Date of Hearing: July 15, 2025

ASSEMBLY COMMITTEE ON HEALTH
Mia Bonta, Chair
SB 257 (Wahab) – As Amended July 3, 2025

SENATE VOTE: 39-0

SUBJECT: Pregnancy As a Recognized Event for Nondiscriminatory Treatment (PARENT) Act.

SUMMARY: Prohibits a health plan or health insurance policy that provides coverage for maternity services or newborn and pediatric care services from seeking reimbursement for maternity services or newborn and pediatric care services because the enrollee is acting as a gestational carrier. Requires health plans and health insurers to allow a pregnant individual to enroll in or change individual health benefit plans and policies outside of existing enrollment time periods. Specifically, **this bill**:

1) Prohibits a health plan or health insurance issued, amended, or renewed on or after January 1, 2026, that provides coverage for maternity services or newborn and pediatric care services from seeking reimbursement for maternity services or newborn and pediatric care services because the enrollee is acting as a gestational carrier.

2) Prohibits a plan or health insurer, to comply with the above, from doing either of the following based on the circumstances of conception:

    a) Denying coverage to an enrollee or the enrollee's newborn; and,

    b) Otherwise discriminating against an enrollee, an enrollee's newborn, or an attending health care provider.

3) Defines "maternity services" to 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.

4) Expands the existing law provisions that require health plans and health insurers to allow an individual to enroll in or change individual health benefit plans and policies as a result of a triggering event by including as an additional triggering event when an individual is pregnant (the effect of this provision is to allow a pregnant individual to enroll in individual coverage, or switch their health plan coverage outside of open enrollment).

5) Prohibits enrollment in an individual health plan contract or health insurance policy from being affected by the circumstances of conception, including if the individual is acting as a gestational carrier.

6) Requires coverage to be extended to individuals who are dependents of the pregnant individual and an individual to whom the pregnant individual is a dependent.

EXISTING LAW:

1) Establishes the Department of Managed Health Care (DMHC) to regulate health plans under the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) and the California Department of Insurance (CDI) to regulate health insurers under the Insurance Code. [HSC § 1340, *et seq.* and INS § 106, *et seq.*]

2) Requires a health plan and health insurer to fairly and affirmatively offer, market, and sell all of the plan's health plans that are sold in the individual market to all individuals and dependents in each service area in which the plan provides or arranges for the provision of health care services. [HSC § 1399.849 and INS § 10965.3]

3) Requires a health plan and health insurer to limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods. [*Ibid.*]

4) Requires a health plan and health insurer to 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 (excluding loss of coverage due to the individual's failure to pay premiums on a timely basis, or situations allowing for a rescission of coverage);

    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 plan, for a specified conditions and that provider is no longer participating in the health benefit plan (the conditions include an acute or serious condition, pregnancy including maternal mental health treatment, terminal illness, newborn care, and surgery);

    h) The individual demonstrates to Covered California, with respect to health benefit plans offered through the Covered California, or to the DMHC or CDI with respect to health benefit plans offered outside the Covered California, 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; and,

j) With respect to individual coverage offered through Covered California, any triggering events listed in federal regulations. [HSC § 1399.849 and INS § 10965.3]

5) Prohibits a lien asserted by a licensee of the DMHC or CDI, or a medical group or an independent practice association for the recovery of money paid or payable to or on behalf of an enrollee or insured for health care services provided under a health plan contract or a disability insurance policy from exceeding exceed the sum of the reasonable costs actually paid, as specified. [Civil Code § 3040]

FISCAL EFFECT: According to the Senate Appropriations Committee:

1) Unknown ongoing costs, potentially hundreds of thousands, for DMHC for state administration (Managed Care Fund);

2) CDI estimates costs of $6,000 in 2025-26 and $18,000 in 2026-27 for state administration (Insurance Fund);

3) Department of Health Care Services (DHCS) indicates no fiscal impact to the Medi-Cal program; and,

4) Unknown potential General Fund costs, likely under $1 million, due to increases in CalPERS plan premiums.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, this bill closes an unfair loophole in health insurance coverage for pregnancy. Health insurers are increasingly exploiting surrogate and gestational carrier contracts to demand reimbursement after claims are paid by asserting a right to reimbursement and placing liens on the policyholder. This practice penalizes surrogates and gestational carriers, the people pursuing family building through surrogacy, and the professionals who support them. The author argues this practice deters participation in surrogacy, and when people do participate, it forces intended parents to pay exorbitant out-of-pocket expenses, putting surrogacy further out of reach for average people. Without proper regulation, some insurers even seek reimbursement beyond deductibles or out-of-pocket maximums. This disproportionately impacts people facing infertility, LGBTQ+ individuals, and single parents. This bill also makes pregnancy a qualifying life event for enrollment in health insurance, so every pregnant person can access essential prenatal care. The author concludes this bill bridges gaps to support consistent, equitable maternal health care coverage and healthy pregnancies for all, including gestational carriers and the families they help create.

