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

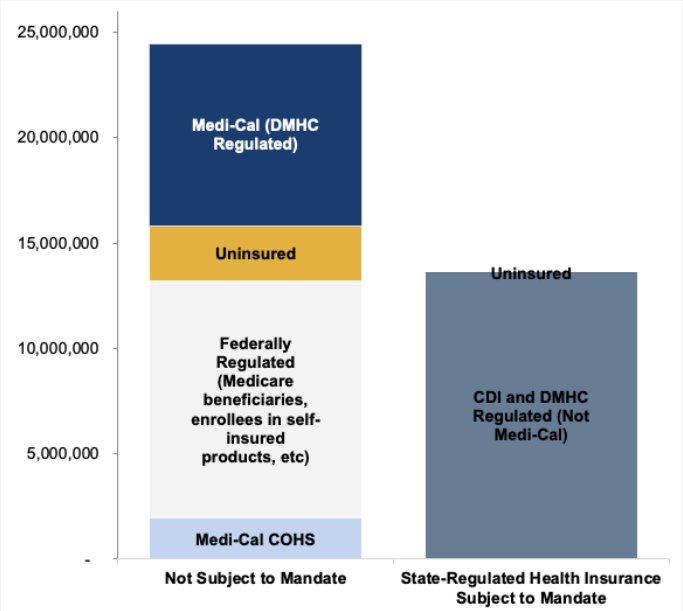
SB 257 would make pregnancy a qualifying event for special enrollment for health insurance on the individual market, regardless of the circumstances of conception (i.e., surrogates and gestational carriers). This special enrollment period would be extended to the pregnant person's dependents and people 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.

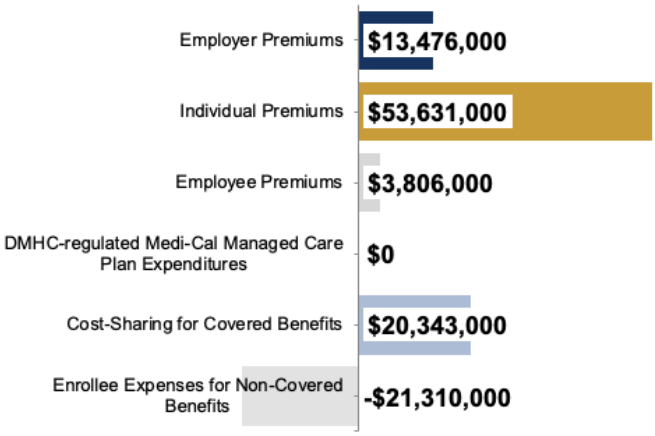
At baseline, enrollees with DMHC-regulated plans or CDI-regulated policies that are not compliant with SB 257 and who are gestational carriers bear the entire average cost ($20,000) of health services.[5] Postmandate, the insurance carrier would be required to pay an average of $17,230 of those costs,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