the Health and Safety Code, and to amend Section 10965.3 of, and to add Section 10119.4 to, the Insurance Code, relating to health care coverage.

LEGISLATIVE COUNSEL'S DIGEST

SB 257, as amended, Wahab. Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act.

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 disability insurers by the Department of Insurance. Existing law requires a health care service plan or disability insurer to allow an individual to enroll in or change their health benefit plan as a result of a specified triggering event. Existing law prohibits a health care service plan contract or disability insurance policy issued, amended, renewed, or delivered on or after July 1, 2003, from imposing a copayment or deductible for specified maternity services that exceeds the most common amount of the copayment or deductible imposed for services provided for other covered medical conditions.

This bill, the Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act, would make pregnancy a triggering event for purposes of enrollment or changing a health benefit plan. The bill would prohibit a health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2026, that provides coverage for maternity services or newborn and pediatric care services from ~~taking specified actions based on the circumstances of conception, including~~ seeking reimbursement for maternity services or newborn and pediatric care services because the enrollee or insured is acting as a gestational carrier. *The bill would prohibit a health care service plan or health insurer from discriminating against an enrollee, insured, enrollee's or insured's newborn, or attending health care provider based on the circumstances of conception.* Because a willful violation of these provisions 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:*

1 SECTION 1. This act shall be known, and may be cited, as the  
2 Pregnancy As a Recognized Event for Nondiscriminatory  
3 Treatment (PARENT) Act.

4 SEC. 2. Section 1374.54 is added to the Health and Safety  
5 Code, to read:

6 1374.54. (a) A health care service plan *contract* issued,  
7 amended, or renewed on or after January 1, 2026, that provides  
8 coverage for maternity services or newborn and pediatric care  
9 services shall not seek reimbursement for maternity services or  
10 newborn and pediatric care services because the enrollee is acting  
11 as a gestational carrier.

12 (b) ~~To comply with subdivision (a), a~~ A health care service plan  
13 shall not do either of the following based on the circumstances of  
14 conception:

15 (1) Deny coverage to an enrollee or the enrollee's newborn.

1 (2) Otherwise discriminate against an enrollee, an enrollee's  
2 newborn, or an attending health care provider.

3 (c) For purposes of this section, "maternity services" include  
4 prenatal care, ambulatory care maternity services, involuntary  
5 complications of pregnancy, neonatal care, and inpatient hospital  
6 maternity care, including labor and delivery and postpartum care.

7 SEC. 3. Section 1399.849 of the Health and Safety Code is  
8 amended to read:

9 1399.849. (a) (1) On and after October 1, 2013, a plan shall  
10 fairly and affirmatively offer, market, and sell all of the plan's  
11 health benefit plans that are sold in the individual market for policy  
12 years on or after January 1, 2014, to all individuals and dependents  
13 in each service area in which the plan provides or arranges for the  
14 provision of health care services. A plan shall limit enrollment in  
15 individual health benefit plans to open enrollment periods, annual  
16 enrollment periods, and special enrollment periods as provided in  
17 subdivisions (c) and (d).

18 (2) A plan shall allow the subscriber of an individual health  
19 benefit plan to add a dependent to the subscriber's plan at the  
20 option of the subscriber, consistent with the open enrollment,  
21 annual enrollment, and special enrollment period requirements in  
22 this section.

23 (b) An individual health benefit plan issued, amended, or  
24 renewed on or after January 1, 2014, shall not impose any  
25 preexisting condition provision upon any individual.

26 (c) (1) With respect to individual health benefit plans offered  
27 outside of the Exchange, a plan shall provide an initial open  
28 enrollment period from October 1, 2013, to March 31, 2014,  
29 inclusive, an annual enrollment period for the policy year beginning  
30 on January 1, 2015, from November 15, 2014, to February 15,  
31 2015, inclusive, annual enrollment periods for policy years  
32 beginning on or after January 1, 2016, to December 31, 2018,  
33 inclusive, from November 1, of the preceding calendar year, to  
34 January 31 of the benefit year, inclusive, and annual enrollment  
35 periods for policy years beginning on or after January 1, 2019,  
36 from October 15, of the preceding calendar year, to January 15 of  
37 the benefit year, inclusive.