2) BACKGROUND. This bill has several provisions dealing with pregnancy and liens placed on gestational carriers, as follows:

a) Liens on Surrogacy Arrangements. This bill prohibits a health plan or health insurance policy that provides coverage for maternity services or newborn and pediatric care services from seeking reimbursement for maternity services or newborn and pediatric care services because the enrollee is acting as a gestational carrier. According to California Health Benefits Review Program (CHBRP), the Kaiser Essential Health Benefits (EHB) benchmark plan's Evidence of Coverage states that enrollees who enter

into a surrogacy arrangement must pay for any covered medical services related to conception, pregnancy, or delivery connected to that arrangement. The amount the enrollee must pay cannot exceed the compensation the surrogate or gestational carrier is entitled to receive under the agreement. The Kaiser policy also requires enrollees to notify the plan in writing within 30 days of entering into a surrogacy arrangement. This notice must include a copy of any contracts or documents explaining the arrangement. By using the plan's surrogacy-related health services, the surrogate or gestational carrier automatically assigns to the plan their right to receive any payments due to them (or a designated payee) under the surrogacy agreement, and allows Kaiser to place a lien on those payments to recover its costs.

CHBRP estimates that 83% of the insurance market has such repayment provisions. Sponsors of this bill report that other insurers, including Blue Shield of California, Molina, Western Health Advantage, Sharp Health care, Sutter Health, L.A. Care, and Inland Empire Health Plan, have similar surrogacy policies.

b) Qualifying Life Event. Under California law, a health plan or health insurer is required to limit enrollment in individual health benefit plans to open enrollment periods, annual enrollment periods, and special enrollment periods. A special enrollment period in the individual market is generally limited to individuals who experience a triggering event (also called a qualifying life event or QLE). For Covered California, the current open enrollment period and annual enrollment period span the same time period of November 1st to January 31st. Without a qualifying event, individuals must wait until the next open enrollment period to apply for coverage, or change health coverage. This bill would make a two-fold change. First, it would allow individuals who are pregnant to purchase coverage outside of existing annual open enrollment periods. Second, it would allow pregnant individuals who already have individual insurance coverage to switch coverage.

c) Newborn Coverage. This bill prohibits a plan or health insurer from denying coverage to an enrollee or the enrollee's newborn. This provision is intended to avoid a gap in care for the newborn because the newborn is not the dependent of the gestational carrier under the surrogacy arrangement (the newborn child is a dependent of the intended parents). This bill would require coverage for the infant in the event the intended parents' coverage does not provide services in California beyond emergency care (for example, if the intended parents reside outside of California).

3) MEDI-CAL POLICY. Medi-Cal covers approximately 45% of all in-hospital births in California. Medi-Cal covers all pregnancy-related services for a Medi-Cal member who is pregnant, regardless of if the individual is a surrogate, during the pregnancy and for one year postpartum. Medi-Cal eligibility extends up to 322% of the federal poverty level, or $7,512 a month or $85,813 a year in 2025 for a family of three. However, any income a gestational carrier received would count as income for purposes of determining Medi-Cal eligibility.

4) CHBRP REPORT. AB 1996 (Thomson), Chapter 795, Statutes of 2002 requests the University of California to assess legislation proposing a mandated benefit or service and prepare a written analysis with relevant data on the medical, economic, and public health impacts of proposed health plan and health insurance benefit mandate legislation. CHBRP was created in response to AB 1996, and reviewed this bill. Key findings include:

a) ***Definitions of gestational carrier vs. surrogates***. A gestational carrier is defined as a person who carries a pregnancy for intended parents 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. Intended parents plan to become the legal parent(s) of a child born through the assistance of a surrogate or gestational carrier. A surrogacy arrangement is a legally binding contract into which a surrogate/gestational carrier and intended parents enter that outlines the rights, responsibilities, and obligations of all parties involved, often including by whom insurance costs will be paid.

b) ***Gestational carrier costs***. CHBRP estimates the average cost of health services for a gestational carrier are $20,000. These are estimates 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. An insurance carrier would be required to pay an average of $17,230 and the enrollee would pay an average of $2,770.

