A REPORT TO THE 2025–2026 CALIFORNIA LEGISLATURE

Analysis of California Senate Bill 257: Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act

APRIL 18, 2025

CHBRP

California Health Benefits Review Program (CHBRP)
University of California, Berkeley

chbrp.org

KEY FINDINGS

Analysis of California Senate Bill 257: Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act

Summary to the 2025-2026 California State Legislature, April 18, 2025

CHBRP

Summary

The version of California Senate Bill (SB) 257 analyzed by California Health Benefits Review Program (CHBRP) would make pregnancy a qualifying event for special enrollment for health insurance on the individual market. It would also mandate that health plans and policies cannot restrict or deny coverage for maternity and newborn/pediatric care services for any pregnant person, regardless of the circumstances of conception (i.e., surrogates or gestational carriers).

In 2026, 13.6 million Californians (36% of all Californians) enrolled in state-regulated health insurance would have insurance subject to SB 257.

Benefit Coverage

Benefit coverage for maternity services and newborn/pediatric care services for all pregnant people regardless of circumstances of conception would increase from 17% at baseline to 100% postmandate. SB 257 would not exceed essential health benefits (EHBs).

Medical Effectiveness

Overall, CHBRP found *some evidence* that special enrollment periods increase take-up of health insurance among pregnant people, but that *not enough research* has been conducted to determine whether special enrollment periods improve utilization of maternity services or maternal and infant health outcomes. CHBRP found that *not enough research* has been conducted to draw conclusions about the effects of generosity of health insurance coverage[1] on utilization of maternity services or maternal and infant health outcomes.

Cost and Health Impacts[2]

In 2026, CHBRP estimates that SB 257 would result in 6,368 people gaining full coverage for maternity and pediatric/newborn services with no requirements to reimburse their insurers. Of those, 5,303 people are expected to be previously uninsured pregnant people and their dependents who would gain full coverage of health services in addition to coverage of maternity and pediatric/newborn services, and 1,065 are expected to be surrogates/gestational carriers and their dependents who would gain full coverage of maternity and pediatric/newborn services.

SB 257 would increase annual net expenditures by $69,946,000 (0.04%). Enrollee expenses for covered benefits would increase, but expenses for noncovered benefits would decrease. This would result in an increase of total net annual expenditures for enrollees with Department of Managed Health Care (DMHC)–regulated plans and California Department of Insurance (CDI)–regulated policies.

Context

The Affordable Care Act (ACA) requires coverage of maternity services as an essential health benefit (EHB), including prenatal care, labor and delivery, and postpartum care. However, the California benchmark health plan Evidence of Coverage states that anyone who enters a “surrogacy arrangement” — a legally binding contract between surrogates/gestational carriers and intended parents (IPs) outlining the rights, responsibilities, and obligations of all parties involved — must pay charges for covered services received related to conception, pregnancy, or delivery in connection with the arrangement. Surrogacy arrangements between surrogates/gestational carriers and IPs often address, among other things, how health and life insurance coverage and costs will be handled during pregnancy. IPs commonly pay out-of-pocket costs (including charges from insurers for covered services), cost sharing,

[1] Generosity of coverage is an industry term used to compare the relative portion of medical costs covered by one health plan versus another.

[2] Similar cost and health impacts could be expected for the following year though possible changes in medical science and other aspects of health make stability of impacts less certain as time goes by.

expenses not covered by the surrogate/gestational carrier's insurance, and/or a supplemental insurance policy if deemed necessary.

Several insurers in California have adopted this language in their Evidence of Coverage, such that they may impose a lien upon the compensation a surrogate or gestational carrier receives for their service to recover medical expenses. As identified through surveys of commercial and CalPERS carriers in California, among enrollees in plans subject to state mandates, 83% of enrollees are in plans or policies that seek reimbursement for maternity services from surrogates/gestational carriers.[3]

Bill Summary

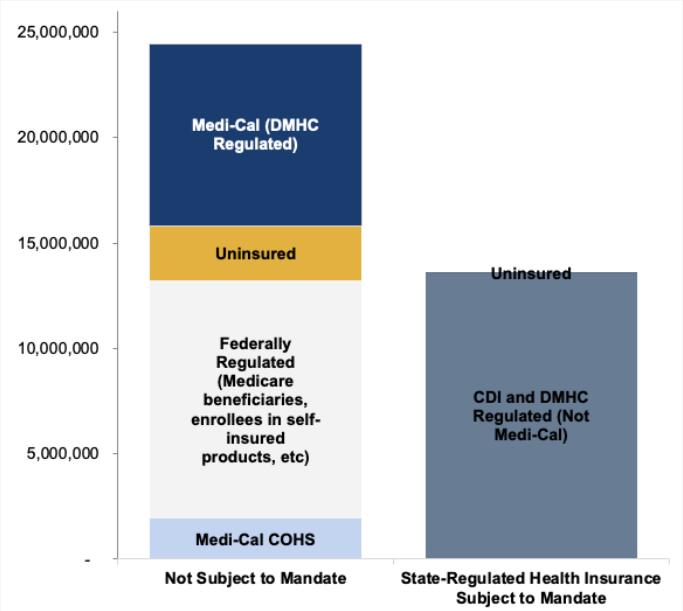
SB 257 would make pregnancy a qualifying event for special enrollment for health insurance on the individual market, regardless of the circumstances of conception (i.e., surrogates and gestational carriers). This special enrollment period would be extended to the pregnant person's dependents and people to whom the pregnant person is a dependent. During a special enrollment period, a person can enroll in a health plan or change their health plan.

Additionally, SB 257 would mandate several requirements of health plans and policies for coverage of maternity and newborn/pediatric care services for pregnant people, regardless of the circumstances of conception. Plans and policies would be prohibited from:

1) Denying, limiting, or seeking reimbursement for maternity or newborn and pediatric care services because the enrollee is acting as a gestational carrier;
2) Denying coverage to an enrollee or the enrollee's newborn;
3) Increasing a premium, deductible, copayment, or coinsurance;
4) Penalizing or otherwise reducing or limiting the reimbursement of an attending health care provider;
5) Reducing coverage; and
6) Otherwise discriminating against an enrollee, their newborn, or an attending health care provider.

If enacted, SB 257 would apply to the health insurance of enrollees in individual health plans (for pregnancy as a qualifying event for special enrollment) and enrollees in commercial or CalPERS health insurance regulated by DMHC and CDI (for prohibitions on restricting coverage).

Figure A. Health Insurance in CA and SB 257



Source: California Health Benefits Review Program, 2025.
Note: CHBRP generally assumes alignment of Medi-Cal managed care plan benefits, with limited exceptions.[4]
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

Impacts

Benefit Coverage

CHBRP estimates that at baseline, 11,216,000 Californians (83%) with state-regulated insurance subject to the mandate are enrolled in DMHC-regulated plans or CDI-regulated policies out of compliance with SB 257, and 2,354,000 (17%) are enrolled in plans or policies that are compliant. While all DMHC-regulated plans and CDI-regulated policies include maternity and prenatal care in their benefit coverage as per federal law (see *Policy Context* section), 17% of enrollees are in plans or policies that do not seek reimbursement for these services from

[3] Refer to CHBRP's full report for full citations and references.
[4] Although COHS plans are not subject to the Knox-Keene Act, DHCS generally updates Medi-Cal managed care plan contracts, All Plan Letters, and other appropriate authorities for alignment of managed care plan benefits, except in cases when the benefit is carved out of the Medi-Cal managed care plan contract or the law exempts specified Medi-Cal contracted providers.

surrogates/gestational carriers and therefore are fully compliant with SB 257 at baseline.

Postmandate, 100% of DMHC-regulated plans and CDI-regulated policies subject to SB 257 would be compliant.

How does utilization impact premiums?

Health insurance, by design, distributes risk and expenditures across everyone enrolled in a plan or policy. It does so to help protect each enrollee from the full impact of health care costs that arise from that enrollee's use of prevention, diagnosis, and/or treatment of a covered medical condition, disease, or injury. Changes in utilization among any enrollees in a plan or policy can result in changes to premiums for all enrollees in that plan or policy.

Utilization

Postmandate, CHBRP estimates that 6,368 people (5,303 previously uninsured pregnant people and their dependents, and 1,065 insured gestational carriers and their dependents) will gain coverage.

At baseline, the total average annual cost of all health care for pregnant enrollees is $21,700, divided between the insurance carrier ($16,217) and the enrollee share of cost ($5,483). Annual average costs per dependent in the individual market are also discussed in this report, as SB 257 would allow for dependents to become qualified for enrollment during pregnancy as well ($5,545 for insurance carriers, and $1,875 for enrollee share of cost). Postmandate, these average costs are expected to remain the same.

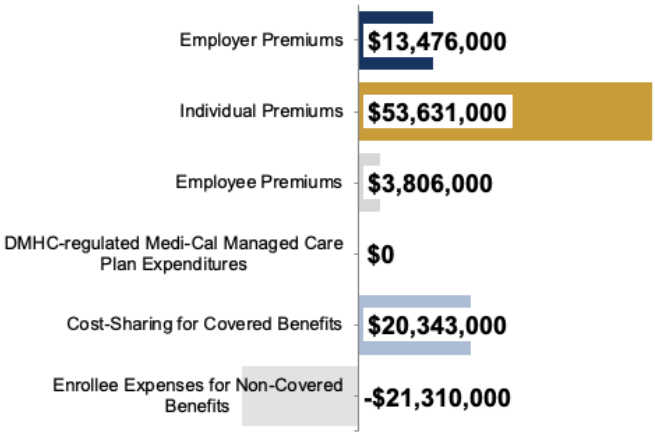
At baseline, enrollees with DMHC-regulated plans or CDI-regulated policies that are not compliant with SB 257 and who are gestational carriers bear the entire average cost ($20,000) of health services.[5] Postmandate, the insurance carrier would be required to pay an average of $17,230 of those costs, and the enrollee would pay an average of $2,770.

Expenditures

For DMHC-regulated plans and CDI-regulated policies, SB 257 would increase annual net expenditures by $69,946,000 (0.04%). Enrollee expenses for covered benefits would increase, but expenses for noncovered benefits would decrease This would result in an increase of total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies.

CHBRP projects no expected offsets postmandate.

Figure B. Expenditure Impacts of SB 257



Source: California Health Benefits Review Program, 2025.
Key: DMHC = Department of Managed Health Care.

Commercial

CHBRP estimates that among DMHC-regulated commercial plans, premium increases would range from $0.1183 per member per month (PMPM) for small-group plans to $2.0421 PMPM for individual-level plans. Among CDI-regulated commercial policies, premium increases would range from $0.1137 PMPM for small-group policies to $0.1278 PMPM for individual-level policies.

Medi-Cal

CHBRP projects that there would be no impact on Medi-Cal expenditures, as the health insurance of all Medi-Cal

[5] Note that these estimates are for all health care, not just maternity services. On average, gestational carriers use slightly fewer services than pregnant people overall and therefore have slightly lower average costs.

beneficiaries is exempt from SB 257 because Medi-Cal eligibility does not include surrogates or gestational carriers, and because people who are pregnant can already enroll in Medi-Cal at any time if they meet the income eligibility determination.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, CHBRP estimates premiums would increase by $0.1252 PMPM.

Number of Uninsured in California

CHBRP estimates that 5,303 previously uninsured pregnant people and their dependents would gain coverage postmandate.

Medical Effectiveness

CHBRP found *some evidence*[6] that special enrollment periods increase take-up of health insurance among pregnant people, but that *not enough research*[7] has been conducted to determine whether special enrollment periods improve utilization of maternity services or maternal and infant health outcomes.

CHBRP concluded that *not enough research* has been conducted to draw conclusions about the impact of presumptive eligibility for health insurance on utilization of maternity services or maternal and infant health outcomes.

CHBRP found that having continuous private health insurance coverage from the preconception to postpartum period is associated with receipt of more adequate and more timely prenatal care.

CHBRP found *conflicting evidence*[8] of the impact of continuous Medicaid coverage, with some studies finding that continuity of coverage was associated with higher likelihood of receiving recommended maternity services and others finding that continuous coverage was associated with lower likelihood of receiving recommended maternity services.

CHBRP concluded that *not enough research* has been conducted to draw conclusions about the effects of generosity of health insurance coverage on utilization of maternity services or maternal and infant health outcomes.

Public Health

Considering the findings noted above, CHBRP concludes that the impact of SB 257 on short-term or long-term public health outcomes is unknown. Although there is *strong evidence* that maternity services improve outcomes for infants and mothers, *not enough research* has been conducted to determine whether special enrollment periods or presumptive eligibility for health insurance for pregnant people improve utilization of maternity services.

Long-Term Impacts

Past the first year postmandate, SB 257 would continue to have similar utilization impacts.

Over the long term, SB 257 could have small impacts on cost savings due to better prenatal care leading to improved health outcomes for both the person who was pregnant and the child. Increases in costs over time would be expected to be in line with what is estimated for Year 1.

Essential Health Benefits and the Affordable Care Act

SB 257 would not exceed the definition of EHBs in California because SB 257 does not create a new coverage requirement.

[6] *Some evidence* indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.
[7] *Not enough research* indicates that there are no studies of the treatment, or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.
[8] *Conflicting evidence* indicates that a similar number of studies of equal quality suggest the treatment is effective as suggest the treatment is not effective.

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation.

The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report.

More detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

Suggested citation

California Health Benefits Review Program (CHBRP). (2025). *Analysis of California Senate Bill 257: Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act.* Berkeley, CA.

Table of Contents

Lists of Tables and Figures

Acronyms and Abbreviations

AB – Assembly Bill
ACA – Affordable Care Act
ACOG – American College of Obstetricians and Gynecologists
ASRM – American Society for Reproductive Medicine
ART – assisted reproductive technology
CA – California
CalPERS – California Public Employees' Retirement System
CDC – Centers for Disease Control and Prevention
CDI – California Department of Insurance
CHBRP – California Health Benefits Review Program
COHS – County Organized Health System
DHCS – Department of Health Care Services
DMHC – Department of Managed Health Care
EHB – essential health benefits
FPL – federal poverty level
HDPH – high deductible health plan
HMO – health maintenance organization
IP – intended parent
MCAP – Medi-Cal Access Program
NVSS-N – National Vital Statistics System
PRAMS – Pregnancy Risk Assessment Monitoring System
SB – Senate Bill

Introduction

The California Senate Committee on Health requested that the California Health Benefits Review Program (CHBRP)[9] conduct an evidence-based assessment of the medical, financial, and public health impacts of Senate Bill (SB) 257, Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act.

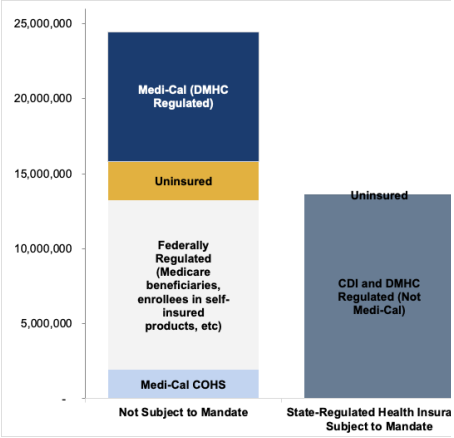
SB 257 PARENT Act Bill Language

SB 257 would make pregnancy a qualifying event for special enrollment for health insurance on the individual market, regardless of the circumstances of conception (i.e., for surrogates and gestational carriers). This special enrollment period would be extended to the pregnant person's dependents and people to whom the pregnant person is a dependent. During a special enrollment period, a person can enroll in a health plan or change their health plan.

Additionally, SB 257 would mandate several requirements of health plans and policies for coverage of maternity and newborn/pediatric care services for pregnant people, regardless of the circumstances of conception. Plans and policies would be prohibited from:

1. Denying, limiting or seeking reimbursement for maternity or newborn and pediatric care services because the enrollee is acting as a gestational carrier;
2. Denying coverage to an enrollee or the enrollee's newborn;
3. Increasing a premium, deductible, copayment, or coinsurance;
4. Penalizing or otherwise reducing or limiting the reimbursement of an attending health care provider;
5. Reducing coverage; and
6. Otherwise discriminating against an enrollee, their newborn, or an attending health care provider.

Figure 1. Health Insurance in CA and SB 257



Source: California Health Benefits Review Program, 2025.
Key: CDI = California Department of Insurance; COHS = County Organized Health System; DHCS = Department of Health Care Services; DMHC = Department of Managed Health Care.

SB 257 defines maternity services as inclusive of prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care.

See the full text of SB 257 in Appendix A.

If enacted, SB 257 would apply to the health insurance of approximately 13,570,000 enrollees (36% of all Californians) (see Figure 1).

- **Includes:**
  - For pregnancy as a qualifying event for special enrollment: enrollees in individual health benefit plans or uninsured individuals who are eligible to enroll in individual health benefit plans.
  - For prohibitions on restricting coverage: enrollees in commercial or CalPERS health insurance regulated by the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI).

- **Excludes:** Medi-Cal beneficiaries enrolled in DMHC-regulated plans, as Medi-Cal eligibility does not include surrogates or gestational carriers and because people who are pregnant can already enroll in Medi-Cal at any time if

[9] See CHBRP's authorizing statute.

they meet the income eligibility determination. Pregnancy raises the income limit for eligibility into Medi-Cal up to 322% of the federal poverty level (FPL) through the Medi-Cal Access Program (MCAP)[10].

See the following *Analytic Approach and Key Assumptions* section for additional information.

What Are Maternity Services for Surrogates and Gestational Carriers?

A typical pregnancy often involves 10 to 15 routine prenatal care visits, with more visits required for high-risk pregnancies (HHS OASH, 2025). As summarized in CHBRP's 2011 analysis of AB 185: Maternity Services, there is strong evidence that several prenatal care services are effective and improve outcomes for either infants or mothers (CHBRP, 2011). See the *Background* section for more detail on health outcomes.

A gestational carrier is defined as a person who carries a pregnancy for intended parents (IPs) but does not provide the egg(s) for fertilization and thus does not have a biological relation to the baby. A surrogate provides their own egg(s) for fertilization and is biologically related to the baby. IPs plan to become the legal parent(s) of a child born through the assistance of a surrogate or gestational carrier.

Surrogates/gestational carriers and IPs commonly enter into a legally binding contract, sometimes called a "surrogacy arrangement," that outlines the rights, responsibilities, and obligations of all parties involved. The Affordable Care Act (ACA) requires coverage of maternity services as an essential health benefit (EHB), including prenatal care, labor and delivery, and postpartum care (see *Policy Context* section for detail). However, the California benchmark health plan Evidence of Coverage states that anyone who enters a "surrogacy arrangement" must pay charges for covered services received related to conception, pregnancy, or delivery in connection with the arrangement. This applies to surrogates and gestational carriers (Kaiser Permanente, 2011). Surrogacy arrangements between IPs and surrogates/gestational carriers often address, among other things, how health and life insurance coverage and costs will be handled during pregnancy. IPs commonly pay out-of-pocket costs (including charges from insurers for covered services), cost sharing, expenses not covered by the surrogate/gestational carrier's insurance, and/or a supplemental insurance policy if deemed necessary. Supplemental insurance policies can be a health plan with a carrier that will cover a surrogate/gestational carrier's maternity services purchased through the individual market during open enrollment, or a private surrogacy insurance policy (American Surrogacy, n.d.). See the *Policy Context* section for more detail.

CHBRP assumes that this bill would likely apply to three populations of enrollees:

1. People (and their dependents) insured through individual health benefit plans who want to switch plans when they become pregnant (i.e., to receive more generous maternity coverage or coverage with lower out-of-pocket costs).
2. Uninsured people (and their dependents) who want coverage for maternity services when they become pregnant but are otherwise ineligible for Medi-Cal or MCAP, which cover pregnant people up to 322% of the FPL.
3. Insured people who are acting as a surrogate or gestational carrier, or who otherwise experience insurance discrimination — i.e., denial or restriction of coverage, requests from insurance carriers to reimburse maternity services (see *Policy Context* section for detail) — while pregnant.

Terminology

Gestational carrier: A person who carries and gives birth to a baby for another couple or person but does not provide the egg(s) for fertilization and thus does not have a biological relation to the baby.

[10] Pregnant individuals who have income between 213 and 322% of the FPL are eligible for the Medi-Cal Access Program (MCAP). Pregnant individuals who are not eligible for full-scope or pregnancy-related Medi-Cal may qualify for the MCAP, regardless of citizenship and immigration status. MCAP offers comprehensive coverage, with no copayments, deductibles, and coinsurance. Pregnant individuals may qualify for both Covered California and the MCAP, but cannot enroll in both.

Surrogate: A person who carries and gives birth to a baby for another couple or person using their own eggs, thus having a biological relation to the baby.

Intended parent(s): The person or people for whom a gestational carrier or surrogate carries a baby; this person or these people plan to become the legal parent(s) of a child born through the assistance of a surrogate or gestational carrier.

Surrogacy arrangement: A legally binding contract into which a surrogate/gestational carrier and IPs enter that outlines the rights, responsibilities, and obligations of all parties involved, often including by whom insurance costs will be paid.

Generosity of coverage: An industry term used to compare the relative portion of medical costs covered by one health plan versus another.

Back to Table of Contents

Analytic Approach and Assumptions

As SB 257 would require that plans and policies consider pregnancy a qualifying event for all pregnant people and may not restrict coverage for any pregnant person regardless of circumstances of conception, CHBRP has assumed that this bill is inclusive of surrogates and gestational carriers. CHBRP reports data on both surrogates and gestational carriers where able, but much of CHBRP's analysis uses billing code Z33.3, which is specified as unique to a pregnant person bearing a genetically unrelated child from an embryo created by in vitro fertilization (AHA Coding Clinic, 2016). Real-world billing practices indicate that Z codes are commonly misused, such that it is possible that surrogates are captured by this code. There is no other billing code that categorizes surrogates.

As SB 257 specifies that pregnancy shall trigger a qualifying event for special enrollment, CHBRP has assumed that a person who changes their insurance for this reason may stay on their new plan beyond pregnancy.

As SB 257 specifies that plans and policies may not restrict newborn and pediatric care services for anyone based on the circumstances of conception, CHBRP has assumed that intended parents (IPs) arrange for a baby born to a surrogate or gestational carrier to be covered under the IPs' health insurance upon birth, such that the surrogate or gestational carrier is not expected or required to cover the cost of newborn or pediatric care services.

As SB 257 specifies that insurers may not increase a premium, deductible, copayment, or coinsurance for a pregnant person regardless of the circumstances of conception, CHBRP has assumed that this restricts insurers from increasing costs beyond rates set for the most recent open enrollment period and does not prohibit them from raising premiums, deductibles, copayments, or coinsurance as part of standard annual rate setting for subsequent open enrollment periods.

As stated in the California benchmark health plan and corroborated by insurance carriers and legal experts, some insurers will cover but seek reimbursement for maternity services for surrogates or gestational carriers if the surrogate or gestational carrier is being compensated by the IPs. CHBRP has assumed that this creates cost implications for insurance carriers that would no longer be permitted to seek reimbursement were SB 257 to be enacted.

CHBRP has assumed that SB 257 would not have an impact on the Medi-Cal Managed Care population, as most surrogacy agencies in California do not permit people who receive government financial assistance to serve as surrogates or gestational carriers (Pinnacle Surrogacy, n.d.; Surrogate.com, 2025) and because people who are pregnant can already enroll in Medi-Cal at any time if they meet the income eligibility determination.

CHBRP has assumed that surrogacy arrangements occur through approved, legal channels.

Back to Table of Contents

Policy Context

Health benefit mandates may interact and align with the following state and federal mandates, programs, and policies.

California Law and Regulations

Existing California Law

Coverage of maternity services under surrogacy arrangements

The ACA requires coverage of maternity services as an EHB, including prenatal care, labor and delivery, and postpartum care. However, the California benchmark health plan Evidence of Coverage states that anyone who enters a surrogacy arrangement must pay charges for covered services received related to conception, pregnancy, or delivery in connection with the arrangement. The amount paid will not exceed the compensation the surrogate/gestational carrier is entitled to receive under the surrogacy arrangement. The benchmark health plan Evidence of Coverage also requires an enrollee to notify the plan in writing within 30 days of entering into a surrogacy arrangement. The notice must include a copy of any contracts or other documents explaining the arrangement. By accepting the plan's Surrogacy Health Services, a surrogate/gestational carrier automatically assigns to the plan their right to receive payments that are payable to the surrogate/gestational carrier or chosen payee under the surrogacy arrangement. The plan places a lien on those payments to secure its rights. A surrogacy arrangement is defined by the benchmark plan as one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child, meaning this policy applies to both surrogates and gestational carriers (Kaiser Permanente, 2011).

Several insurers in California have adopted this language in their Evidence of Coverage, such that they may impose a lien upon the compensation a surrogate or gestational carrier receives for their service to recover medical expenses. As identified through surveys of commercial and CalPERS carriers in California, 83% of enrollees are in plans or policies that claim to seek reimbursement for maternity services from surrogates/gestational carriers.

Fertility services

SB 729, signed into law by Governor Newsom in September 2024, requires that large-group health plans and policies cover fertility services, and that small-group health plans and policies give employers the option to add coverage to their benefits ("offer coverage") for fertility services. SB 729 offers an exemption for religious employers. As defined, fertility services include a maximum of three completed oocyte retrievals and unlimited embryo transfers. SB 729 prohibits denial of fertility coverage based on a covered person's participation in fertility services provided by or to a third party, which includes "an oocyte, sperm, or embryo donor, gestational carrier, or surrogate that enables an intended recipient to become a parent" (CHBRP, 2023).

Similar Legislation in Other States

In 2015, legislation was passed to make New York the first state to make pregnancy a qualifying event for special enrollment into Marketplace health insurance (Norris, 2025). Findings from a study of the effect on New York's special enrollment period for Marketplace coverage for pregnant people on health insurance enrollment can be found in the *Medical Effectiveness* section of this report. Since then, seven other states — Connecticut, New Jersey, Maryland, Maine, Rhode Island, Colorado, and Vermont — and the District of Columbia have made pregnancy a qualifying event for special enrollment through state-run exchanges. Illinois and Virginia enacted legislation in 2024 and 2025, respectively, that will make pregnancy a qualifying event for special enrollment for Marketplace health insurance beginning in 2026 (Norris, 2025).