38 (2) With respect to individual health benefit plans offered  
39 through the Exchange, a plan shall provide an annual enrollment  
40 period for the policy years beginning on January 1, 2016, to

1 December 31, 2018, inclusive, from November 1, of the preceding  
2 calendar year, to January 31 of the benefit year, inclusive, and  
3 annual enrollment periods for policy years beginning on or after  
4 January 1, 2019, from November 1 to December 15 of the  
5 preceding calendar year, inclusive.

6 (3) With respect to individual health benefit plans offered  
7 through the Exchange, for policy years beginning on or after  
8 January 1, 2019, a plan shall provide a special enrollment period  
9 for all individuals selecting an individual health benefit plan  
10 through the Exchange from October 15 to October 31 of the  
11 preceding calendar year, inclusive, and from December 16, of the  
12 preceding calendar year, to January 15 of the benefit year,  
13 inclusive. An application for a health benefit plan submitted during  
14 these two special enrollment periods shall be treated the same as  
15 an application submitted during the annual open enrollment period.  
16 The effective date of coverage for plan selections made between  
17 October 15 and October 31, inclusive, shall be January 1 of the  
18 benefit year, and for plan selections made from December 16 to  
19 January 15, inclusive, shall be no later than February 1 of the  
20 benefit year.

21 (4) Pursuant to Section 147.104(b)(2) of Title 45 of the Code  
22 of Federal Regulations, for individuals enrolled in noncalendar  
23 year individual health plan contracts, a plan shall also provide a  
24 limited open enrollment period beginning on the date that is 30  
25 calendar days prior to the date the policy year ends in 2014.

26 (d) (1) Subject to paragraph (2), commencing January 1, 2014,  
27 a plan shall allow an individual to enroll in or change individual  
28 health benefit plans as a result of the following triggering events:

29 (A) The individual or the individual's dependent loses minimum  
30 essential coverage. For purposes of this paragraph, the following  
31 definitions shall apply:

32 (i) "Minimum essential coverage" has the same meaning as that  
33 term is defined in Section 1345.5 or subsection (f) of Section  
34 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

35 (ii) "Loss of minimum essential coverage" includes, but is not  
36 limited to, loss of that coverage due to the circumstances described  
37 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the  
38 Code of Federal Regulations and the circumstances described in  
39 Section 1163 of Title 29 of the United States Code. "Loss of

1 minimum essential coverage” also includes loss of that coverage  
2 for a reason that is not due to the fault of the individual.

3 (iii) “Loss of minimum essential coverage” does not include  
4 loss of that coverage due to the individual’s failure to pay  
5 premiums on a timely basis or situations allowing for a rescission,  
6 subject to clause (ii) and Sections 1389.7 and 1389.21.

7 (B) The individual gains a dependent or becomes a dependent.

8 (C) The individual is mandated to be covered as a dependent  
9 pursuant to a valid state or federal court order.

10 (D) The individual has been released from incarceration.

11 (E) The individual’s health coverage issuer substantially violated  
12 a material provision of the health coverage contract.

13 (F) The individual gains access to new health benefit plans as  
14 a result of a permanent move.

15 (G) The individual was receiving services from a contracting  
16 provider under another health benefit plan, as defined in Section  
17 1399.845 of this code or Section 10965 of the Insurance Code, for  
18 one of the conditions described in subdivision (c) of Section  
19 1373.96 of this code and that provider is no longer participating  
20 in the health benefit plan.

21 (H) The individual demonstrates to the Exchange, with respect  
22 to health benefit plans offered through the Exchange, or to the  
23 department, with respect to health benefit plans offered outside  
24 the Exchange, that the individual did not enroll in a health benefit  
25 plan during the immediately preceding enrollment period available  
26 to the individual because the individual was misinformed that the  
27 individual was covered under minimum essential coverage.

28 (I) The individual is a member of the reserve forces of the United  
29 States military returning from active duty or a member of the  
30 California National Guard returning from active duty service under  
31 Title 32 of the United States Code.