c) ***Coverage impacts and enrollees covered***. CHBRP estimates that 83% of Californians (11,216,000) with state regulated insurance (not Medi-Cal) are enrolled in health plans or insurance policies that have requirements that people with surrogacy arrangements must pay charges for covered services received related to conception, pregnancy, or delivery in connection with the surrogacy arrangement.

d) ***Medical effectiveness***. 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.

e) ***Utilization***. In 2026, CHBRP estimates that 6,368 people would gain full coverage for maternity and pediatric newborn services without having to reimburse their health plan or insurer. Of those, 5,303 people are expected to be previously uninsured pregnant people and their dependents who would gain full coverage because of the special enrollment period. An additional 1,065 are expected to be surrogates or gestational carriers and their dependents. CHBRP indicates total average annual cost of all health care for pregnant enrollees is $21,700, divided between insurance carrier ($16,217) and the enrollee cost-sharing ($5,483). Annual average costs per dependent are $5,545 for insurance carriers and $1,875 for enrollee cost-sharing.

f) ***Impact on expenditures***. This bill would increase total premiums paid by employers and enrollees for newly covered benefits by $70,912,000. Enrollee cost-sharing for these benefits is estimated at $20,343,000 compared to expenses previously not covered of $21,310,000. Premium increases will range from $.12 per member per month to as high as over $2 per member per month for plans that are purchased in the individual market not through an employer.

g) ***CalPERs***. For enrollees associated with CalPERs in DMHC-regulated plan, premium are expected to increase by $.13 per member per month.

h) ***Essential health benefits***. This bill does not exceed EHBs because it does not create a new coverage requirement.

5) **SUPPORT**. This bill is sponsored by the Insurance Access and Equity Alliance. Proponents write that this vital legislation addresses critical gaps in health care coverage, ensuring that all pregnant individuals receive equitable treatment, regardless of the circumstances surrounding their pregnancy. Proponents believe the enactment of this bill would signify a monumental step forward in eliminating discriminatory practices in health care coverage related to pregnancy, and that it aligns with California's longstanding commitment to reproductive freedom and the protection of individual rights.

   The American College of Obstetricians and Gynecologists (ACOG) writes pregnancy is a significant medical and life circumstance that deserves the same flexibility and responsiveness currently afforded to other triggering events like marriage or job loss. ACOG says ensuring that individuals can access or adjust their health coverage when they become pregnant is a commonsense step that promotes maternal and infant health, especially in communities where coverage gaps contribute to disparities in care.

   The California WIC Association writes this bill is especially timely and needed given California's ongoing efforts to reduce maternal mortality, eliminate racial disparities in birth outcomes, and expand reproductive justice. The California WIC Association believes this bill takes a clear stand that pregnancy, no matter the pathway, deserves respect, timely care, and equal insurance treatment.

   The San Francisco Women's Political Committee writes that insurance discrimination disproportionately impacts women, LGBTQ+ individuals, people of color, and those in nontraditional family structures, and, that this bill ensures that all pregnant individuals have equitable access to health care, a crucial step toward reproductive freedom and gender justice in California.

6) **OPPOSITION**. The California Association of Health Plans (CAHP) and the Association of California Life and Health Insurance Companies (ACLHIC) write in opposition that in 2014, California saw the complete implementation of the Affordable Care Act (ACA), which brought substantial reforms to the health care landscape. One of the pivotal changes was the introduction of guaranteed issue coverage in the individual market, granting individuals and families the ability to secure health insurance without preexisting condition restrictions. A balancing measure to sustain a healthy insurance market required establishing an individual mandate and limiting enrollment periods to annual open enrollments and designated special enrollment periods linked to life events. Historically, unregulated enrollment opportunities without coverage constraints have led to market instability, as demonstrated in Washington State during the 1990s.

   CAHP and ACLHIC write that special enrollment periods are currently confined to "qualifying life events," such as relocation, marriage, family expansion, or the loss of employer-sponsored coverage. These exceptions, generic and universally applicable, maintain market integrity without tying access to specific medical conditions. This bill challenges this equilibrium by introducing condition-based enrollment provisions, potentially setting precedent for favoring particular medical conditions over others, thereby destabilizing the market. A significant component of California's strategy to ensure broad access to affordable quality health care is the encouragement and incentivization of insurance purchases, even in the absence of immediate medical need. CAHP and ACLHIC argue this practice sustains the financial robustness of the insurance market. CAHP and ACLHIC write

that this bill risks undermining this objective by potentially permitting individuals to defer purchasing insurance until its necessity becomes apparent.