In 2019, the Nevada Surrogacy Insurance Bill was passed to prohibit insurers from denying, limiting, or seeking reimbursement for maternity care because the insured acts as a gestational carrier. The law also deems a child born by a gestational carrier to be a child of the intended parents.[11]

In 2019, legislation was proposed in the Oregon Senate to require health benefit plans, other than employer-sponsored plans, to cover the cost of pregnancy care and childbirth for enrollees who are surrogates. The legislation did not pass.[12]

New York passed the Child-Parent Security Act (CPSA) in 2020, which legalized compensated gestational surrogacy, created a path to establish legal parental rights for parents who rely on assisted reproductive technology (ART) to have children, and created a Surrogates' Bill of Rights to ensure the right of surrogates to make their own healthcare decisions. (New York State Department of Health, 2021; New York State Department of Health, 2023).

Federal Policy Landscape

Affordable Care Act

A number of ACA provisions have the potential to or do interact with state benefit mandates. Below is an analysis of how SB 257 may interact with requirements of the ACA as presently exist in federal law, including the requirement for certain health insurance to cover essential health benefits (EHBs).[13,14] As per the ACA, pregnancy is not considered a preexisting condition, meaning insurers cannot restrict or deny coverage because a person becomes pregnant or is pregnant at time of seeking coverage.

Essential health benefits

In California, nongrandfathered[15] individual and small-group health insurance is generally required to cover essential health benefits (EHBs).[16] In 2026, approximately 11% of all Californians will be enrolled in a plan or policy that must cover EHBs.[17] Maternity and newborn care are a specific category of EHBs and include delivery and all inpatient services for maternity care; prenatal and postnatal care; and maternity-prenatal alpha fetoprotein programs.

SB 257 would not exceed the definition of EHBs in California because SB 257 does not create a new coverage requirement.

Back to Table of Contents

[11] Nevada State Assembly Bill No. 472.
[12] Oregon State Senate Bill 242.
[13] The ACA requires nongrandfathered small-group and individual market health insurance — including but not limited to qualified health plans sold in Covered California — to cover 10 specified categories of EHBs. Policy and issue briefs on EHBs and other ACA impacts are available on the CHBRP website.
[14] Although many provisions of the ACA have been codified in California law, the ACA was established by the federal government, and therefore, CHBRP generally discusses the ACA as a federal law.
[15] A grandfathered health plan is "a group health plan that was created – or an individual health insurance policy that was purchased – on or before March 23, 2010. Plans or policies may lose their 'grandfathered' status if they make certain significant changes that reduce benefits or increase costs to consumers."
[16] For more detail, see CHBRP's issue brief *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*.
[17] See CHBRP's resource *Sources of Health Insurance in California*.

Background on Maternity Services and Gestational Carriers

As described in the *Policy Context* section, SB 257 would make pregnancy a qualifying event for special enrollment for health insurance on the individual market, regardless of the circumstances of conception (i.e., for surrogates and gestational carriers). This special enrollment period would be extended to the pregnant person's dependents and people to whom the pregnant person is a dependent. Additionally, SB 257 would prohibit health plans and policies that provide coverage for maternity, newborn, or pediatric care services from denying, limiting, or seeking reimbursement for maternity, newborn, or pediatric care services, including if the enrollee is acting as a gestational carrier.

This *Background* section will provide contextual information about maternity care services, surrogates and gestational carriers.

Maternity Care Services

A typical pregnancy often involves 10 to 15 routine prenatal care visits, with more visits required for high-risk pregnancies (HHS OASH, 2025). As summarized in CHBRP's 2011 analysis of AB 185: Maternity Services, there is strong evidence that several prenatal care services are effective and improve outcomes for either infants or mothers, including but not limited to counseling on behavioral risks such as smoking and domestic violence; screening for genetic disorders and structural abnormalities; screening for and treating infectious diseases such as asymptomatic bacteriuria, hepatitis B, HIV, STIs, and group B streptococcus; screening and management of hypertensive disorders, gestational diabetes, anemia, and Rh(D) incompatibility; and screening and management of women at risk for preterm deliveries. Utilization of effective maternity care services can reduce low-birthweight births, preterm births, and other causes of infant and maternal mortality (CHBRP, 2011). American College of Obstetricians and Gynecologists (ACOG) guidance highlights the importance of the postpartum care period to assess physical, social, and psychological well-being, evaluate chronic medical conditions, and coordinate ongoing care with primary care providers (ACOG, 2018). The postpartum care period also represents a crucial opportunity to diagnose and treat postpartum depression and other maternal mental health conditions, which can have serious consequences for the health and wellbeing of both mother and infant (Slomian et al., 2019).

Disparities[18] in Maternity Care Service Use

Disparities are noticeable and preventable or modifiable differences between groups of people. Health insurance benefit mandates or related legislation may impact disparities. Where intersections between health insurance benefit mandates and social determinants or systemic factors exist, CHBRP describes relevant literature.

According to 2022 data from the National Vital Statistics System - Natality (NVSS-N), women who are younger; are Black/African American, American Indian/Alaska Native, Native Hawaiian/Pacific Islander, or Hispanic/Latino; have less educational attainment; and are born outside of the United States are less likely to receive early and adequate prenatal care. Krukowski et al.'s analysis of 2016 Pregnancy Risk Assessment Monitoring System (PRAMS) data found that women who are younger, Hispanic, have less educational attainment, and are unmarried were more likely to report that they did not receive prenatal care as early as they wanted (Krukowski et al., 2022).

Barriers to Accessing Maternity Care

According to 2018–2022 data from NVSS-N, approximately three-quarters of pregnant women report receiving early and adequate prenatal care, which is below the Healthy People 2030 target of 80.5% (ODPHP, 2025). Research has identified

[18] Several competing definitions of "health disparities" exist. CHBRP relies on the following definition: Health disparity is defined as the differences, whether unjust or not, in health status or outcomes within a population (Wyatt et al., 2016).

several factors impeding use of prenatal care, including lack of transportation, limited available time off from work or school, lack of childcare, not wanting to disclose the pregnancy, not being aware of the pregnancy, and financial or structural barriers to accessing care (Krukowski et al., 2022; Testa et al., 2023; Testa and Jackson, 2021). Krukowski et al. (2022) analyzed data from the 2016 PRAMS and found that 28% of respondents reported lack of insurance or funds to pay for a prenatal care visit as one reason for not seeking early prenatal care. The authors found that younger women, women with less education, and women receiving benefits from the Supplemental Nutrition Program for Women, Infants, and Children were more likely to report financial barriers to early prenatal care (Krukowski et al., 2022).

Surrogates and Gestational Carriers

As discussed in the *Introduction*, a gestational carrier is defined as a person who carries a pregnancy for the intended parents (IPs) but does not provide the egg(s) for fertilization and thus does not have a biological relation to the baby. A surrogate provides their own egg(s) for fertilization and is biologically related to the baby. The IPs plan to become the legal parent(s) of a child born through the assistance of a surrogate or gestational carrier.

Practice recommendations from the American Society for Reproductive Medicine (ASRM) state that surrogates or gestational carriers are used when a medical condition precludes an IP from carrying a pregnancy or when carrying a pregnancy presents a significant risk to the IP or the fetus. Examples include absence of the uterus (e.g., due to treatment for gynecological cancer), malformed uterus, medical contraindications to pregnancy (e.g., severe cardiac or respiratory disease, severe preeclampsia or gestational hypertension in a previous pregnancy), or biologic inability to conceive or carry a pregnancy (ASRM, 2022).

According to the Centers for Disease Control and Prevention (CDC) National Assisted Reproductive Technology (ART) surveillance system, 4.7% of the 206,271 embryo transfers occurring in 2022 used a gestational carrier (CDC, 2022). A recent analysis of data from the Healthcare Cost and Utilization Project (HCUP) including over 14 million deliveries calculated that 13.7 per 100,000 deliveries each year involve a gestational carrier pregnancy, or one in every 7,284 hospital deliveries (Masjedi et al., 2025). Between 2017 and 2020, the prevalence of gestational carrier pregnancies increased significantly (from 11.8 to 18.2 per 100,000 deliveries). *(Note: these data reflect gestational carriers only and are not inclusive of pregnancies involving a surrogate, as there is no ICD code specific to surrogates.)*

Compared to nongestational carrier pregnancies, gestational carriers are more likely to be white, 35 years of age or older, and less likely to have certain comorbidities, such as obesity, chronic hypertension, or tobacco use (Masjedi et al., 2025). CDC's ART surveillance data shows that embryo transfers involving gestational carriers were more common among patients older than 40 years of age (9.6%) (CDC, 2022). A survey of 222 gestational carriers and surrogates found that the vast majority (92%) had private health insurance with the remaining 8% on Medicaid or lacking health insurance (Fuchs and Berenson, 2018). Similarly, the analysis of national discharge data found that 91.3% of gestational carriers had private insurance (including HMO) (Masjedi et al., 2025). *(Note: These data reflect gestational carriers only and are not inclusive of pregnancies involving a surrogate, as there is no ICD code specific to surrogates.)*

Please refer to the *Introduction* and *Policy Context* sections for additional information regarding surrogacy-specific insurance, fertility benefits, and reimbursement for IPs.

Back to Table of Contents

Medical Effectiveness

As discussed in the *Policy Context* section, SB 257 would make pregnancy a qualifying event for special enrollment for health insurance on the individual market, and would make several requirements of health plans and policies for coverage of maternity and newborn/pediatric care services for all pregnant people, regardless of the circumstances of conception (i.e., for surrogates and gestational carriers). The special enrollment period would be extended to the pregnant person's dependents and people to whom the pregnant person is a dependent. Additional information regarding maternity services and gestational carriers is included in the *Background* section.

The medical effectiveness review summarizes findings from evidence[19] on the effects of special enrollment periods for pregnant people. Because CHBRP identified only one study that directly addressed this topic, CHBRP expanded its literature review to include studies that provide indirect evidence of the potential impact of special enrollment periods. These studies address the impact of presumptive eligibility for health insurance coverage for pregnant people, continuity in coverage during the perinatal period, and generosity of coverage[20] during the perinatal period.

Research Approach and Methods

A total of eight studies were included in the medical effectiveness review for this report. The other articles were eliminated because they did not focus on birthing people; did not address special enrollment periods, presumptive eligibility, continuity of coverage, or generosity of coverage; were of poor quality; or did not report findings from research studies. A more thorough description of the methods used to conduct the medical effectiveness review and the process used to grade the evidence for each outcome measure is presented in CHBRP's Medical Effectiveness Analysis and Research Approach.

The conclusions below are based on the best available evidence from peer-reviewed and grey literature.[21] Unpublished studies are not reviewed because the results of such studies, if they exist, cannot be obtained within the 60-day timeframe for CHBRP reports.

Key Questions

1. Does providing a special enrollment period for health insurance for pregnant people reduce the rate of uninsurance among pregnant people, increase use of maternity services, or improve maternal and infant health outcomes compared to being uninsured during pregnancy?
2. Does providing presumptive eligibility for health insurance for pregnant people reduce the rate of uninsurance among pregnant people, increase use of maternity services, or improve maternal and infant health outcomes compared to being uninsured during pregnancy?
3. Does obtaining health insurance during pregnancy increase use of maternity services or improve maternal and infant health outcomes compared to being uninsured during pregnancy?
4. Does switching from a health plan with less generous coverage to a health plan with more generous coverage during pregnancy increase use of maternity services or improve maternal and infant health outcomes compared to being uninsured during pregnancy?

[19] Much of the discussion in this section is focused on reviews of available literature. However, as noted in the section on Implementing the Hierarchy of Evidence in the Medical Effectiveness Analysis and Research Approach document, in the absence of fully applicable to the analysis peer-reviewed literature on well-designed randomized controlled trials (RCTs), CHBRP's hierarchy of evidence allows for the inclusion of other evidence.
[20] Generosity of coverage is an industry term used to compare the relative portion of medical costs covered by one health plan versus another.
[21] Grey literature consists of material that is not published commercially or indexed systematically in bibliographic databases. See CHBRP's website for more information.

Methodological Considerations

CHBRP identified only one study of the impact of a special enrollment period for health insurance (Eliason and Steenland, 2023). This study only assessed the impact of a special enrollment period on take-up of health insurance and did not examine effects on use of maternity services or maternal or infant health outcomes.

To supplement this study, CHBRP reviewed other studies that provide indirect evidence of the potential impact of special enrollment periods. These studies included a study of presumptive eligibility for Medicaid, which enables pregnant people to obtain coverage immediately without waiting for an eligibility worker to determine whether they are eligible for coverage. Since a special enrollment period would also enable pregnant people to obtain coverage more quickly, findings from this study of presumptive eligibility may provide insights into the impact of a special enrollment period for pregnancy.

CHBRP also reviewed studies of the impact of having continuous health insurance coverage during pregnancy and the postpartum period versus discontinuity in coverage, such as transitioning from being uninsured at the time pregnancy occurs to obtaining Medicaid or private health insurance at some point during pregnancy; or having pregnancy-only Medicaid coverage, which has historically ended 60 days after birth. Findings from such studies may be relevant to SB 257 because a special enrollment period would enable pregnant people to obtain health insurance early in their pregnancies and to keep their coverage or for a longer period of time after giving birth, which could facilitate initiation of prenatal care during the first trimester, receipt of all recommended prenatal visits and services, and receipt of recommended postpartum care.

Finally, CHBRP reviewed studies of pregnant people enrolled in health plans with more versus less generous coverage (i.e., low deductible vs. high deductible) because a special enrollment period would enable pregnant people to switch from a less generous health plan to a more generous health plan (e.g., from a health plan with a high deductible to a health plan with a low deductible) early in pregnancy. Having more generous coverage would reduce out-of-pocket costs for maternity services, which could facilitate initiation of prenatal care during the first trimester and receipt of all recommended prenatal visits and services.

