

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

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 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:*

- 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 seek reimbursement for maternity services
- 12 or newborn and pediatric care services because the enrollee is
- 13 acting as a gestational carrier.
- 14 (2) Deny coverage to an enrollee or the enrollee’s newborn.
- 15 (3) Increase a premium, deductible, copayment, or coinsurance.
- 16 (4) Penalize or otherwise reduce or limit the reimbursement of
- 17 an attending health care provider.
- 18 (5) Reduce coverage.
- 19 (6) Otherwise discriminate against an enrollee, an enrollee’s
- 20 newborn, or an attending health care provider.
- 21 (b) For purposes of this section, “maternity services” include
- 22 prenatal care, ambulatory care maternity services, involuntary

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

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

5 1399.849. (a) (1) On and after October 1, 2013, a plan shall  
6 fairly and affirmatively offer, market, and sell all of the plan's  
7 health benefit plans that are sold in the individual market for policy  
8 years on or after January 1, 2014, to all individuals and dependents  
9 in each service area in which the plan provides or arranges for the  
10 provision of health care services. A plan shall limit enrollment in  
11 individual health benefit plans to open enrollment periods, annual  
12 enrollment periods, and special enrollment periods as provided in  
13 subdivisions (c) and (d).

14 (2) A plan shall allow the subscriber of an individual health  
15 benefit plan to add a dependent to the subscriber's plan at the  
16 option of the subscriber, consistent with the open enrollment,  
17 annual enrollment, and special enrollment period requirements in  
18 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 plan shall provide an initial open  
24 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 plan shall provide an annual enrollment  
36 period for the policy years beginning on January 1, 2016, to  
37 December 31, 2018, inclusive, from November 1, of the preceding  
38 calendar year, to January 31 of the benefit year, inclusive, and  
39 annual enrollment periods for policy years beginning on or after

1 January 1, 2019, from November 1 to December 15 of the  
2 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 plan shall provide a special enrollment period  
6 for all individuals selecting an individual health benefit plan  
7 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 plan shall also provide a  
21 limited open enrollment period beginning on the date that is 30  
22 calendar days prior to the date the policy year ends in 2014.

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

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

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

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

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

- 1 premiums on a timely basis or situations allowing for a rescission,  
2 subject to clause (ii) and Sections 1389.7 and 1389.21.
- 3 (B) The individual gains a dependent or becomes a dependent.
- 4 (C) The individual is mandated to be covered as a dependent  
5 pursuant to a valid state or federal court order.
- 6 (D) The individual has been released from incarceration.
- 7 (E) The individual's health coverage issuer substantially violated  
8 a material provision of the health coverage contract.
- 9 (F) The individual gains access to new health benefit plans as  
10 a result of a permanent move.
- 11 (G) The individual was receiving services from a contracting  
12 provider under another health benefit plan, as defined in Section  
13 1399.845 of this code or Section 10965 of the Insurance Code, for  
14 one of the conditions described in subdivision (c) of Section  
15 1373.96 of this code and that provider is no longer participating  
16 in the health benefit plan.
- 17 (H) The individual demonstrates to the Exchange, with respect  
18 to health benefit plans offered through the Exchange, or to the  
19 department, with respect to health benefit plans offered outside  
20 the Exchange, that the individual did not enroll in a health benefit  
21 plan during the immediately preceding enrollment period available  
22 to the individual because the individual was misinformed that the  
23 individual was covered under minimum essential coverage.
- 24 (I) The individual is a member of the reserve forces of the United  
25 States military returning from active duty or a member of the  
26 California National Guard returning from active duty service under  
27 Title 32 of the United States Code.
- 28 (J) *The individual is pregnant. Enrollment shall not be affected*  
29 *by the circumstances of conception, including if the individual is*  
30 *acting as a gestational carrier, and shall be extended to individuals*  
31 *who are dependents of the pregnant individual and an individual*  
32 *to whom the pregnant individual is a dependent.*
- 33 (J)
- 34 (K) With respect to individual health benefit plans offered  
35 through the Exchange, in addition to the triggering events listed  
36 in this paragraph, any other events listed in Section 155.420(d) of  
37 Title 45 of the Code of Federal Regulations.
- 38 (2) With respect to individual health benefit plans offered  
39 outside the Exchange, an individual shall have 60 days from the  
40 date of a triggering event identified in paragraph (1) to apply for

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

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

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

17 (1) After an individual submits a completed application form  
18 for a plan contract, the health care service plan shall, within 30  
19 days, notify the individual of the individual's actual premium  
20 charges for that plan established in accordance with Section  
21 1399.855. The individual shall have 30 days in which to exercise  
22 the right to buy coverage at the quoted premium charges.