CAHP and ACLHIC also write that additional complexities arise with provisions allowing gestational carriers to add newborn children to their coverage, stating this raises various legal questions, such as what defines a dependent, noting that gestational carriers often have no legal or biological ties to the child, and there is the matter of who holds responsibility for medical and financial decisions for the child's care. Finally, CAHP and ACLHIC write that forbidding insurers from recouping maternity service costs when an enrollee functions as a gestational carrier risks promoting a phenomenon referred to as surrogacy tourism, wherein non-California residents exploit California's accommodating health care framework, potentially further straining resources and affordability for the state's residents.

7) **PREVIOUS LEGISLATION**.

a) SB 729 (Menjivar) Chapter 930, Statutes of 2024 requires a health plan contract or policy of disability insurance sold in the large group market (employers with more than 100 covered individuals) to provide coverage for the diagnosis and treatment of infertility and fertility services, including services of a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine using single embryo transfer when recommended and medically appropriate.

b) AB 116 (Committee on Budget), Chapter 21, Statutes of 2025, the health budget trailer bill, delays the operative date of SB 729 by six months (from July 1 2025 to January 1, 2026), authorized the DMHC and CDI to issue guidance regarding compliance with the provisions of SB 729 until January 1, 2027, and exempted that guidance from the rulemaking provisions of the Administrative Procedure Act. AB 116 also required DMHC and CDI to consult with each other and stakeholders in issuing the guidance.

c) AB 1102 (Santiago) of 2015 would have required a health plan or health insurer to allow an individual to enroll in or change an individual plan or policy as a result of pregnancy. AB 1102 was later amended to address a different subject matter.

d) SB 1471 (Schiff), Chapter 848, Statutes of 2000 prohibits a health plan, insurer, medical group or independent practice association lien for recovery of money paid for health care services for an enrollee or insured from exceeding the amount actually paid for those health care services. This bill was passed in response to health insurers placing liens of judgements in excess of medical costs associated with medical care when there is a judgement or settlement.

8) **TECHNICAL AMENDMENTS**. Section 1 of this bill applies to health plans but an amendment is needed to clarify that it applies to health plan "contracts" in the same way that this bill applies to health insurance policies. In addition, staff recommends deleting language in Section 2 and 4 that reads "to comply with subdivision (a)," as the newly amended language no longer refers to subdivision (a).

REGISTERED SUPPORT / OPPOSITION:

Support

Academy of California Adoption Lawyers (ACAL)
Acorn Surrogacy Center
Adbundant Beginnings Co.
Alcea Surrogacy, LLC
All Families Surrogacy
All Family Legal
All Love Surrogacy
American College of Obstetricians & Gynecologists - District IX
American Federation of State, County and Municipal Employees, AFL-CIO
Art Risk Financial & Insurance Solutions, Inc.
Bright Futures Families
Brinkley Law Firm LLC
Brownstone Surrogacy
California WIC Association
Compass Creative Consultants
Compass Family Journeys
Copps Dipaola Silverman, PLLC
County of Santa Clara
Creative Family Connections LLC
Eggceptional Match, LLC
Embra Health
Equality California
Family Match Consulting, LLC
Gaston & Gaston, APLC
Genesis Group
Guided Surrogacy Solutions, LLC
Hatch Egg Donation and Surrogacy
Heart to Hands Surrogacy LLC
Insurance Access and Equity Alliance
International Fertility Law Group
International Surrogacy Center
Joy of Life
K.B. Surrogacy
Law Office of Erin C. O'Kane, Esq.
Law Office of Melissa L. Torto
Law Offices of Robert Rettenmaier, P.C.
Modern Fertility Law
National Association of Pediatric Nurse Practitioners (NAPNAP)
New Family Fertility Law
New Life Agency Inc.
New York Surrogacy Center
NewGen Families
NW Surrogacy Center
OC Child and Family Formation Law Group
Omega Family Global

Palo Alto Psychology Group
Reproductive Law Center
Reproductive Possibilities, LLC
Roots Surrogacy
Seeds
Seedtrust Escrow
SoCal Workers Comp
Surrogacy Mentor
Surrogacy Partnership
SurrogateFirst
Tarnoff Family Formation
The Cooley Law Firm
The Fertility Law Center, P.C.
Tsong Law Group
United Surrogacy
Vorzimer Masserman Fertility & Family Law
Several individuals

Oppose

Association of California Life & Health Insurance Companies
California Association of Health Plans

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