Outcomes Assessed

The medical effectiveness review addressed the effects of special enrollment periods for pregnant people, presumptive eligibility for health insurance, continuity of coverage, and generosity of coverage on obtaining health insurance, utilization of maternity services, and maternal and infant health outcomes. Special enrollment periods and presumptive eligibility make it easier for pregnant people to obtain coverage in a timely manner which could improve their ability to obtain maternity services. Timely receipt of prenatal care is associated with better maternal health and pregnancy outcomes (Partridge et al., 2012).

Utilization outcomes included initiation of prenatal care in the first trimester, number of prenatal care visits, receipt of recommended prenatal screening tests, receipt of recommended treatment for pregnancy complications (e.g., medication for gestational diabetes or preeclampsia).

Maternal and infant health outcomes included preterm birth, low birthweight, and postpartum depression.

Study Findings

This following section summarizes CHBRP's findings regarding the strength of evidence for the effectiveness of the enrollment and coverage requirements for pregnant persons and newborns specified in SB 257. Each section is accompanied by a corresponding figure. The title of the figure indicates the test, treatment, or service for which evidence is summarized. The statement in the box above the figure presents CHBRP's conclusion regarding the strength of evidence about the effect of a particular test, treatment, or service based on a specific relevant outcome and the number

of studies on which CHBRP's conclusion is based. Definitions of CHBRP's grading scale terms are included in the box below.

The following terms are used to characterize the body of evidence regarding an outcome:

Very strong evidence indicates that there are multiple studies of a treatment and the large majority of studies are of high quality and consistently find that the treatment is either effective or not effective. Conclusions are unlikely to be altered by additional evidence.

Strong evidence indicates that the majority of the studies reviewed are consistent in their findings that treatment is either effective or not effective. Conclusions could be altered with additional strong evidence.

Some evidence indicates that a small number of studies have limited generalizability to the population of interest and/or the studies have a serious methodological concern in research design or implementation. Conclusions could be altered with additional evidence.

Conflicting evidence indicates that a similar number of studies of equal quality suggest the treatment is effective as suggest the treatment is not effective.

Not enough research indicates that there are no studies of the treatment or the available studies are not of high quality, meaning there is not enough evidence available to know whether or not a treatment is effective. It does not indicate that a treatment is not effective.

Special Enrollment Periods

An observational study with a comparison group assessed the effect of New York's special enrollment period for Marketplace coverage for pregnant people on take-up of health insurance coverage (Eliason and Steenland, 2023). The authors compared the trend in insurance coverage among pregnant people in New York following the establishment of its special enrollment period in 2016 to trends in 17 other states that do not have a special enrollment period for pregnant people. To isolate effects on pregnant people likely to be eligible to purchase subsidized coverage through New York's Marketplace, analysis was limited to pregnant people whose incomes were between New York's threshold for pregnancy-related Medicaid coverage (225% of poverty) and the income limit for subsidies for health insurance purchased through a marketplace (400% of poverty). The authors found that, relative to states without a special enrollment period, the special enrollment period in New York was associated with a 6.3 percentage point increase (95% CI: 4.4 to 8.2) in the number of pregnant persons with Marketplace coverage and 1.4 percentage point (95% CI: -2.1 to -0.7) decrease in the number of pregnant persons who were uninsured. The study did not assess whether the special enrollment period was associated with differences in utilization of maternity services or maternal or infant health outcomes.

Summary of findings regarding the effectiveness of special enrollment periods for pregnant people: There is *some evidence* that special enrollment periods for pregnant people are associated with increased enrollment in health insurance among pregnant people, based on one study of a special enrollment period for Marketplace health plans in New York. *Not enough research* has been conducted to determine whether special enrollment periods for pregnant people improve utilization of maternity services or maternal and infant health outcomes; CHBRP did not identify any studies of the effects of special enrollment periods on use of maternity services or maternal or infant health outcomes.

Figure 2. Evidence of Effects of Special Enrollment Periods on Having Health Insurance

Figure 3. Evidence of Effects of Special Enrollment Periods on Utilization of Maternity Services and Maternal and Infant Health Outcomes

Presumptive Eligibility for Health Insurance

One study examined the impact of presumptive eligibility for health insurance on use of prenatal care services (Eliason and Daw, 2022). To enable pregnant people to have timely access to prenatal care, 29 states and the District of Columbia have instituted presumptive eligibility for Medicaid coverage for uninsured pregnant people. Presumptive eligibility also guarantees that prenatal care providers will be reimbursed for services even if the pregnant person is later found to be ineligible for Medicaid (Eliason and Daw, 2022). The authors hypothesized that a guarantee that Medicaid will cover prenatal care services could increase utilization. The study assessed the impact of the introduction of presumptive eligibility for Medicaid in Kansas in 2016 by comparing pregnant people in Kansas to pregnant people in seven states that consistently had presumptive eligibility during the time period studied and had not expanded eligibility for Medicaid under the Affordable Care Act. The authors used level of education as a proxy for Medicaid eligibility because they did not have access to data regarding pregnant peoples' incomes. The study found that presumptive eligibility for Medicaid was associated with a small increase (1.92 percentage points [95% CI: 0.64 to 4.35]) in use of prenatal care during the first trimester among pregnant people with a high school education or less (i.e., the group of pregnant people most likely to be presumptively eligible for Medicaid).

Summary of findings regarding the effectiveness of presumptive eligibility for health insurance: *Not enough research* has been conducted to assess the effectiveness of presumptive eligibility for health insurance for pregnant people. Although CHBRP identified one study on effects of the implementation of presumptive eligibility for Medicaid in Kansas, the findings may not generalize to SB 257 because SB 257 applies to pregnant people eligible for Marketplace coverage and not to those who are eligible for Medicaid. CHBRP did not identify any studies of the impact of presumptive eligibility on maternal or infant health outcomes.

Figure 4. Evidence of Effects of Presumptive Eligibility on Use of Maternity Services and Maternal and Infant Health Outcomes

Continuity of Health Insurance Coverage

CHBRP identified seven observational studies of the impact of continuity in health insurance coverage on use of maternity services. One study that is most generalizable to SB 257 compared utilization of prenatal care by pregnant persons who were continuously enrolled in a marketplace plan during preconception, prenatal, and postpartum periods to pregnant people who enrolled in a marketplace plan during pregnancy (Gordon et al., 2021). Continuous coverage was associated with a higher rate of adequate prenatal care (77.94% vs. 70.33%), earlier prenatal care initiation, (89.38% vs. 83.96%), and greater likelihood of having 12 or more prenatal visits (50.04% vs. 44.19%).

Another observational study (Booman et al., 2024) assessed continuity in health insurance coverage among pregnant people who obtained care at a community-based health care organization, such as a federally qualified health center. The authors analyzed electronic health record data for 74,980 pregnant people and compared four groups: (1) people with discontinuous health insurance coverage; (2) people who had continuous private health insurance coverage; (3) people who had continuous coverage through Medicaid or another public program; and (4) people who remained uninsured throughout their pregnancy. The majority of pregnant people with discontinuity in health insurance transitioned from uninsured to public insurance. Pregnant people who had discontinuous coverage and transitioned from uninsured to private insurance were less likely to receive intensive or adequate prenatal care than pregnant people who had continuous private health insurance coverage, but more likely to receive intensive or adequate prenatal care than people continuously enrolled in public coverage, people who transitioned from uninsured to public coverage, and people who remained uninsured throughout their pregnancy (54.5% for continuous private coverage, 52.1% transition from uninsured to private insurance, 47.2% for transition from uninsured to public coverage, 45.5% for continuously enrolled in public coverage, 44.6% for remained uninsured).

One observational study examined the impact of the timing of enrollment in health insurance on adequacy of prenatal care. The authors examined claims data on a cohort of 1,858 birthing people enrolled in Massachusetts' Medicaid Managed Care Program (Weir et al., 2011). The authors used Medicaid enrollment records to classify the timing and duration of Medicaid coverage before delivery as "before pregnancy" (≥280 days), "first trimester" (180–279 days), and "second trimester or later" (<180 days). Pregnant people who obtained Medicaid coverage during the first trimester of pregnancy were more likely to have the frequency of prenatal care visits recommended by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists than pregnant people with continuous Medicaid coverage. There were no differences between the two groups in the timeliness of prenatal care or likelihood of having a postpartum visit.

Two observational studies compared receipt of postpartum visits by birthing people with continuous Medicaid coverage to birthing people with pregnancy-only Medicaid coverage. People with pregnancy-only Medicaid coverage usually enroll after they become pregnant and, at the time data were collected for these studies, ended 60 days postpartum. One study analyzed data on a cohort of 105,718 birthing people in Wisconsin and compared birthing people with continuous Medicaid coverage to birthing people with pregnancy-only Medicaid coverage (i.e., coverage limited to the perinatal period). The authors found that birthing people with continuous Medicaid coverage were six percentage points (RD: 6.27; 95% CI: 5.72 to 6.82) more likely to have a postpartum visit than birthing people with pregnancy-only Medicaid coverage (DeSisto et al., 2020). Another study examined a cohort of 58,500 birthing people enrolled in Arizona's Medicaid program (Okechukwu et al., 2024). The authors found that birthing people with pregnancy-only Medicaid coverages were less likely to have any postpartum visits (0.70; 95% CI: 0.66 to 0.74) than birthing people with continuous Medicaid coverage.

None of the studies of continuity of insurance coverage examined effects on maternal or infant health outcomes.

Summary of findings regarding the impact of continuity in insurance coverage: There is *some evidence* that pregnant people who have continuous private health insurance coverage are more likely to initiate prenatal care during the first trimester, to receive adequate prenatal care, and to have a postpartum visit. Evidence regarding the impact of having continuous Medicaid coverage is *conflicting*. Two studies find that pregnant people transitioning to Medicaid during the first trimester of pregnancy were more likely to receive adequate prenatal care than pregnant people who were continuously enrolled in Medicaid from preconception to the postpartum period. One study found that low-income pregnant people transitioning to Medicaid were more likely to receive adequate prenatal care than low-income pregnant people with continuous private insurance. Two studies found that birthing people who have continuous Medicaid coverage are more likely to have a postpartum visit than those with pregnancy-only coverage. CHBRP did not identify any studies of the impact of continuity of insurance coverage on maternal or infant health outcomes.

Figure 5. Evidence of Effects of Continuity in Private Health Insurance Coverage on Use of Maternity Services

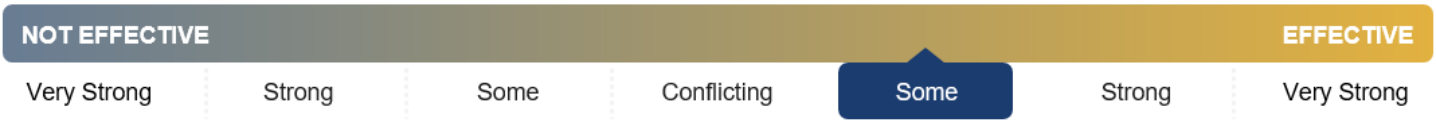


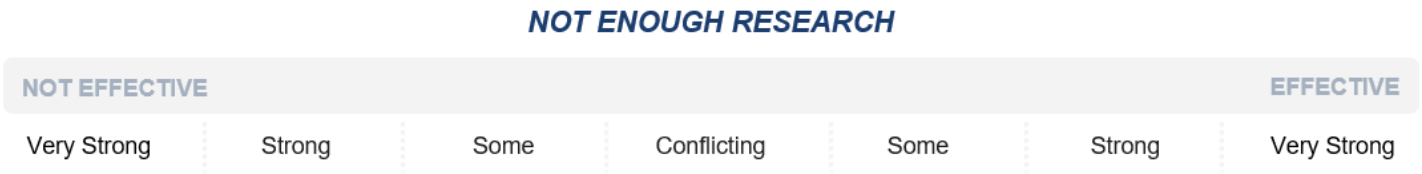
Figure 6. Evidence of Effects of Continuity in Medicaid Coverage on Use of Maternity Services

Generosity of Health Insurance Coverage

CHBRP identified one study that assessed whether use of prenatal care services varied with the generosity of health insurance coverage (Kozhimannil et al., 2011). The study compared pregnant people who delivered babies before or after their employer shifted their health insurance coverage from a health maintenance organization (HMO) to several high deductible health plans (HDHPs) to pregnant people whose employers continuously provided coverage through an HMO. Persons enrolled in these HDHPs were not eligible to enroll in a Health Savings Account. The HDHPs waived the deductible for routine prenatal and postpartum visits, fetal ultrasounds, routine urinalysis, Papanicolaou tests, and screenings for sexually transmitted infections The authors found no statistically significant differences between the HDHP and HMO groups in the odds of receiving any prenatal care, recommended prenatal visits, or postpartum care. The study did not examine the effect of switching to an HDHP on maternal or infant health outcomes.