32 (J) The individual is pregnant. Enrollment shall not be affected  
33 by the circumstances of conception, including if the individual is  
34 acting as a gestational carrier, and shall be extended to individuals  
35 who are dependents of the pregnant individual and an individual  
36 to whom the pregnant individual is a dependent.

37 (K) With respect to individual health benefit plans offered  
38 through the Exchange, in addition to the triggering events listed  
39 in this paragraph, any other events listed in Section 155.420(d) of  
40 Title 45 of the Code of Federal Regulations.

(2) With respect to individual health benefit plans offered outside the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to apply for coverage from a health care service plan subject to this section.

With respect to individual health benefit plans offered through the Exchange, an individual shall have 60 days from the date of a triggering event identified in paragraph (1) to select a plan offered through the Exchange, unless a longer period is provided in Part 155 (commencing with Section 155.10) of Subchapter B of Subtitle A of Title 45 of the Code of Federal Regulations.

(e) With respect to individual health benefit plans offered through the Exchange, the effective date of coverage required pursuant to this section shall be consistent with the dates specified in Section 155.410 or 155.420 of Title 45 of the Code of Federal Regulations, as applicable. A dependent who is a registered domestic partner pursuant to Section 297 of the Family Code shall have the same effective date of coverage as a spouse.

(f) With respect to individual health benefit plans offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan contract, the health care service plan shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 1399.855. The individual shall have 30 days in which to exercise the right to buy coverage at the quoted premium charges.

(2) With respect to an individual health benefit plan for which an individual applies during the initial open enrollment period described in paragraph (1) of subdivision (c), when the subscriber submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, by December 15, 2013, coverage under the individual health benefit plan shall become effective no later than January 1, 2014. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16, 2013, to December 31, 2013, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in paragraph (1) of subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15 of the preceding calendar year, coverage shall become effective on January 1 of the benefit year. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 to December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the plan receives the request for special enrollment.

(g) (1) A health care service plan shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

1 (C) Claims experience.

2 (D) Receipt of health care.

3 (E) Medical history.

4 (F) Genetic information.

5 (G) Evidence of insurability, including conditions arising out  
6 of acts of domestic violence.

7 (H) Disability.

8 (I) Any other health status-related factor as determined by any  
9 federal regulations, rules, or guidance issued pursuant to Section  
10 2705 of the federal Public Health Service Act (Public Law 78-410).

11 (2) Notwithstanding Section 1389.1, a health care service plan  
12 shall not require an individual applicant or the applicant's  
13 dependent to fill out a health assessment or medical questionnaire  
14 prior to enrollment under an individual health benefit plan. A health  
15 care service plan shall not acquire or request information that  
16 relates to a health status-related factor from the applicant or the  
17 applicant's dependent or any other source prior to enrollment of  
18 the individual.

19 (h) (1) A health care service plan shall consider as a single risk  
20 pool for rating purposes in the individual market the claims  
21 experience of all insureds and all enrollees in all nongrandfathered  
22 individual health benefit plans offered by that health care service  
23 plan in this state, whether offered as health care service plan  
24 contracts or individual health insurance policies, including those  
25 insureds and enrollees who enroll in individual coverage through  
26 the Exchange and insureds and enrollees who enroll in individual  
27 coverage outside of the Exchange. Student health insurance  
28 coverage, as that coverage is defined in Section 147.145(a) of Title  
29 45 of the Code of Federal Regulations, shall not be included in a  
30 health care service plan's single risk pool for individual coverage.

31 (2) Each calendar year, a health care service plan shall establish  
32 an index rate for the individual market in the state based on the  
33 total combined claims costs for providing essential health benefits,  
34 as defined pursuant to Section 1302 of PPACA, within the single  
35 risk pool required under paragraph (1). The index rate shall be  
36 adjusted on a marketwide basis based on the total expected  
37 marketwide payments and charges under the risk adjustment  
38 program established for the state pursuant to Section 1343 of  
39 PPACA and Exchange user fees, as described in subdivision (d)  
40 of Section 156.80 of Title 45 of the Code of Federal Regulations.



