

AMENDED IN ASSEMBLY JULY 3, 2025

SENATE BILL

No. 257

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

February 3, 2025

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 ~~disability 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 ~~denying, limiting, or seeking~~ reimbursement for maternity services or newborn and pediatric care services because the enrollee or insured is acting as a gestational carrier. 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 issued, amended, or
- 7 renewed on or after January 1, 2026, that provides coverage for
- 8 maternity services or newborn and pediatric care services shall ~~not~~
- 9 ~~do any of the following based on the circumstances of conception,~~
- 10 ~~including if the enrollee is acting as a gestational carrier:~~
- 11 (1) ~~Deny, limit, or not~~ seek reimbursement for maternity services
- 12 or newborn and pediatric care services because the enrollee is
- 13 acting as a gestational carrier.
- 14 (b) *To comply with subdivision (a), a health care service plan*
- 15 *shall not do either of the following based on the circumstances of*
- 16 *conception:*
- 17 (2)
- 18 (1) Deny coverage to an enrollee or the enrollee's newborn.
- 19 (3) ~~Increase a premium, deductible, copayment, or coinsurance.~~

1 ~~(4) Penalize or otherwise reduce or limit the reimbursement of~~
2 ~~an attending health care provider.~~

3 ~~(5) Reduce coverage.~~

4 ~~(6)~~

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

7 ~~(b)~~

8 (c) For purposes of this section, "maternity services" include
9 prenatal care, ambulatory care maternity services, involuntary
10 complications of pregnancy, neonatal care, and inpatient hospital
11 maternity care, including labor and delivery and postpartum care.

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

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

23 (2) A plan shall allow the subscriber of an individual health
24 benefit plan to add a dependent to the subscriber's plan at the
25 option of the subscriber, consistent with the open enrollment,
26 annual enrollment, and special enrollment period requirements in
27 this section.

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

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

1 from October 15, of the preceding calendar year, to January 15 of
2 the benefit year, inclusive.

3 (2) With respect to individual health benefit plans offered
4 through the Exchange, a plan shall provide an annual enrollment
5 period for the policy years beginning on January 1, 2016, to
6 December 31, 2018, inclusive, from November 1, of the preceding
7 calendar year, to January 31 of the benefit year, inclusive, and
8 annual enrollment periods for policy years beginning on or after
9 January 1, 2019, from November 1 to December 15 of the
10 preceding calendar year, inclusive.

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

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

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

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

37 (i) "Minimum essential coverage" has the same meaning as that
38 term is defined in Section 1345.5 or subsection (f) of Section
39 5000A of the Internal Revenue Code (26 U.S.C. Sec. 5000A).

1 (ii) “Loss of minimum essential coverage” includes, but is not
2 limited to, loss of that coverage due to the circumstances described
3 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
4 Code of Federal Regulations and the circumstances described in
5 Section 1163 of Title 29 of the United States Code. “Loss of
6 minimum essential coverage” also includes loss of that coverage
7 for a reason that is not due to the fault of the individual.

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

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

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

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

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

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

20 (G) The individual was receiving services from a contracting
21 provider under another health benefit plan, as defined in Section
22 1399.845 of this code or Section 10965 of the Insurance Code, for
23 one of the conditions described in subdivision (c) of Section
24 1373.96 of this code and that provider is no longer participating
25 in the health benefit plan.

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

33 (I) The individual is a member of the reserve forces of the United
34 States military returning from active duty or a member of the
35 California National Guard returning from active duty service under
36 Title 32 of the United States Code.

37 (J) The individual is pregnant. Enrollment shall not be affected
38 by the circumstances of conception, including if the individual is
39 acting as a gestational carrier, and shall be extended to individuals

1 who are dependents of the pregnant individual and an individual
2 to whom the pregnant individual is a dependent.

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

7 (2) With respect to individual health benefit plans offered
8 outside the Exchange, an individual shall have 60 days from the
9 date of a triggering event identified in paragraph (1) to apply for
10 coverage from a health care service plan subject to this section.
11 With respect to individual health benefit plans offered through the
12 Exchange, an individual shall have 60 days from the date of a
13 triggering event identified in paragraph (1) to select a plan offered
14 through the Exchange, unless a longer period is provided in Part
15 155 (commencing with Section 155.10) of Subchapter B of Subtitle
16 A of Title 45 of the Code of Federal Regulations.