Summary of findings regarding the effects of generosity of health insurance coverage: *Not enough research* has been conducted to assess the relationship between the generosity of health insurance coverage and utilization of maternity care services. Although CHBRP identified one study on effects of generosity of coverage, the generalizability of this study to SB 257 is limited. The study examined the impact of an employer's decision to switch all employees from an HMO to an HDHP regardless of their preferences, whereas SB 257 would enable pregnant people to choose voluntarily whether to switch from a less generous to a more generous health plan or vice versa. In addition, the HDHPs studied waived the deductible for prenatal and postpartum visits and prenatal screening tests, which may have led to different results than if those services had been subject to a deductible. CHBRP did not identify any studies of the relationship between generosity of health insurance coverage and maternal or infant health outcomes.

Figure 7. Evidence of the Impact of More versus Less Generous Health Insurance Coverage on Use of Maternity Services



Summary of Findings

CHBRP found *some evidence* that special enrollment periods increase take-up of health insurance among pregnant people, but that *not enough research* has been conducted to determine whether special enrollment periods improve utilization of maternity services or maternal and infant health outcomes.

CHBRP concluded that *not enough research* has been conducted to draw conclusions about the impact of presumptive eligibility for health insurance on utilization of maternity services or maternal and infant health outcomes.

CHBRP found that having continuous private health insurance coverage from the preconception to postpartum period is associated with receipt of more adequate and more timely prenatal care.

CHBRP found *conflicting evidence* of the impact of continuous Medicaid coverage, with some studies finding that continuity of coverage was associated with higher likelihood of receiving recommended maternity services and others finding that continuous coverage was associated with lower likelihood of receiving recommended maternity services.

CHBRP concluded that *not enough research* has been conducted to draw conclusions about the effects of generosity of health insurance coverage on utilization of maternity services or maternal and infant health outcomes.

Back to Table of Contents

Benefit Coverage, Utilization, and Cost Impacts

As discussed in the *Policy Context* section, SB 257 would require health plans and health policies regulated by DMHC or CDI to make pregnancy a qualifying event for special enrollment for health insurance on the individual market, and would make several requirements of health plans and policies for coverage of maternity and newborn/pediatric care services for all pregnant people, regardless of the circumstances of conception (i.e., for surrogates and gestational carriers). The special enrollment period would be extended to the pregnant person's dependents and people to whom the pregnant person is a dependent. Additional information regarding maternity services and gestational carriers is included in the *Background* section. This section reports the potential incremental impacts of SB 257 on estimated baseline benefit coverage, utilization, and overall cost.

Analytic Approach and Key Assumptions

SB 257 would affect three populations postmandate: (1) pregnant people who have current health insurance coverage through an individual-level DMHC-regulated plan or a CDI-regulated policy and would be qualified to change their existing coverage; (2) pregnant people who are insured in all health insurance market segments and also are surrogates or gestational carriers; and (3) pregnant people who are currently uninsured who would be newly qualified to obtain coverage on the individual market. CHBRP modeled the impact of SB 257 on each of these populations by using the following approach:

- SB 257 does not affect the benefit coverage package or the cost sharing provisions of health insurance plans.
- DMHC-regulated plans and CDI-regulated policies that currently seek reimbursement from surrogates or gestational carriers for maternity or prenatal health services are not fully compliant with SB 257 at baseline.

To model the impact of SB 257, CHBRP made the following assumptions:

- Using data from the California Health Interview Survey, CHBRP estimates that 2% of uninsured women are currently pregnant.[22] Of these, a smaller proportion would become newly eligible to purchase individual-level insurance, as pregnant people with household income up to 322% of the FPL are eligible to enroll in Medi-Cal at baseline (see *Policy Context* section).
- Among pregnant people, 0.5% are identified as gestational carriers through the applicable ICD-10 code (see Appendix B). There is no ICD-10 code for surrogates, therefore CHBRP was not able to separately analyze that population and assumes they are included in people who are pregnant.
- When estimating the number of uninsured pregnant people that would gain coverage from SB 257, CHBRP used the 2023 California Health Interview Survey data to determine that an estimated 2,000 people in this population had household incomes that would make them eligible for individual-level coverage (see *Policy Context* section). CHBRP assumed that this entire population who is eligible would take up coverage so that estimates determine an upper boundary for the impact of SB 257. CHBRP is aware that take-up is likely to be lower than the full population but is unable to model how much lower.
- For each pregnant person who is eligible for new benefit coverage under SB 257, CHBRP assumed an average of 1.65 dependents per pregnant person (see Appendix B). Populations reported in Tables 1 and 2 reflect this, including pregnant people plus an average of 1.65 dependents per pregnant person. This also applies to gestational carriers, as surrogacy agencies in California commonly require that a surrogate or gestational carrier have a history of successful pregnancies and deliveries and, sometimes, that they be raising a child of their own.
- Pregnant people who would gain insurance from SB 257 postmandate would have similar medical expenses to pregnant people who are insured at baseline.

[22] CHBRP assumed that 2% of the uninsured population in California is pregnant based on author's analysis of a pooled estimate of the 2021-2022-2023 California Health Interview Surveys using www.askchis.ucla.edu, accessed on April 4, 2025.

For further details on the underlying data sources and methods used in this analysis, please see Appendix B.

Baseline and Postmandate Benefit Coverage

As discussed in the *Policy Context* section, SB 257 would apply to state-regulated health insurance for commercial enrollees and enrollees with insurance through the California Public Employees' Retirement System (CalPERS). Medi-Cal beneficiaries enrolled in DMHC-regulated plans are not subject to SB 257, as Medi-Cal eligibility does not include surrogates/gestational carriers and people who are pregnant can already enroll in Medi-Cal at any time if they meet the income eligibility determination. It should be noted that DMHC regulates the plans and policies of approximately 74% of enrollees associated with CalPERS, in addition to commercial enrollees.[23]

CHBRP estimates that at baseline, 11,216,000 Californians (83%) with state-regulated insurance subject to the mandate are enrolled in DMHC-regulated plans or CDI-regulated policies out of compliance with SB 257, and 2,354,000 (17%) are enrolled in plans or policies that are compliant (Figure 1).

While all DMHC-regulated plans and CDI-regulated policies include maternity and prenatal care in their benefit coverage as per federal law (see *Policy Context* section), 17% of enrollees are in plans or policies that do not seek reimbursement for these services from surrogates/gestational carriers, and therefore are fully compliant with SB 257 at baseline.

How does utilization impact premiums?

Health insurance, by design, distributes risk and expenditures across everyone enrolled in a plan or policy. It does so to help protect each enrollee from the full impact of health care costs that arise from that enrollee's use of prevention, diagnosis, and/or treatment of a covered medical condition, disease, or injury. Changes in utilization among any enrollees in a plan or policy can result in changes to premiums for all enrollees in that plan or policy.

Postmandate, 100% of DMHC-regulated plans and CDI-regulated policies subject to SB 257 would be compliant with SB 257.

Below, Table 1 provides estimates of how many Californians have health insurance that would have to comply with SB 257 in terms of benefit coverage. Since SB 257 would enable pregnant people who are uninsured at baseline to enroll in new coverage for themselves and their dependents, CHBRP estimates an increase in the number of people enrolled in health insurance postmandate (Table 1 and Table 2).

[23] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Table 1. Impacts of SB 257 on Benefit Coverage, 2026

	Baseline	Postmandate	Increase/ Decrease	Percentage Change
Total enrollees with health insurance subject to state benefit mandates (a)	22,207,000	22,212,303	5,303	0.02%
Total enrollees with health insurance subject to SB 257	13,570,000	13,575,303	5,303	0.04%
Percent of enrollees with fully compliant coverage under SB 257 (% of total)	17%	100%	83%	476.36%
Number of enrollees with fully compliant coverage for mandated benefit	2,354,429	13,575,303	11,220,873	476.59%

Source: California Health Benefits Review Program, 2025.
Notes: (a) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[24]
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; DMHC = Department of Managed Health Care.

Baseline and Postmandate Utilization and Unit Cost

Utilization of maternity and prenatal services relevant to SB 257 includes pregnant people who are enrolled in health insurance in the individual market DMHC-regulated plans or CDI-regulated policies, surrogates/gestational carriers enrolled in DMHC-regulated plans or CDI-regulated policies in every market segment, and people currently uninsured (Table 2). CHBRP estimates that 111,692 pregnant people are currently enrolled in individual-level plans or policies. Additionally, there are 136,980 uninsured pregnant people at baseline in California.

Postmandate, CHBRP estimates that 6,368 people (5,303 previously uninsured pregnant people and their dependents, and 1,065 insured gestational carriers and their dependents) will gain full coverage for all maternity and labor/delivery services, with no requirement to reimburse their carriers (Table 2).[25] Those who were previously uninsured would gain coverage for all health services covered by their plan, in addition to maternity and labor/delivery services. While some enrollees who are pregnant may choose to switch to a different tier of coverage within the individual market, CHBRP's Cost and Coverage Model is unable to estimate that population.

Average annual costs of all health care[26] for pregnant enrollees are also shown in Table 2. At baseline, the total average cost for pregnant enrollees is $21,700, divided between the insurance carrier ($16,217) and the enrollee share of cost ($5,483). Annual average costs per dependent in the individual market are also shown, as SB 257 would allow for dependents to become qualified for enrollment during pregnancy as well ($5,545 for insurance carriers, and $1,875 for enrollee share of cost). Postmandate, these average costs are expected to remain the same.

The major shift in costs would be from the new maternity and prenatal services coverage for surrogates/gestational carriers under SB 257. At baseline, enrollees with DMHC-regulated plans or CDI-regulated policies that are not compliant with SB 257 and who are gestational carriers bear the entire average cost ($20,000) of health services as shown in medical claims data.[27] Note that these estimates of costs are for all health care, not just maternity services, and that gestational carriers use, on average, slightly fewer services than pregnant people overall, and therefore have slightly

[24] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.
[25] Populations are estimated based on not being eligible for Medi-Cal coverage, which covers roughly 40% of all births in California due to increased eligibility levels for pregnant people.
[26] All health costs are included because pregnant people gain full insurance coverage, not just coverage for maternity and prenatal services.
[27] Note that these are the insurance claims paid and do not include any contracted fee or payment between the gestational carrier and the intended parents. That is outside the scope of CHBRP's analysis.

lower average costs. Postmandate, the insurance carrier would be required to pay for an average $17,230 of those costs, and the enrollee would pay an average share of cost of $2,770.

Below, Table 2 provides estimates of the impacts of SB 257 on utilization and unit cost of maternity and prenatal services.

Table 2. Impacts of SB 257 on Utilization and Unit Cost, 2026

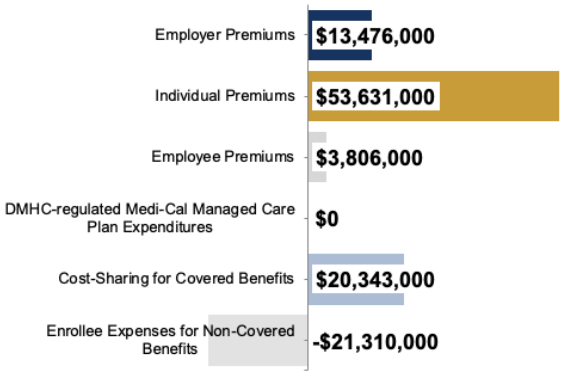
	Baseline	Postmandate	Increase/Decrease	Percentage Change
Number of pregnant people & dependents				
Insured in individual market	111,692	116,995	5,303	4.75%
Purchase insurance with lower enrollee cost sharing		-		
Stay in same health plan		111,692		
Uninsured who become insured postmandate		5,303		
Insured gestational carriers	1,065	1,065 (a)	0	0%
Uninsured both at baseline and postmandate	136,980	131,678	-5,303	-3.87%
Insurer cost				
Average annual cost per insured pregnant person	$16,217	$16,217	0	0%
Average annual cost per insured dependent	$5,545	$5,545	0	0%
Average annual cost of maternity services only (gestational carriers)	$0	$17,230	$17,230	100%
Enrollee share of cost				
Average annual cost per insured pregnant person	$5,483	$5,558	$75	1.36%
Average annual cost per insured dependent	$1,875	$1,875	$0	0%
Average annual cost of maternity services only (gestational carriers)	$20,000	$2,770	-$17,230	-86.15%

Source: California Health Benefits Review Program, 2025.
Note: (a) Increase in the number of insured gestational carriers due to increased benefit coverage is likely to be <10 and cannot be modeled, due to the other requirements for entering into a surrogacy arrangement. Pregnant people uninsured at baseline are not likely to meet those requirements and therefore are assumed to not be gestational carriers.

Baseline and Postmandate Expenditures

For DMHC-regulated plans and CDI-regulated policies, SB 257 would increase annual net expenditures by $69,946,000 (0.04%). SB 257 would increase total premiums paid by employers and enrollees for newly covered benefits by $70,912,000. Enrollee expenses for covered benefits would increase, but expenses for noncovered benefits would decrease. The premium increases are largely due to an additional estimated 5,303 uninsured pregnant people and their dependents who would become insured postmandate under SB 257. This would result in an increase of total net annual expenditures for enrollees with DMHC-regulated plans and CDI-regulated policies (Figure 8).

Figure 8. Expenditure Impacts of SB 257



Source: California Health Benefits Review Program, 2025.
Key: DMHC = Department of Managed Health Care.

Below, Table 3 provides estimates of the impacts of SB 257 on expenditures, which include premiums, enrollee cost sharing, and enrollee expenses for noncovered benefits. Postmandate expenditures include the new expenses for benefit coverage for people who were uninsured at baseline.