1 The premium rate for all of the health benefit plans in the individual  
2 market within the single risk pool required under paragraph (1)  
3 shall use the applicable marketwide adjusted index rate, subject  
4 only to the adjustments permitted under paragraph (3).

5 (3) A health care service plan may vary premium rates for a  
6 particular health benefit plan from its index rate based only on the  
7 following actuarially justified plan-specific factors:

8 (A) The actuarial value and cost-sharing design of the health  
9 benefit plan.

10 (B) The health benefit plan's provider network, delivery system  
11 characteristics, and utilization management practices.

12 (C) The benefits provided under the health benefit plan that are  
13 in addition to the essential health benefits, as defined pursuant to  
14 Section 1302 of PPACA and Section 1367.005. These additional  
15 benefits shall be pooled with similar benefits within the single risk  
16 pool required under paragraph (1) and the claims experience from  
17 those benefits shall be utilized to determine rate variations for  
18 plans that offer those benefits in addition to essential health  
19 benefits.

20 (D) With respect to catastrophic plans, as described in subsection  
21 (e) of Section 1302 of PPACA, the expected impact of the specific  
22 eligibility categories for those plans.

23 (E) Administrative costs, excluding user fees required by the  
24 Exchange.

25 (i) This section shall only apply with respect to individual health  
26 benefit plans for policy years on or after January 1, 2014.

27 (j) This section shall not apply to a grandfathered health plan.

28 SEC. 4. Section 10119.4 is added to the Insurance Code, to  
29 read:

30 10119.4. (a) A health insurance policy issued, amended, or  
31 renewed on or after January 1, 2026, that provides coverage for  
32 maternity services or newborn and pediatric care services shall not  
33 seek reimbursement for maternity services or newborn and pediatric  
34 care services because the insured is acting as a gestational carrier.

35 (b) ~~To comply with subdivision (a), a~~ A health insurer shall not  
36 do either of the following based on the circumstances of  
37 conception:

38 (1) Deny coverage to an insured or the insured's newborn.

39 (2) Otherwise discriminate against an insured, an insured's  
40 newborn, or an attending health care provider.

1 (c) For purposes of this section, “maternity services” has the  
2 same meaning as in Section 10123.865.

3 SEC. 5. Section 10965.3 of the Insurance Code is amended to  
4 read:

5 10965.3. (a) (1) On and after October 1, 2013, a health insurer  
6 shall fairly and affirmatively offer, market, and sell all of the  
7 insurer’s health benefit plans that are sold in the individual market  
8 for policy years on or after January 1, 2014, to all individuals and  
9 dependents in each service area in which the insurer provides or  
10 arranges for the provision of health care services. A health insurer  
11 shall limit enrollment in individual health benefit plans to open  
12 enrollment periods, annual enrollment periods, and special  
13 enrollment periods as provided in subdivisions (c) and (d).

14 (2) A health insurer shall allow the policyholder of an individual  
15 health benefit plan to add a dependent to the policyholder’s health  
16 benefit plan at the option of the policyholder, consistent with the  
17 open enrollment, annual enrollment, and special enrollment period  
18 requirements in this section.

19 (b) An individual health benefit plan issued, amended, or  
20 renewed on or after January 1, 2014, shall not impose any  
21 preexisting condition provision upon any individual.

22 (c) (1) With respect to individual health benefit plans offered  
23 outside of the Exchange, a health insurer shall provide an initial  
24 open enrollment period from October 1, 2013, to March 31, 2014,  
25 inclusive, an annual enrollment period for the policy year beginning  
26 on January 1, 2015, from November 15, 2014, to February 15,  
27 2015, inclusive, annual enrollment periods for policy years  
28 beginning on or after January 1, 2016, to December 31, 2018,  
29 inclusive, from November 1, of the preceding calendar year, to  
30 January 31 of the benefit year, inclusive, and annual enrollment  
31 periods for policy years beginning on or after January 1, 2019,  
32 from October 15 of the preceding calendar year, to January 15 of  
33 the benefit year, inclusive.