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

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

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

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

1 effective no later than the first day of the following month. When
2 that payment is delivered or postmarked between December 16,
3 2013, to December 31, 2013, inclusive, or after the 15th day of
4 any subsequent month, coverage shall become effective no later
5 than the first day of the second month following delivery or
6 postmark of the payment.

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

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

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

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

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

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

- 5 (A) Health status.
- 6 (B) Medical condition, including physical and mental illnesses.
- 7 (C) Claims experience.
- 8 (D) Receipt of health care.
- 9 (E) Medical history.
- 10 (F) Genetic information.
- 11 (G) Evidence of insurability, including conditions arising out
12 of acts of domestic violence.
- 13 (H) Disability.

14 (I) Any other health status-related factor as determined by any
15 federal regulations, rules, or guidance issued pursuant to Section
16 2705 of the federal Public Health Service Act (Public Law 78-410).

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

25 (h) (1) A health care service plan shall consider as a single risk
26 pool for rating purposes in the individual market the claims
27 experience of all insureds and all enrollees in all nongrandfathered
28 individual health benefit plans offered by that health care service
29 plan in this state, whether offered as health care service plan
30 contracts or individual health insurance policies, including those
31 insureds and enrollees who enroll in individual coverage through
32 the Exchange and insureds and enrollees who enroll in individual
33 coverage outside of the Exchange. Student health insurance
34 coverage, as that coverage is defined in Section 147.145(a) of Title
35 45 of the Code of Federal Regulations, shall not be included in a
36 health care service plan's single risk pool for individual coverage.

37 (2) Each calendar year, a health care service plan shall establish
38 an index rate for the individual market in the state based on the
39 total combined claims costs for providing essential health benefits,
40 as defined pursuant to Section 1302 of PPACA, within the single

1 risk pool required under paragraph (1). The index rate shall be
2 adjusted on a marketwide basis based on the total expected
3 marketwide payments and charges under the risk adjustment
4 program established for the state pursuant to Section 1343 of
5 PPACA and Exchange user fees, as described in subdivision (d)
6 of Section 156.80 of Title 45 of the Code of Federal Regulations.
7 The premium rate for all of the health benefit plans in the individual
8 market within the single risk pool required under paragraph (1)
9 shall use the applicable marketwide adjusted index rate, subject
10 only to the adjustments permitted under paragraph (3).

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

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

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

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

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

29 (E) Administrative costs, excluding user fees required by the
30 Exchange.

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

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

34 SEC. 4. Section 10119.4 is added to the Insurance Code, to
35 read:

36 10119.4. (a) A ~~disability~~ *health* insurance policy issued,
37 amended, or renewed on or after January 1, 2026, that provides
38 coverage for maternity services or newborn and pediatric care
39 services ~~shall not do any of the following based on the~~

1 ~~circumstances of conception, including if the insured is acting as~~
2 ~~a gestational carrier.~~

3 ~~(1) Deny, limit, or not seek reimbursement for maternity services~~
4 ~~or newborn and pediatric care services because the insured is acting~~
5 ~~as a gestational carrier.~~

6 *(b) To comply with subdivision (a), a health insurer shall not*
7 *do either of the following based on the circumstances of*
8 *conception:*

9 ~~(2)~~

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

11 ~~(3) Increase a premium, deductible, copayment, or coinsurance.~~

12 ~~(4) Penalize or otherwise reduce or limit the reimbursement of~~
13 ~~an attending health care provider.~~

14 ~~(5) Reduce coverage.~~

15 ~~(6)~~

16 ~~(2) Otherwise discriminate against an insured, an insured's~~
17 ~~newborn, or an attending health care provider.~~

18 ~~(b)~~

19 *(c) For purposes of this section, "maternity services" has the*
20 *same meaning as in Section 10123.865.*

21 SEC. 5. Section 10965.3 of the Insurance Code is amended to
22 read:

23 10965.3. (a) (1) On and after October 1, 2013, a health insurer
24 shall fairly and affirmatively offer, market, and sell all of the
25 insurer's health benefit plans that are sold in the individual market
26 for policy years on or after January 1, 2014, to all individuals and
27 dependents in each service area in which the insurer provides or
28 arranges for the provision of health care services. A health insurer
29 shall limit enrollment in individual health benefit plans to open
30 enrollment periods, annual enrollment periods, and special
31 enrollment periods as provided in subdivisions (c) and (d).