Table 3. Impacts of SB 257 on Expenditures, 2026

	Baseline	Postmandate	Increase/Decrease	Percentage Change
Premiums				
Employer-sponsored (a)	$68,752,638,000	$68,764,964,000	$12,326,000	0.02%
CalPERS employer (b)	$7,881,873,000	$7,883,023,000	$1,150,000	0.01%
Medi-Cal (excludes COHS) (c)	$31,818,731,000	$31,818,731,000	$0	0.00%
Enrollee premiums (expenditures)				
Enrollees, individually purchased insurance	$21,757,790,000	$21,811,421,000	$53,631,000	0.25%
Outside Covered California	$6,011,399,000	$6,024,740,000	$13,341,000	0.22%
Through Covered California	$15,746,391,000	$15,786,681,000	$40,290,000	0.26%
Enrollees, group insurance (d)	$21,712,866,000	$21,716,672,000	$3,806,000	0.02%
Enrollee out-of-pocket expenses				
Cost-sharing for covered benefits (deductibles, copayments, etc.)	$18,992,422,000	$19,012,765,000	$20,343,000	0.11%
Expenses for noncovered benefits (e) (f)	$21,310,000	$0	-$21,310,000	-100.00%
Total expenditures	$170,937,630,000	$171,007,576,000	$69,946,000	0.04%

Source: California Health Benefits Review Program, 2025.
Notes: (a) In some cases, a union or other organization. Excludes CalPERS.
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 54.0% are state retirees, state employees, or their dependents. About one in five (20.5%) of these enrollees has a pharmacy benefit not subject to DMHC. CHBRP has projected no impact for those enrollees. However, CalPERS could, postmandate, require equivalent coverage for all its members (which could increase the total impact on CalPERS).

(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. In addition, CHBRP is estimating it seems likely that there would also be a proportional increase of $0 million for Medi-Cal beneficiaries enrolled in COHS managed care.
(d) Enrollee premium expenditures include contributions by enrollees to health insurance sponsored by employer (or union or other organization), health insurance purchased through Covered California, and any contributions to enrollment through Medi-Cal to a DMHC-regulated plan.
(e) Includes only expenses paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered postmandate. Other components of expenditures in this table include all health care services covered by insurance.
(f) For covered benefits, such expenses would be eliminated, although enrollees with newly compliant benefit coverage might pay some expenses if benefit coverage is denied (through utilization management review).
Key: CalPERS = California Public Employees' Retirement System; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care

Premiums

At the end of this section, Table 5 and Table 6 present baseline and postmandate expenditures by market segment for DMHC-regulated plans and CDI-regulated policies. The tables present per member per month (PMPM) premiums, enrollee expenses for both covered and noncovered benefits, and total expenditures (premiums as well as enrollee expenses).

Changes in premiums as a result of SB 257 would vary by market segment. Note that such changes are related to the number of enrollees (see Table 3, Table 5, and Table 6), with health insurance that would be subject to SB 257. Total premiums are expected to increase by $70,912,000.

Commercial

Among DMHC-regulated commercial plans, premium increases range from $0.1183 PMPM for small-group plans to $2.0421 PMPM for individual-level plans. Among CDI-regulated commercial policies, premium increases range from $0.1137 PMPM for small-group policies to $0.1278 PMPM for individual-level policies.

CalPERS

For enrollees associated with CalPERS in DMHC-regulated plans, premiums are expected to increase by $0.1252 PMPM postmandate.

Medi-Cal

For Medi-Cal beneficiaries enrolled in DMHC-regulated plans, there is no estimated impact of SB 257 because SB 257 does not affect the coverage of Medi-Cal beneficiaries enrolled in DMHC-regulated plans.

Enrollee Expenses

SB 257–related changes in cost sharing for covered benefits (deductibles, copays, etc.) and out-of-pocket expenses for noncovered benefits would vary by market segment. Note that such changes are related to the number of enrollees (see Table 3, Table 5, and Table 6) with health insurance that would be subject to SB 257 expected to use maternity services due to becoming qualified during the year after enactment.

CHBRP projects no change to copayments or coinsurance rates but does project an increase in utilization of covered maternity and prenatal care among newly enrolled gestational carriers. CHBRP assumes that gestational carriers and pregnant people who were uninsured at baseline obtain maternity health care services that they cover out of pocket.

Postmandate, enrollee expenditures for noncovered benefits would decrease by $0.1309 PMPM for most market segments, while cost sharing for covered benefits would increase by a range of $0.0119 PMPM for enrollees in DMHC-regulated large-group plans to $0.6959 PMPM for enrollees in DMHC-regulated individual plans (Table 6).

Average enrollee out-of-pocket expenses per user

For enrollees for whom postmandate benefit coverage would be new, 6,368 enrollees would experience an average decrease in out-of-pocket expenses for noncovered benefits ranging from $14,946 for enrollees in individual plans to

$18,154 for enrollees in large group plans. CHBRP estimates are based on claims data and may underestimate the cost savings for enrollees due to plans and insurers negotiating discounted rates that are unavailable to patients and their families.

Table 4. Impact of SB 257 on Average Annual Enrollee Out-of-Pocket Expenses Per User

	Large Group	Small Group	Individual	CalPERS	Medi-Cal (b)
Enrollees with baseline benefit coverage					
% of enrollees with out-of-pocket expenses impact due to SB 257 (a)	0.008%	0.008%	0.008%	0.008%	0.000%
Avg. annual out-of-pocket expenses impact for enrollees	($18,154)	($15,854)	($14,946)	($17,600)	$0.00

Source: California Health Benefits Review Program, 2025.
Notes: Average enrollee out-of-pocket expenses include expenses for both covered and noncovered benefits.
(a) Not including impacts on premiums.
(b) Benefit coverage for Medi-Cal beneficiaries does not generally include any cost sharing.
Key: CalPERS = California Public Employees' Retirement System.

The presence of a deductible not yet met for the year[28] could result in the enrollee paying the full unit cost, but hitting the annual out-of-pocket maximum[29] would result in the enrollee having no further cost sharing.

Postmandate Administrative and Other Expenses

CHBRP estimates that the increase in administrative costs of DMHC-regulated plans and/or CDI-regulated policies will remain proportional to the increase in premiums. CHBRP assumes that if health care costs increase as a result of increased utilization or changes in unit costs, there is a corresponding proportional increase in administrative costs. CHBRP assumes that the administrative cost portion of premiums is unchanged. All health plans and insurers include a component for administration and profit in their premiums.

Other Considerations for Policymakers

In addition to the impacts a bill may have on benefit coverage, utilization, and cost, related considerations for policymakers are discussed below.

Postmandate Changes in the Number of Uninsured Persons

Because the change in average premiums does not exceed 1% for any market segment (see Table 3, Table 5, and Table 6), CHBRP would expect no measurable change in the number of uninsured persons due to the enactment of SB 257.

Changes in Public Program Enrollment

CHBRP estimates that the mandate would produce no measurable impact on enrollment in publicly funded insurance programs due to the enactment of SB 257.

[28] For estimates of enrollees in plans and policies with deductibles, see CHBRP's resource *Deductibles in State-Regulated Health Insurance*.
[29] For most enrollees in most plans and policies regulated by DMHC or CDI, applicable copays and coinsurance is limited to $250, or $500 for enrollees in the "bronze plans" available from Covered California, the state's ACA marketplace (HSC 1342.73; INS 10123.1932). Cost sharing could be higher for an enrollee in a plan or policy that includes a deductible.

How Lack of Benefit Coverage Results in Cost Shifts to Other Payers

CHBRP is aware that surrogates and gestational carriers may have their maternity and prenatal care covered through other means, including potentially through a short-duration insurance plan, a policy purchased by intended parents, or cash payments from the intended parents (see *Introduction* section). Public programs that provide reproductive health services do not provide coverage for care to surrogates or gestational carriers. However, CHBRP is unable to quantify the potential impact of surrogates or gestational carriers who are using other coverage, and modeled the more likely outcome of getting services through noncovered benefits.

Table 5. Baseline Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	DMHC-Regulated						CDI-Regulated			
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	Total
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,034,000	2,076,000	2,181,000	914,000	7,787,000	850,000	264,000	65,000	36,000	22,207,000
Total enrollees in plans/policies subject to SB 257	8,034,000	2,076,000	2,181,000	914,000	0	0	264,000	65,000	36,000	13,570,000
Premiums										
Average portion of premium paid by employer (e)	$557.33	$507.76	$0.00	$718.62	$276.79	$583.72	$609.11	$567.83	$0.00	$108,453,242,000
Average portion of premium paid by enrollee	$145.58	$212.63	$818.51	$139.09	$0.00	$0.00	$224.25	$185.49	$777.47	$43,470,656,000
Total premium	**$702.91**	**$720.39**	**$818.51**	**$857.71**	**$276.79**	**$583.72**	**$833.35**	**$753.32**	**$777.47**	**$151,923,898,000**
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$64.42	$164.36	$272.54	$81.59	$0.00	$0.00	$122.99	$249.30	$173.93	$18,992,422,000
Expenses for noncovered benefits (f)	$0.13	$0.13	$0.13	$0.13	$0.00	$0.00	$0.13	$0.13	$0.13	$21,310,000
Total expenditures	**$767.46**	**$884.88**	**$1,091.18**	**$939.43**	**$276.79**	**$583.72**	**$956.47**	**$1,002.76**	**$951.53**	**$170,937,630,000**

Source: California Health Benefits Review Program, 2025.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents.
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[30]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

[30] For more detail, see CHBRP's resource *Sources of Health Insurance in California.*

Table 6. Postmandate Change in Per Member Per Month Premiums and Total Expenditures by Market Segment, California, 2026

	DMHC-Regulated						CDI-Regulated			Total
	Commercial Plans (by Market) (a)			Publicly Funded Plans			Commercial Policies (by Market) (a)			
	Large Group	*Small Group*	*Individual*	*CalPERS (b)*	*Medi-Cal (Excludes COHS) (c)*		*Large Group*	*Small Group*	*Individual*	
					Under 65	*65+*				
Enrollee counts										
Total enrollees in plans/policies subject to state mandates (d)	8,034,000	2,076,000	2,186,303	914,000	7,787,000	850,000	264,000	65,000	36,000	22,212,303
Total enrollees in plans/policies subject to SB 257	8,034,000	2,076,000	2,186,303	914,000	0	0	264,000	65,000	36,000	13,57,303
Premiums										
Average portion of premium paid by employer (e)	$0.1026	$0.0834	$0.0000	$0.01049	$0.0000	$0.0000	$0.0930	$0.0857	$0.0000	$13,476,000
Average portion of premium paid by enrollee	$0.0268	$0.0349	$2.0421	$0.0203	$0.0000	$0.0000	$0.0343	$0.0280	$0.1278	$57,436,000
Total premium	$0.1294	$0.1183	$2.0421	$0.1252	$0.0000	$0.0000	$0.1273	$0.1137	$0.1278	$70,912,000
Enrollee expenses										
Cost sharing for covered benefits (deductibles, copays, etc.)	$0.0119	$0.0268	$0.6959	$0.0157	$0.0000	$0.0000	$0.0188	$0.0376	$0.0286	$20,342,000
Expenses for noncovered benefits (f)	-$0.1309	-$0.1309	-$0.1305	-$0.1309	$0.0000	$0.0000	-$0.1309	-$0.1309	-$0.1309	-$21,310,000
Total expenditures	$0.0103	$0.0142	$2.6075	$0.0100	$0.0000	$0.0000	$0.0153	$0.0205	$0.0256	**$69,946,000**
Percent change										
Premiums	0.0184%	0.0164%	0.2495%	0.0146%	0.0000%	0.0000%	0.0153%	0.0151%	0.0164%	0.0467%
Total expenditures	0.0013%	0.0016%	0.2390%	0.0011%	0.0000%	0.0000%	0.0016%	0.0020%	0.0027%	0.0409%

Source: California Health Benefits Review Program, 2025.
Notes: (a) Includes enrollees with grandfathered and nongrandfathered health insurance acquired outside or through Covered California (the state's health insurance marketplace).
(b) Includes only CalPERS enrollees in DMHC-regulated plans. Approximately 51.6% are state retirees, state employees, or their dependents.
(c) Includes only Medi-Cal beneficiaries enrolled in DMHC-regulated plans. Includes those who are also Medicare beneficiaries.
(d) Enrollees in plans and policies regulated by DMHC or CDI. Includes those associated with Covered California, CalPERS, or Medi-Cal.[31]
(e) In some cases, a union or other organization, or Medi-Cal for its beneficiaries.
(f) Includes only those expenses that are paid directly by enrollees (or other sources) to providers for services related to the mandated benefit that are not covered by insurance at baseline. This only includes those expenses that would be newly covered, postmandate. Other components of expenditures in this table include all health care services covered by insurance.
Key: CalPERS = California Public Employees' Retirement System; CDI = California Department of Insurance; COHS = County Organized Health Systems; DMHC = Department of Managed Health Care.

Back to Table of Contents

[31] For more detail, see CHBRP's resource *Sources of Health Insurance in California*.

Public Health Impacts

As discussed in the *Policy Context* section, SB 257 would make pregnancy a qualifying event for special enrollment for health insurance on the individual market, and would make several requirements of health plans and policies for coverage of maternity and newborn/pediatric care services for all pregnant people, regardless of the circumstances of conception (i.e., for surrogates and gestational carriers). The special enrollment period would be extended to the pregnant person's dependents and people to whom the pregnant person is a dependent. Additional information regarding maternity services and gestational carriers is included in the *Background* section.