34 (2) With respect to individual health benefit plans offered  
35 through the Exchange, a health insurer shall provide an annual  
36 enrollment period for the policy years beginning on January 1,  
37 2016, to December 31, 2018, inclusive, from November 1, of the  
38 preceding calendar year, to January 31 of the benefit year,  
39 inclusive, and annual enrollment periods for policy years beginning

1 on or after January 1, 2019, from November 1 to December 15 of  
2 the preceding calendar year, inclusive.

3 (3) With respect to individual health benefit plans offered  
4 through the Exchange, for policy years beginning on or after  
5 January 1, 2019, a health insurer shall provide a special enrollment  
6 period for all individuals selecting an individual health benefit  
7 plan through the Exchange from October 15 to October 31 of the  
8 preceding calendar year, inclusive, and from December 16, of the  
9 preceding calendar year, to January 15 of the benefit year,  
10 inclusive. An application for a health benefit plan submitted during  
11 these two special enrollment periods shall be treated the same as  
12 an application submitted during the annual open enrollment period.  
13 The effective date of coverage for plan selections made between  
14 October 15 and October 31, inclusive, shall be January 1 of the  
15 benefit year, and for plan selections made from December 16 to  
16 January 15, inclusive, shall be no later than February 1 of the  
17 benefit year.

18 (4) Pursuant to Section 147.104(b)(2) of Title 45 of the Code  
19 of Federal Regulations, for individuals enrolled in noncalendar  
20 year individual health plan contracts, a health insurer shall also  
21 provide a limited open enrollment period beginning on the date  
22 that is 30 calendar days prior to the date the policy year ends in  
23 2014.

24 (d) (1) Subject to paragraph (2), commencing January 1, 2014,  
25 a health insurer shall allow an individual to enroll in or change  
26 individual health benefit plans as a result of the following triggering  
27 events:

28 (A) The individual or the individual's dependent loses minimum  
29 essential coverage. For purposes of this paragraph, ~~both~~ all of the  
30 following definitions shall apply:

31 (i) "Minimum essential coverage" has the same meaning as that  
32 term is defined in Section 1345.5 of the Health and Safety Code  
33 or subsection (f) of Section 5000A of the Internal Revenue Code  
34 (26 U.S.C. Sec. 5000A).

35 (ii) "Loss of minimum essential coverage" includes, but is not  
36 limited to, loss of that coverage due to the circumstances described  
37 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the  
38 Code of Federal Regulations and the circumstances described in  
39 Section 1163 of Title 29 of the United States Code. "Loss of

1 minimum essential coverage” also includes loss of that coverage  
2 for a reason that is not due to the fault of the individual.

3 (iii) “Loss of minimum essential coverage” does not include  
4 loss of that coverage due to the individual’s failure to pay  
5 premiums on a timely basis or situations allowing for a rescission,  
6 subject to clause (ii) and Sections 10119.2 and 10384.17.

7 (B) The individual gains a dependent or becomes a dependent.

8 (C) The individual is mandated to be covered as a dependent  
9 pursuant to a valid state or federal court order.

10 (D) The individual has been released from incarceration.

11 (E) The individual’s health coverage issuer substantially violated  
12 a material provision of the health coverage contract.

13 (F) The individual gains access to new health benefit plans as  
14 a result of a permanent move.

15 (G) The individual was receiving services from a contracting  
16 provider under another health benefit plan, as defined in Section  
17 10965 of this code or Section 1399.845 of the Health and Safety  
18 Code, for one of the conditions described in subdivision (a) of  
19 Section 10133.56 of this code and that provider is no longer  
20 participating in the health benefit plan.

21 (H) The individual demonstrates to the Exchange, with respect  
22 to health benefit plans offered through the Exchange, or to the  
23 department, with respect to health benefit plans offered outside  
24 the Exchange, that the individual did not enroll in a health benefit  
25 plan during the immediately preceding enrollment period available  
26 to the individual because the individual was misinformed that the  
27 individual was covered under minimum essential coverage.

28 (I) The individual is a member of the reserve forces of the United  
29 States military returning from active duty or a member of the  
30 California National Guard returning from active duty service under  
31 Title 32 of the United States Code.