32 (2) A health insurer shall allow the policyholder of an individual
33 health benefit plan to add a dependent to the policyholder's health
34 benefit plan at the option of the policyholder, consistent with the
35 open enrollment, annual enrollment, and special enrollment period
36 requirements in this section.

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

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

(2) With respect to individual health benefit plans offered through the Exchange, a health insurer shall provide an annual enrollment period for the policy years beginning on January 1, 2016, to December 31, 2018, inclusive, from November 1, of the preceding calendar year, to January 31 of the benefit year, inclusive, and annual enrollment periods for policy years beginning on or after January 1, 2019, from November 1 to December 15 of the preceding calendar year, inclusive.

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

(4) Pursuant to Section 147.104(b)(2) of Title 45 of the Code of Federal Regulations, for individuals enrolled in noncalendar year individual health plan contracts, a health insurer shall also provide a limited open enrollment period beginning on the date

1 that is 30 calendar days prior to the date the policy year ends in
2 2014.

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

7 (A) The individual or the individual's dependent loses minimum
8 essential coverage. For purposes of this paragraph, both of the
9 following definitions shall apply:

10 (i) "Minimum essential coverage" has the same meaning as that
11 term is defined in Section 1345.5 of the Health and Safety Code
12 or subsection (f) of Section 5000A of the Internal Revenue Code
13 (26 U.S.C. Sec. 5000A).

14 (ii) "Loss of minimum essential coverage" includes, but is not
15 limited to, loss of that coverage due to the circumstances described
16 in Section 54.9801-6(a)(3)(i) to (iii), inclusive, of Title 26 of the
17 Code of Federal Regulations and the circumstances described in
18 Section 1163 of Title 29 of the United States Code. "Loss of
19 minimum essential coverage" also includes loss of that coverage
20 for a reason that is not due to the fault of the individual.

21 (iii) "Loss of minimum essential coverage" does not include
22 loss of that coverage due to the individual's failure to pay
23 premiums on a timely basis or situations allowing for a rescission,
24 subject to clause (ii) and Sections 10119.2 and 10384.17.

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

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

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

29 (E) The individual's health coverage issuer substantially violated
30 a material provision of the health coverage contract.

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

33 (G) The individual was receiving services from a contracting
34 provider under another health benefit plan, as defined in Section
35 10965 of this code or Section 1399.845 of the Health and Safety
36 Code, for one of the conditions described in subdivision (a) of
37 Section 10133.56 of this code and that provider is no longer
38 participating in the health benefit plan.

39 (H) The individual demonstrates to the Exchange, with respect
40 to health benefit plans offered through the Exchange, or to the

1 department, with respect to health benefit plans offered outside
2 the Exchange, that the individual did not enroll in a health benefit
3 plan during the immediately preceding enrollment period available
4 to the individual because the individual was misinformed that the
5 individual was covered under minimum essential coverage.

6 (I) The individual is a member of the reserve forces of the United
7 States military returning from active duty or a member of the
8 California National Guard returning from active duty service under
9 Title 32 of the United States Code.

10 (J) The individual is pregnant. Enrollment shall not be affected
11 by the circumstances of conception, including if the individual is
12 acting as a gestational carrier, and shall be extended to individuals
13 who are dependents of the pregnant individual and an individual
14 to whom the pregnant individual is a dependent.

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

19 (2) With respect to individual health benefit plans offered
20 outside the Exchange, an individual shall have 60 days from the
21 date of a triggering event identified in paragraph (1) to apply for
22 coverage from a health care service plan subject to this section.
23 With respect to individual health benefit plans offered through the
24 Exchange, an individual shall have 60 days from the date of a
25 triggering event identified in paragraph (1) to select a plan offered
26 through the Exchange, unless a longer period is provided in Part
27 155 (commencing with Section 155.10) of Subchapter B of Subtitle
28 A of Title 45 of the Code of Federal Regulations.

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

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

38 (1) After an individual submits a completed application form
39 for a plan, the insurer shall, within 30 days, notify the individual
40 of the individual's actual premium charges for that plan established

1 in accordance with Section 10965.9. The individual shall have 30
2 days in which to exercise the right to buy coverage at the quoted
3 premium charges.