The public health impact analysis includes estimated impacts in the short term (within 12 months of implementation) and in the long term (beyond the first 12 months postmandate). This section estimates the short-term impact[32] and long-term impacts of SB 257 on maternity services, potential disparities, and financial burden.

Estimated Public Health Outcomes

As presented in the *Medical Effectiveness* section, there is *some evidence* that pregnant people with continuous private health insurance coverage are more likely to initiate prenatal care during the first trimester, receive adequate prenatal care, and to have a postpartum visit. However, evidence is *conflicting* regarding the impact of continuous Medicaid coverage versus pregnancy-only Medicaid coverage or remaining uninsured.

There is *some evidence* that special enrollment periods for pregnant people are associated with increased take up of health insurance among pregnant people, but *not enough research* has been conducted to determine whether special enrollment periods for pregnant people improves utilization of maternity services or maternal and infant health outcomes. Similarly, *not enough research* has been conducted to assess the effectiveness of presumptive eligibility for health insurance for pregnant people and to assess the impact of health insurance coverage generosity on utilization of healthcare services.

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, CHBRP estimates that 6,368 people (including 5,303 previously uninsured pregnant people and their dependents and 1,065 insured gestational carriers and their dependents) will gain full coverage for all maternity and labor/delivery services, with no requirement to reimburse their carrier. Those who were previously uninsured would gain coverage for all health services covered by their plan, in addition to maternity and labor/delivery services. While some enrollees who are pregnant may choose to switch to a different tier of coverage within the individual market, the *Benefit Coverage, Utilization, and Cost Impacts* section notes that it is unable to estimate this population.

Considering the findings noted above, CHBRP concludes that the impact of SB 257 on short-term or long-term public health outcomes is unknown. Although there is *strong evidence* that maternity services improve outcomes for infants and mothers, *not enough research* has been conducted to determine whether special enrollment periods or presumptive eligibility for health insurance for pregnant people improve utilization of maternity services.

In the first year postmandate, the public health impact of SB 257 is unknown as *not enough research* has been conducted to determine whether special enrollment periods or presumptive eligibility for pregnant people improves utilization of maternity care services. Please note that the absence of evidence is not evidence of no effect.

[32] CHBRP defines short-term impacts as changes occurring within 12 months of bill implementation.

Impact on Disparities[33]

As described in the *Background* section, disparities in the receipt of early and adequate prenatal care exist by age, race/ethnicity, and socioeconomic status.

The impact of SB 257 on reducing documented disparities (see the *Background* section) is unknown because data are unavailable to estimate changes in the utilization of early and adequate prenatal care among newly covered enrollees.

Financial Burden

As presented in the *Benefit Coverage, Utilization, and Cost Impacts* section, the major shift in costs attributed to SB 257 would be from the new maternity and prenatal services covered for surrogates/gestational carriers. Postmandate, the insurance carrier would be required to pay for an average of $17,230 for maternity and prenatal care services and the surrogate/gestational carrier enrollee would pay an average $2,770 (versus bearing the entire average cost of $20,000 premandate); however, it is likely that the intended parents would cover those costs.

Back to Table of Contents

[33] For details about CHBRP's methodological approach to analyzing disparities, see the *Benefit Mandate Structure and Unequal Racial/Ethnic Health Impacts* document.

Long-Term Impacts

In this section, CHBRP estimates the long-term impact of SB 257, which CHBRP defines as impacts occurring beyond the first 12 months postmandate. These estimates are qualitative and based on the existing evidence available in the literature. CHBRP does not provide quantitative estimates of long-term impacts because of unknown improvements in clinical care, changes in prices, implementation of other complementary or conflicting policies, and other unexpected factors.

Long-Term Utilization and Cost Impacts

Utilization Impacts

Past the first year postmandate, SB 257 would continue to have similar utilization impacts. There is the potential for an increase in access to surrogacy or gestational carrier services, but the extent to which insurance carriers seeking reimbursement dampened the supply of this service is unknown.

Cost Impacts

Over the long term, SB 257 may have small impacts on cost savings due to better prenatal care leading to improved health outcomes for both the pregnant person and the child. Increases in costs over time are expected to be in line with what is estimated for Year 1.

Back to Table of Contents

Appendix A. Text of Bill Analyzed

On February 19, 2025, the California Senate Committee on Health requested that CHBRP analyze SB 257, as introduced on February 3, 2025.

Back to Table of Contents

CALIFORNIA LEGISLATURE— 2025–2026 REGULAR SESSION

SENATE BILL

NO. 257

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

February 03, 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.

DIGEST KEY

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

---

BILL TEXT

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.

~~(J)~~

(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.

~~(J)~~

(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.

Back to Table of Contents

Appendix B. Cost Impact Analysis: Data Sources, Caveats, and Assumptions

With the assistance of CHBRP's contracted actuarial firm, Milliman, Inc., the cost analysis presented in this report was prepared by the faculty and researchers connected to CHBRP's Task Force with expertise in health economics.[34] Information on the generally used data sources and estimation methods, as well as caveats and assumptions generally applicable to CHBRP's cost impacts analyses, are available on CHBRP's website.[35]

This appendix describes analysis-specific data sources, estimation methods, caveats, and assumptions used in preparing this cost impact analysis.

Analysis-Specific Data Sources

Baseline coverage of maternity services for gestational carriers for commercial enrollees was determined by a survey of the largest (by enrollment) providers of health insurance in California. Responses to this survey represented approximately 35% of the CDI-regulated market and 88% of the DMHC-regulated market. Combined, responses to this survey represented 86% of commercial enrollees with health insurance that can be subject to state benefit mandates. In addition, CalPERS plans were queried regarding related benefit coverage. As necessary, CHBRP extrapolated from responses of similarly situated plans/policies.

For this analysis, CHBRP relied on Current Procedural Terminology (CPT®) codes to identify relevant services: CPT copyright 2025 American Medical Association (AMA). All rights reserved.[36]

Health Cost Guidelines

The health cost guidelines (HCGs) are a health care pricing tool used by actuaries in many of the major health plans in the United States. The guidelines provide a flexible but consistent basis for estimating health care costs for a wide variety of commercial health insurance plans. It is likely that these organizations use the HCGs, among other tools, to determine the initial premium impact of any new mandate. Thus, in addition to producing accurate estimates of the costs of a mandate, we believe the HCG-based values are also good estimates of the premium impact as estimated by the HMOs and insurance companies.

The highlights of the commercial HCGs include:

- Specific major medical, managed care, and prescription drug rating sections and guidance with step-by-step rating instructions.
- Other helpful analysis resources, such as inpatient length of stay distribution tables, Medicare Severity-Adjusted Diagnosis Related Group (MS-DRG) models, and supplementary sections addressing EHBs and mandated benefits, experience rating, and individual and small group rating considerations.
- Presentation of loosely and well-managed nationwide utilization and cost information by Milliman benefit-aligned service categories used throughout the Rating Structures – inpatient hospital services for both loosely and well-managed are also supported by DRG level utilization and cost benchmarks.

[34] CHBRP's authorizing statute requires that CHBRP use a certified actuary or "other person with relevant knowledge and expertise" to determine financial impact.
[35] See CHBRP's Cost Impact Analysis landing page; in particular, see *Cost Impact Analyses: Data Sources, Caveats, and Assumptions*.
[36] Fee schedules, relative value units, conversion factors, and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein. CPT is a registered trademark of the AMA.

- Annual updates address emerging regulatory considerations such as health care reform and mental health parity requirements.
- Annually updated benefit descriptions used in the HCG service categories.
- Annually updated medical trend assumptions and considerations.
- Presentation of two sets of nationwide area factors to facilitate development of area-specific claim costs, including separate utilization and charge level factors by type of benefit, state and Metropolitan Statistical Area for first-dollar coverage, and composite factors by deductible amount.
- Claim Probability Distributions (CPDs) by type of coverage that contain distributions of claim severity patterns for unique combinations of benefits and member types (adult, child, composite member).
- The Prescription Drug Rating Model (RXRM), an automated rating tool that provides a detailed analysis of prescription drug costs and benefits.

Consolidated Health Cost Guidelines Sources Database

Milliman maintains benchmarking and analytic databases that include health care claims data for nearly 60 million commercial lives and over 3 million lives of Medicaid managed care data. This dataset is routinely used to evaluate program impacts on cost and other outcomes.

Detailed Cost Notes Regarding Analysis-Specific Caveats and Assumptions

The analytic approach and key assumptions are determined by the subject matter and language of the bill being analyzed. As a result, analytic approaches may differ between topically similar analyses, and therefore the approach and findings may not be directly comparable. The analysis of SB 257 was developed using total medical and pharmacy costs and pregnancy-related costs for pregnant individuals.

Methodology and Assumptions for Baseline Benefit Coverage

- The population subject to the mandated offering includes individuals covered by DMHC-regulated commercial insurance plans, CDI-regulated policies, and CalPERS plans subject to the requirements of the Knox-Keene Health Care Service Plan Act.
- CHBRP surveyed the carriers to determine the percentage of the population with coverage for maternity services for gestational carriers where gestational carriers are not requested to reimburse the carrier at a later date.

Methodology and Assumptions for Baseline Population

- CHBRP identified a sample of pregnant individuals and their dependents using Milliman's proprietary 2023 Consolidated Health Cost Guidelines™ Sources Database (CHSD).
  - Pregnant individuals were identified in the claims data using ICD-10 codes that either indicated a preventive pregnancy visit or that started with "O", for female enrollees aged 18 or older. Based on this sample, CHBRP estimated that 1.9% of the insured commercial population is pregnant at some point during a year.
  - CHBRP identified spouses and dependents of pregnant people using the eligibility data in CHSD. On average, CHBRP estimates that 1.65 other people are enrolled on health insurance contracts with a pregnant enrollee during the year.
  - Gestational carriers were identified as a subset of pregnant individuals, who also had the ICD-10 diagnosis "Z33.3" in the claims data at least once throughout the year. Based on a sample from CHSD, CHBRP estimates that gestational carriers represent 0.5% of all pregnant individuals covered by commercial insurers.
  - CHBRP assumed that 2% of the uninsured population in California is pregnant based on author's analysis of a pooled estimate of the 2021-2022-2023 California Health Interview Surveys (CHIS), accessed online on April 4, 2025.

Methodology and Assumptions for Baseline Cost

- CHBRP calculated the total annual cost for medical and pharmacy benefits for the pregnant individuals, their spouses, and their dependents at baseline using Milliman CHSD.
- Pregnancy-related costs for gestational carriers were calculated as the total annual costs after an individual's first pregnancy-related diagnosis during the calendar year.
- The costs per person for all individuals were trended from 2023 to 2026 using a 6.20% annual trend, based on the 2024 Milliman Health Cost Guidelines.

Methodology and Assumptions for Baseline Cost Sharing

- CHBRP assumed the cost sharing for pregnant enrollees and their dependents is the same as major medical cost sharing. Enrollee cost share is equal to one minus the paid-to-allowed ratio by line of business multiplied by the enrollee's total annual cost.
- Services provided to enrollees without coverage are assumed to be paid by the enrollee in full.

Methodology and Assumptions for Postmandate Cost

- CHBRP assumed the cost per enrollee would not change as a result of SB 257.

Methodology and Assumptions for Postmandate Cost Sharing

- CHBRP assumed the cost sharing per covered enrollee would not change as a result of SB 257.

Methodology and Assumptions Related to Uninsured Individuals

- CHBRP assumed that 2,000 pregnant people — and 3,303 of their dependents — would join the individual market as a result of SB 257. This is based on CHBRP's review data from CHIS reporting the number of pregnant people above 322% of the federal poverty limit.

Determining Public Demand for the Proposed Mandate

CHBRP reviews public demand for benefits by comparing the benefits provided by self-insured health plans or policies (which are not regulated by DMHC or CDI and therefore not subject to state-level mandates) with the benefits that are provided by plans or policies that would be subject to the mandate.

Among publicly funded self-insured health insurance policies, the preferred provider organization (PPO) plans offered by CalPERS have the largest number of enrollees. The CalPERS PPOs currently provide benefit coverage similar to what is available through group health insurance plans and policies that would be subject to the mandate.

To further investigate public demand, CHBRP used the bill-specific coverage survey to ask plans and insurers who act as third-party administrators for (non-CalPERS) self-insured group health insurance programs whether the relevant benefit coverage differed from what is offered in group market plans or policies that would be subject to the mandate. The responses indicated that there were no substantive differences.

Second-Year Impacts on Benefit Coverage, Utilization, and Cost

CHBRP has considered whether continued implementation during the second year of the benefit coverage requirements of SB 257 would have a substantially different impact on utilization of either the tests, treatments, or services for which coverage was directly addressed, the utilization of any indirectly affected utilization, or both. CHBRP reviewed the literature and consulted content experts about the possibility of varied second-year impacts and determined the second year's impacts of SB 257 would be substantially the same as the impacts in the first year (see Table 3, Table 5, and Table

6). Minor changes to utilization and expenditures are due to population changes between the first year postmandate and the second year postmandate.

Back to Table of Contents

References

American College of Obstetricians and Gynecologists (ACOG). ACOG Committee Opinion No. 736: Optimizing Postpartum Care. *Obstetrics & Gynecology.* 2018;131(5):e140-e150.

American Hospital Association (AHA) Coding Clinic. Guidance on coding Z33.3. 2016, Fourth Quarter, pages 76-79.