32 (J) The individual is pregnant. Enrollment shall not be affected  
33 by the circumstances of conception, including if the individual is  
34 acting as a gestational carrier, and shall be extended to individuals  
35 who are dependents of the pregnant individual and an individual  
36 to whom the pregnant individual is a dependent.

37 (K) With respect to individual health benefit plans offered  
38 through the Exchange, in addition to the triggering events listed  
39 in this paragraph, any other events listed in Section 155.420(d) of  
40 Title 45 of the Code of Federal Regulations.

1 (2) With respect to individual health benefit plans offered  
2 outside the Exchange, an individual shall have 60 days from the  
3 date of a triggering event identified in paragraph (1) to apply for  
4 coverage from a health care service plan subject to this section.  
5 With respect to individual health benefit plans offered through the  
6 Exchange, an individual shall have 60 days from the date of a  
7 triggering event identified in paragraph (1) to select a plan offered  
8 through the Exchange, unless a longer period is provided in Part  
9 155 (commencing with Section 155.10) of Subchapter B of Subtitle  
10 A of Title 45 of the Code of Federal Regulations.

11 (e) With respect to individual health benefit plans offered  
12 through the Exchange, the effective date of coverage required  
13 pursuant to this section shall be consistent with the dates specified  
14 in Section 155.410 or 155.420 of Title 45 of the Code of Federal  
15 Regulations, as applicable. A dependent who is a registered  
16 domestic partner pursuant to Section 297 of the Family Code shall  
17 have the same effective date of coverage as a spouse.

18 (f) With respect to an individual health benefit plan offered  
19 outside the Exchange, the following provisions shall apply:

20 (1) After an individual submits a completed application form  
21 for a plan, the insurer shall, within 30 days, notify the individual  
22 of the individual's actual premium charges for that plan established  
23 in accordance with Section 10965.9. The individual shall have 30  
24 days in which to exercise the right to buy coverage at the quoted  
25 premium charges.

26 (2) With respect to an individual health benefit plan for which  
27 an individual applies during the initial open enrollment period  
28 described in paragraph (1) of subdivision (c), when the policyholder  
29 submits a premium payment, based on the quoted premium charges,  
30 and that payment is delivered or postmarked, whichever occurs  
31 earlier, by December 15, 2013, coverage under the individual  
32 health benefit plan shall become effective no later than January 1,  
33 2014. When that payment is delivered or postmarked within the  
34 first 15 days of any subsequent month, coverage shall become  
35 effective no later than the first day of the following month. When  
36 that payment is delivered or postmarked between December 16,  
37 2013, to December 31, 2013, inclusive, or after the 15th day of  
38 any subsequent month, coverage shall become effective no later  
39 than the first day of the second month following delivery or  
40 postmark of the payment.

(3) With respect to an individual health benefit plan for which an individual applies during the annual open enrollment period described in paragraph (1) of subdivision (c), when the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs later, by December 15 of the preceding calendar year, coverage shall become effective on January 1 of the benefit year. When that payment is delivered or postmarked within the first 15 days of any subsequent month, coverage shall become effective no later than the first day of the following month. When that payment is delivered or postmarked between December 16 to December 31, inclusive, or after the 15th day of any subsequent month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(4) With respect to an individual health benefit plan for which an individual applies during a special enrollment period described in subdivision (d), the following provisions shall apply:

(A) When the individual submits a premium payment, based on the quoted premium charges, and that payment is delivered or postmarked, whichever occurs earlier, within the first 15 days of the month, coverage under the plan shall become effective no later than the first day of the following month. When the premium payment is neither delivered nor postmarked until after the 15th day of the month, coverage shall become effective no later than the first day of the second month following delivery or postmark of the payment.

(B) Notwithstanding subparagraph (A), in the case of a birth, adoption, or placement for adoption, the coverage shall be effective on the date of birth, adoption, or placement for adoption.

(C) Notwithstanding subparagraph (A), in the case of marriage or becoming a registered domestic partner or in the case where a qualified individual loses minimum essential coverage, the coverage effective date shall be the first day of the month following the date the insurer receives the request for special enrollment.

(g) (1) A health insurer shall not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of an individual health benefit plan based on any of the following factors:

(A) Health status.

