SENATE BILL No. 257

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

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 introduced, 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 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:

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

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

1374.54. (a) A health care service plan issued, amended, or renewed on or after January 1, 2026, that provides coverage for maternity services or newborn and pediatric care services shall not do any of the following based on the circumstances of conception, including if the enrollee is acting as a gestational carrier:

(1) Deny, limit, or seek reimbursement for maternity services or newborn and pediatric care services because the enrollee is acting as a gestational carrier.

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

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

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

(5) Reduce coverage.

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

(b) For purposes of this section, "maternity services" include prenatal care, ambulatory care maternity services, involuntary

complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care.

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

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

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

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

(c) (1) With respect to individual health benefit plans offered outside of the Exchange, a plan 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 plan 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 plan 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 plan shall also provide a limited open enrollment period beginning on the date that is 30 calendar days prior to the date the policy year ends in 2014.

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

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

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

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

(iii) "Loss of minimum essential coverage" does not include loss of that coverage due to the individual's failure to pay

premiums on a timely basis or situations allowing for a rescission, subject to clause (ii) and Sections 1389.7 and 1389.21.

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

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

(D) The individual has been released from incarceration.

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

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

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

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

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

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

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(K) With respect to individual health benefit plans offered through the Exchange, in addition to the triggering events listed in this paragraph, any other events listed in Section 155.420(d) of 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.

(C) Claims experience.

(D) Receipt of health care.

(E) Medical history.

(F) Genetic information.

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

(H) Disability.

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

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

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

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

shall use the applicable marketwide adjusted index rate, subject only to the adjustments permitted under paragraph (3).

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

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

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

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

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

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

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

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

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

10119.4. (a) A disability insurance policy issued, amended, or renewed on or after January 1, 2026, that provides coverage for maternity services or newborn and pediatric care services shall not do any of the following based on the circumstances of conception, including if the insured is acting as a gestational carrier:

(1) Deny, limit, or seek reimbursement for maternity services or newborn and pediatric care services because the insured is acting as a gestational carrier.

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

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

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

(5) Reduce coverage.

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

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

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

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

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

(b) An individual health benefit plan issued, amended, or renewed on or after January 1, 2014, shall not impose any 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 that is 30 calendar days prior to the date the policy year ends in 2014.

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

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

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

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

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

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

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

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

(D) The individual has been released from incarceration.

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

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

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

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

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

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

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(K) With respect to individual health benefit plans offered through the Exchange, in addition to the triggering events listed

in this paragraph, any other events listed in Section 155.420(d) of 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 an individual health benefit plan offered outside the Exchange, the following provisions shall apply:

(1) After an individual submits a completed application form for a plan, the insurer shall, within 30 days, notify the individual of the individual's actual premium charges for that plan established in accordance with Section 10965.9. 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 policyholder 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 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.
(C) Claims experience.
(D) Receipt of health care.
(E) Medical history.
(F) Genetic information.
(G) Evidence of insurability, including conditions arising out of acts of domestic violence.
(H) Disability.
(I) Any other health status-related factor as determined by any federal regulations, rules, or guidance issued pursuant to Section 2705 of the federal Public Health Service Act (Public Law 78-410).

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

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

(2) Each calendar year, a health insurer shall establish an index rate for the individual market in the state based on the total combined claims costs for providing essential health benefits, as defined pursuant to Section 1302 of PPACA, within the single risk pool required under paragraph (1). The index rate shall be adjusted on a marketwide basis based on the total expected marketwide payments and charges under the risk adjustment program established for the state pursuant to Section 1343 of PPACA and Exchange user fees, as described in subdivision (d) of Section

156.80 of Title 45 of the Code of Federal Regulations. The premium rate for all of the health benefit plans in the individual market within the single risk pool required under paragraph (1) shall use the applicable marketwide adjusted index rate, subject only to the adjustments permitted under paragraph (3).

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

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

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

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

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

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

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

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

SEC. 6. 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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