American Surrogacy. *Surrogacy Insurance For Intended Parents*. Available at: https://www.americansurrogacy.com/parents/surrogacy-insurance-intended-parents. Accessed on March 15, 2025.

Booman A, Stratton K, Vesco KK, et al. Insurance coverage and discontinuity during pregnancy: Frequency and Associations Documented in the Promise Cohort. *Health Services Research*. 2024;59(2):e14265.

California Health Benefits Review Program (CHBRP). *Abbreviated Analysis: California Senate Bill 729: Treatment for Infertility and Fertility Services.* Report to California State Legislature. Berkeley, CA: CHBRP; 2023.

California Health Benefits Review Program (CHBRP). *Analysis of Assembly Bill 185: Maternity Services.* Report to California State Legislature. Oakland, CA: CHBRP; 2011.

Centers for Disease Control and Prevention (CDC) Assisted Reproductive Technology (ART) Surveillance System. ART Data for Reporting Year 2022 (National Data). 2022. Available at: https://art.cdc.gov/#/. Accessed March 12, 2025.

Centers for Medicare & Medicaid Services (CMS). California EHB Benchmark Plan. Available at: https://www.cms.gov/cciio/resources/data-resources/downloads/updated-california-benchmark-summary.pdf. Accessed March 12, 2025.

DeSisto CL, Rohan A, Handler, Awadalla SS, Johnson T, Rankin K. The Effect of Continuous Versus Pregnancy-Only Medicaid Eligibility on Routine Postpartum Care in Wisconsin, 2011–2015. *Maternal and Child Health Journal.* 2020;24(9):1138–1150.

Eliason EL, Daw JR. Presumptive Eligibility for Pregnancy Medicaid and Timely Access to Prenatal Care. *Health Services Research*. 2022;57(6):1288–1294.

Eliason EL, Steenland MW. Association of New York State's Marketplace Special Enrollment Period for Pregnancy With Prenatal Insurance Coverage. *JAMA Health Forum.* 2023;4(1):e224907.

Fuchs EL, Berenson AB. Outcomes for Gestational Carriers Versus Traditional Surrogates in the United States. *Journal of Women's Health (Larchmt).* 2018;27(5):640-64H5.

Gordon SH, Alger CL, Declercq ER, Garrido MM. The Association Between Marketplace Coverage During Pregnancy and Receipt of Prenatal Care. *Health Affairs (Millwood)*. 2021(10): 1618–1626.

Kaiser Permanente. Kaiser Permanente for Small Businesses Evidence of Coverage for SAMPLE GROUP AGREEMENT GRP SMALL NONM – PLAN 1637 PLAN 30-N; OPT. 2011. Available at: https://www.insurance.ca.gov/01-consumers/110-health/60-resources/upload/KaiserSmallGroupHMO.pdf. Accessed March 25, 2025.

Kozhimannil KB, Huskamp H. High-Deductible Health Plans and Costs and Utilization of Maternity Care. *American Journal of Managed Care*. 2011;17(1):e17-e25.

Krukowski RA, Jacobson LT, John J, et al. Correlates of Early Prenatal Care Access among U.S. Women: Data from the Pregnancy Risk Assessment Monitoring System (PRAMS). *Maternal and Child Health Journal.* 2022;26(2):328-341.

Masjedi AD, Mandelbaum RS, Erickson KV, et al. National-level assessment of gestational carrier pregnancies in the United States. *Journal of Assisted Reproduction and Genetics.* 2025;42(1):201-211.

Norris L. *Exceptional circumstances for special enrollment.* HealthInsurance.org. 2025. Available at: https://www.healthinsurance.org/special-enrollment-guide/exceptional-circumstances-for-special-enrollment/#pregnancy. Accessed March 12, 2025.

New York State Department of Health. The Child-Parent Security Act: Gestational Surrogacy Agreements, Acknowledgment of Parentage and Orders of Parentage. 2021. Available at: https://www.health.ny.gov/vital_records/child_parent_security_act/. Accessed March 12, 2025.

New York State Department of Health. *The Child-Parent Security Act: Gestational Surrogacy.* 2023. Available at: https://www.health.ny.gov/community/pregnancy/surrogacy/. Accessed March 12, 2025.

Office of Disease Prevention and Health Promotion. (ODPHP). Increase the proportion of pregnant women who receive early and adequate prenatal care — MICH-08. Healthy People 2030. U.S. Department of Health and Human Services; 2025. Available at: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/pregnancy-and-childbirth/increase-proportion-pregnant-women-who-receive-early-and-adequate-prenatal-care-mich-08. Accessed March 17, 2025.

Office on Women's Health (HHS OASH). *Prenatal care and tests.* 2025. Available at: https://womenshealth.gov/pregnancy/youre-pregnant-now-what/prenatal-care-and-tests. Accessed March 17, 2025.

Okechukwu A, Abraham I, Okechukwu C, et al. Extended Medicaid Coverage Will Improve Access but Insufficient to Enhance Postpartum Care Utilization: A Secondary Analysis of 2016-2019 Arizona Medicaid Claims. *Frontiers in Public Health*. 2024;11:1281574.

Pinnacle Surrogacy. Surrogacy in California. Available at: https://www.pinnaclesurrogacy.com/surrogacy-near-me-laws-and-guidelines/california. Accessed March 13, 2025.

Practice Committee of the American Society for Reproductive Medicine (ASRM), Practice Committee of the Society for Assisted Reproductive Technology (SART). Recommendations for practices using gestational carriers: a committee opinion. *Fertility and Sterility.* 2022;118(1):65-74.

Slomian J, Honvo G, Emonts P, Reginster JY, Bruyère O. Consequences of maternal postpartum depression: A systematic review of maternal and infant outcomes. *Womens Health (Lond).* 2019;15:1745506519844044.

Surrogate.com. Surrogacy By State: California Surrogacy Requirements. 2025. Available at: https://surrogate.com/surrogacy-by-state/california-surrogacy/surrogacy-requirements-in-california/. Accessed March 13, 2025.

Testa A, Jackson DB. Barriers to Prenatal Care Among Food-Insufficient Women: Findings from the Pregnancy Risk Assessment Monitoring System. *Journal of Women's Health (Larchmt).* 2021;30(9):1268-1277.

Testa A, Lee J, Semenza DC, Jackson DB, Ganson KT, Nagata JM. Intimate partner violence and barriers to prenatal care. *Social Science & Medicine.* 2023;320:115700.

Weir S, Posner HE, Zhang J, Willis G, Baxter JD, Clark RE. Predictors of Prenatal and Postpartum Care Adequacy in a Medicaid Managed Care Population. *Women's Health Issues*. 2011;21(4):277-285.

Wyatt R, Laderman M, Botwinick L, Mate K, Whittington J. *Achieving Health Equity: A Guide for Health Care Organizations*. IHI White Paper. Cambridge, MA: Institute for Health care Improvement; 2016.

California Health Benefits Review Program Committees and Staff

CHBRP is an independent program administered and housed by the University of California, Berkeley, under the Office of the Vice Chancellor for Research. A group of faculty, researchers, and staff complete the analysis that informs CHBRP reports. The CHBRP **Faculty Task Force** comprises rotating senior faculty from University of California (UC) campuses. In addition to these representatives, there are other ongoing researchers and analysts who are **Task Force Contributors** to CHBRP from UC that conduct much of the analysis. The **CHBRP staff** works with Task Force members in preparing parts of the analysis, and manages external communications, including those with the California Legislature. As required by CHBRP's authorizing legislation, UC contracts with an independent actuarial firm, **Milliman, Inc.**, to assist in assessing the financial impact of each legislative proposal mandating or repealing a health insurance benefit. The **National Advisory Council** provides expert reviews of draft analyses and offers general guidance on the program to CHBRP staff and the Faculty Task Force. Information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications, are available at chbrp.org.

CHBRP Staff

Garen Corbett, MS, Director
Adara Citron, MPH, Associate Director
An-Chi Tsou, PhD, Principal Policy Analyst
Anna Pickrell, MPH Principal Policy Analyst
Karen Shore, PhD, Contractor*
Nisha Kurani, MPP, Contractor*
*Independent Contractor working with CHBRP to support analyses and other projects.

Faculty Task Force

Paul Brown, PhD, University of California, Merced
Timothy T. Brown, PhD, University of California, Berkeley
Shana Charles, PhD, MPP, University of California, Los Angeles, and California State University, Fullerton
Janet Coffman, MA, MPP, PhD, *Vice Chair for Medical Effectiveness,* University of California, San Francisco
Todd Gilmer, PhD, University of California, San Diego
Sylvia Guendelman, PhD, LCSW, University of California, Berkeley
Elizabeth Magnan, MD, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, Davis
Sara McMenamin, PhD, *Vice Chair for Medical Effectiveness and Public Health*, University of California, San Diego
Joy Melnikow, MD, MPH, University of California, Davis
Aimee Moulin, MD, University of California, Davis
Jack Needleman, PhD, University of California, Los Angeles
Mark A. Peterson, PhD, University of California, Los Angeles
Nadereh Pourat, PhD, *Vice Chair for Cost*, University of California, Los Angeles
Dylan Roby, PhD, University of California, Irvine
Marilyn Stebbins, PharmD, University of California, San Francisco
Jonathan Watanabe, PharmD, MS, PhD, University of California, San Francisco

Task Force Contributors

Bethney Bonilla-Herrera, MA, University of California, Davis
Danielle Casteel, MA, University of California, San Diego
Margaret Fix, MPH, University of California, San Francisco
Carlos Gould, PhD, University of California, San Diego
Julia Huerta, BSN, RN, MPH, University of California, Davis
Michelle Keller, PhD, MPH, University of California, Los Angeles, and University of Southern California
Thet Nwe Myo Khin, MPH, University of California, San Diego
Xenia Mendez, MPH, University of California, San Francisco
Jacqueline Miller, University of California, San Francisco
Marykate Miller, MS, University of California, Davis
Katrine Padilla, MPP, University of California, Davis
Kyoko Peterson, MPH, University of California, San Francisco
Amy Quan, MPH, University of California, San Francisco
Dominique Ritley, MPH, University of California, Davis
Riti Shimkhada, PhD, University of California, Los Angeles
Meghan Soulsby Weyrich, MPH, University of California, Davis
Steven Tally, PhD, University of California, San Diego

National Advisory Council

Lauren LeRoy, PhD, Strategic Advisor, L. LeRoy Strategies, *Chair*
Stuart H. Altman, PhD, Professor of National Health Policy, Brandeis University, Waltham, MA
Deborah Chollet, PhD, Senior Fellow, Mathematica Policy Research, Washington, DC
Allen D. Feezor, Former Deputy Secretary for Health Services, North Carolina Department of Health and Human Services, Raleigh, NC
Charles "Chip" Kahn, MPH, President and CEO, Federation of American Hospitals, Washington, DC
Jeffrey Lerner, PhD, President Emeritus, ECRI Institute Headquarters, Plymouth Meeting, PA; Adjunct Senior Fellow, Leonard Davis Institute of Health Economics, University of Pennsylvania
Donald E. Metz, Executive Editor, *Health Affairs,* Washington, DC
Dolores Mitchell, (Retired) Executive Director, Group Insurance Commission, Boston, MA
Marilyn Moon, PhD, (Retired) Senior Fellow, American Institutes for Research, Washington, DC
Rachel Nuzman, MPH, Senior Vice President for Federal and State Health Policy, The Commonwealth Fund, New York, NY
Carolyn Pare, (Retired) President and CEO, Minnesota Health Action Group, Bloomington, MN
Osula Evadne Rushing, MPH, Senior Vice President for Strategic Engagement, KFF, Washington, DC
Ruchika Talwar, MD, MMHC, Assistant Professor Department of Urology and Medical Director Episodes of Care, Population Health, Vanderbilt University Medical Center
Alan Weil, JD, MPP, Senior Vice President for Public Policy, AARP, Washington, DC

Acknowledgments

CHBRP gratefully acknowledges the efforts of the team contributing to this analysis:

Janet Coffman, MA, MPP, PhD, of the University of California, San Francisco, prepared the medical effectiveness analysis. Megan Van Noord, MS, of the University of California, Davis, conducted the literature search. Meghan Soulsby Weyrich, MPH, and Joy Melnikow, MD, MPH, both of the University of California, Davis, prepared the public health impact analysis. Shana Charles, PhD, MPP of the University of California, Los Angeles, prepared the cost impact analysis. Liam Kussman, ASA, MAAA and T.J. Gray, FSA, MAAA, of Milliman provided actuarial analysis. Anna Pickrell, MPH, of CHBRP staff prepared the Policy Context and synthesized the individual sections into a single report. A subcommittee of CHBRP's National Advisory Council (see previous page of this report) and members of the CHBRP Faculty Task Force Sylvia Guendelman, PhD, LCSW, of the University of California, Berkeley Mark A. Peterson, PhD, of the University of California, Los Angeles, and Elizabeth Magnan, MD, PhD, of the University of California, Davis, reviewed the analysis for its accuracy, completeness, clarity, and responsiveness to the Legislature's request.

CHBRP assumes full responsibility for the report and the accuracy of its contents. All CHBRP bill analyses and other publications are available at chbrp.org.

Garen Corbett, MS
Director

Please direct any questions concerning this document to: California Health Benefits Review Program, MC 3116, Berkeley, CA 94720-3116; info@chbrp.org; or chbrp.org.