(B) Medical condition, including physical and mental illnesses.

1 (C) Claims experience.

2 (D) Receipt of health care.

3 (E) Medical history.

4 (F) Genetic information.

5 (G) Evidence of insurability, including conditions arising out  
6 of acts of domestic violence.

7 (H) Disability.

8 (I) Any other health status-related factor as determined by any  
9 federal regulations, rules, or guidance issued pursuant to Section  
10 2705 of the federal Public Health Service Act (Public Law 78-410).

11 (2) Notwithstanding subdivision (c) of Section 10291.5, a health  
12 insurer shall not require an individual applicant or the applicant's  
13 dependent to fill out a health assessment or medical questionnaire  
14 prior to enrollment under an individual health benefit plan. A health  
15 insurer shall not acquire or request information that relates to a  
16 health status-related factor from the applicant or the applicant's  
17 dependent or any other source prior to enrollment of the individual.

18 (h) (1) A health insurer shall consider as a single risk pool for  
19 rating purposes in the individual market the claims experience of  
20 all insureds and enrollees in all nongrandfathered individual health  
21 benefit plans offered by that insurer in this state, whether offered  
22 as health care service plan contracts or individual health insurance  
23 policies, including those insureds and enrollees who enroll in  
24 individual coverage through the Exchange and insureds and  
25 enrollees who enroll in individual coverage outside the Exchange.  
26 Student health insurance coverage, as such coverage is defined in  
27 Section 147.145(a) of Title 45 of the Code of Federal Regulations,  
28 shall not be included in a health insurer's single risk pool for  
29 individual coverage.

30 (2) Each calendar year, a health insurer shall establish an index  
31 rate for the individual market in the state based on the total  
32 combined claims costs for providing essential health benefits, as  
33 defined pursuant to Section 1302 of PPACA, within the single risk  
34 pool required under paragraph (1). The index rate shall be adjusted  
35 on a marketwide basis based on the total expected marketwide  
36 payments and charges under the risk adjustment program  
37 established for the state pursuant to Section 1343 of PPACA and  
38 Exchange user fees, as described in subdivision (d) of Section  
39 156.80 of Title 45 of the Code of Federal Regulations. The  
40 premium rate for all of the health benefit plans in the individual

1 market within the single risk pool required under paragraph (1)  
2 shall use the applicable marketwide adjusted index rate, subject  
3 only to the adjustments permitted under paragraph (3).

4 (3) A health insurer may vary premium rates for a particular  
5 health benefit plan from its index rate based only on the following  
6 actuarially justified plan-specific factors:

7 (A) The actuarial value and cost-sharing design of the health  
8 benefit plan.

9 (B) The health benefit plan's provider network, delivery system  
10 characteristics, and utilization management practices.

11 (C) The benefits provided under the health benefit plan that are  
12 in addition to the essential health benefits, as defined pursuant to  
13 Section 1302 of PPACA and Section 10112.27. These additional  
14 benefits shall be pooled with similar benefits within the single risk  
15 pool required under paragraph (1) and the claims experience from  
16 those benefits shall be utilized to determine rate variations for  
17 plans that offer those benefits in addition to essential health  
18 benefits.

19 (D) With respect to catastrophic plans, as described in subsection  
20 (e) of Section 1302 of PPACA, the expected impact of the specific  
21 eligibility categories for those plans.

22 (E) Administrative costs, excluding any user fees required by  
23 the Exchange.

24 (i) This section shall only apply with respect to individual health  
25 benefit plans for policy years on or after January 1, 2014.

26 (j) This section shall not apply to a grandfathered health plan.

27 SEC. 6. No reimbursement is required by this act pursuant to  
28 Section 6 of Article XIII B of the California Constitution because  
29 the only costs that may be incurred by a local agency or school  
30 district will be incurred because this act creates a new crime or  
31 infraction, eliminates a crime or infraction, or changes the penalty  
32 for a crime or infraction, within the meaning of Section 17556 of  
33 the Government Code, or changes the definition of a crime within  
34 the meaning of Section 6 of Article XIII B of the California  
35 Constitution.