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

38 (3) With respect to an individual health benefit plan for which  
39 an individual applies during the annual open enrollment period  
40 described in paragraph (1) of subdivision (c), when the individual

1 submits a premium payment, based on the quoted premium charges,  
2 and that payment is delivered or postmarked, whichever occurs  
3 later, by December 15 of the preceding calendar year, coverage  
4 shall become effective on January 1 of the benefit year. When that  
5 payment is delivered or postmarked within the first 15 days of any  
6 subsequent month, coverage shall become effective no later than  
7 the first day of the following month. When that payment is  
8 delivered or postmarked between December 16 to December 31,  
9 inclusive, or after the 15th day of any subsequent month, coverage  
10 shall become effective no later than the first day of the second  
11 month following delivery or postmark of the payment.

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

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

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

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

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

36 (A) Health status.

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

38 (C) Claims experience.

39 (D) Receipt of health care.

40 (E) Medical history.

1 (F) Genetic information.

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

4 (H) Disability.

5 (I) Any other health status-related factor as determined by any  
6 federal regulations, rules, or guidance issued pursuant to Section  
7 2705 of the federal Public Health Service Act (Public Law 78-410).

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

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

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



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

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

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

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

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

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

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

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

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

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

28 10119.4. (a) A disability insurance policy issued, amended,  
29 or renewed on or after January 1, 2026, that provides coverage for  
30 maternity services or newborn and pediatric care services shall not  
31 do any of the following based on the circumstances of conception,  
32 including if the insured is acting as a gestational carrier:

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

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

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

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

40 (5) Reduce coverage.

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

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

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

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

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

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

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

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

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

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

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

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

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

32 (i) "Minimum essential coverage" has the same meaning as that  
33 term is defined in Section 1345.5 of the Health and Safety Code  
34 or subsection (f) of Section 5000A of the Internal Revenue Code  
35 (26 U.S.C. Sec. 5000A).

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

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

1 in this paragraph, any other events listed in Section 155.420(d) of  
2 Title 45 of the Code of Federal Regulations.

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

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

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

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

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

1 than the first day of the second month following delivery or  
2 postmark of the payment.

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

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

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

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

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

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

- 1 (A) Health status.
- 2 (B) Medical condition, including physical and mental illnesses.
- 3 (C) Claims experience.
- 4 (D) Receipt of health care.
- 5 (E) Medical history.
- 6 (F) Genetic information.
- 7 (G) Evidence of insurability, including conditions arising out
- 8 of acts of domestic violence.
- 9 (H) Disability.
- 10 (I) Any other health status-related factor as determined by any
- 11 federal regulations, rules, or guidance issued pursuant to Section
- 12 2705 of the federal Public Health Service Act (Public Law 78-410).
- 13 (2) Notwithstanding subdivision (c) of Section 10291.5, a health
- 14 insurer shall not require an individual applicant or the applicant's
- 15 dependent to fill out a health assessment or medical questionnaire
- 16 prior to enrollment under an individual health benefit plan. A health
- 17 insurer shall not acquire or request information that relates to a
- 18 health status-related factor from the applicant or the applicant's
- 19 dependent or any other source prior to enrollment of the individual.
- 20 (h) (1) A health insurer shall consider as a single risk pool for
- 21 rating purposes in the individual market the claims experience of
- 22 all insureds and enrollees in all nongrandfathered individual health
- 23 benefit plans offered by that insurer in this state, whether offered
- 24 as health care service plan contracts or individual health insurance
- 25 policies, including those insureds and enrollees who enroll in
- 26 individual coverage through the Exchange and insureds and
- 27 enrollees who enroll in individual coverage outside the Exchange.
- 28 Student health insurance coverage, as such coverage is defined in
- 29 Section 147.145(a) of Title 45 of the Code of Federal Regulations,
- 30 shall not be included in a health insurer's single risk pool for
- 31 individual coverage.
- 32 (2) Each calendar year, a health insurer shall establish an index
- 33 rate for the individual market in the state based on the total
- 34 combined claims costs for providing essential health benefits, as
- 35 defined pursuant to Section 1302 of PPACA, within the single risk
- 36 pool required under paragraph (1). The index rate shall be adjusted
- 37 on a marketwide basis based on the total expected marketwide
- 38 payments and charges under the risk adjustment program
- 39 established for the state pursuant to Section 1343 of PPACA and
- 40 Exchange user fees, as described in subdivision (d) of Section

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

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

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

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

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

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

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

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

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

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

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