4 (2) With respect to an individual health benefit plan for which
5 an individual applies during the initial open enrollment period
6 described in paragraph (1) of subdivision (c), when the policyholder
7 submits a premium payment, based on the quoted premium charges,
8 and that payment is delivered or postmarked, whichever occurs
9 earlier, by December 15, 2013, coverage under the individual
10 health benefit plan shall become effective no later than January 1,
11 2014. When that payment is delivered or postmarked within the
12 first 15 days of any subsequent month, coverage shall become
13 effective no later than the first day of the following month. When
14 that payment is delivered or postmarked between December 16,
15 2013, to December 31, 2013, inclusive, or after the 15th day of
16 any subsequent month, coverage shall become effective no later
17 than the first day of the second month following delivery or
18 postmark of the payment.

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

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

36 (A) When the individual submits a premium payment, based
37 on the quoted premium charges, and that payment is delivered or
38 postmarked, whichever occurs earlier, within the first 15 days of
39 the month, coverage under the plan shall become effective no later
40 than the first day of the following month. When the premium

1 payment is neither delivered nor postmarked until after the 15th
2 day of the month, coverage shall become effective no later than
3 the first day of the second month following delivery or postmark
4 of the payment.

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

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

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

17 (A) Health status.

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

19 (C) Claims experience.

20 (D) Receipt of health care.

21 (E) Medical history.

22 (F) Genetic information.

23 (G) Evidence of insurability, including conditions arising out
24 of acts of domestic violence.

25 (H) Disability.

26 (I) Any other health status-related factor as determined by any
27 federal regulations, rules, or guidance issued pursuant to Section
28 2705 of the federal Public Health Service Act (Public Law 78-410).

29 (2) Notwithstanding subdivision (c) of Section 10291.5, a health
30 insurer shall not require an individual applicant or the applicant's
31 dependent to fill out a health assessment or medical questionnaire
32 prior to enrollment under an individual health benefit plan. A health
33 insurer shall not acquire or request information that relates to a
34 health status-related factor from the applicant or the applicant's
35 dependent or any other source prior to enrollment of the individual.

36 (h) (1) A health insurer shall consider as a single risk pool for
37 rating purposes in the individual market the claims experience of
38 all insureds and enrollees in all nongrandfathered individual health
39 benefit plans offered by that insurer in this state, whether offered
40 as health care service plan contracts or individual health insurance

1 policies, including those insureds and enrollees who enroll in
2 individual coverage through the Exchange and insureds and
3 enrollees who enroll in individual coverage outside the Exchange.
4 Student health insurance coverage, as such coverage is defined in
5 Section 147.145(a) of Title 45 of the Code of Federal Regulations,
6 shall not be included in a health insurer's single risk pool for
7 individual coverage.

8 (2) Each calendar year, a health insurer shall establish an index
9 rate for the individual market in the state based on the total
10 combined claims costs for providing essential health benefits, as
11 defined pursuant to Section 1302 of PPACA, within the single risk
12 pool required under paragraph (1). The index rate shall be adjusted
13 on a marketwide basis based on the total expected marketwide
14 payments and charges under the risk adjustment program
15 established for the state pursuant to Section 1343 of PPACA and
16 Exchange user fees, as described in subdivision (d) of Section
17 156.80 of Title 45 of the Code of Federal Regulations. The
18 premium rate for all of the health benefit plans in the individual
19 market within the single risk pool required under paragraph (1)
20 shall use the applicable marketwide adjusted index rate, subject
21 only to the adjustments permitted under paragraph (3).

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

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

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

29 (C) The benefits provided under the health benefit plan that are
30 in addition to the essential health benefits, as defined pursuant to
31 Section 1302 of PPACA and Section 10112.27. These additional
32 benefits shall be pooled with similar benefits within the single risk
33 pool required under paragraph (1) and the claims experience from
34 those benefits shall be utilized to determine rate variations for
35 plans that offer those benefits in addition to essential health
36 benefits.

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

1 (E) Administrative costs, excluding any user fees required by
2 the Exchange.

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

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

6 SEC. 6. No reimbursement is required by this act pursuant to
7 Section 6 of Article XIII B of the California Constitution because
8 the only costs that may be incurred by a local agency or school
9 district will be incurred because this act creates a new crime or
10 infraction, eliminates a crime or infraction, or changes the penalty
11 for a crime or infraction, within the meaning of Section 17556 of
12 the Government Code, or changes the definition of a crime within
13 the meaning of Section 6 of Article XIII B of the California
14 Constitution.