REPORT OF THE
SPECIAL ADVISORY COMMISSION ON
MANDATED HEALTH INSURANCE BENEFITS ON

The Social and Financial Impact and the Medical Efficacy of House Bill 883: Mandated Health Insurance Coverage of Adoptive Children

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 32

COMMONWEALTH OF VIRGINIA
RICHMOND
1991

SENATE OF VIRGINIA

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January 7, 1991

To: The Honorable L. Douglas Wilder
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein is pursuant to Section 9-299 of the Code of Virginia as created by House Bill 1106 and Senate Bill 478 of the 1990 Session of the General Assembly of Virginia.

This report documents a study conducted by the Special Advisory Commission on Mandated Health Insurance Benefits to assess the social and financial impact and medical efficacy of 1990 House Bill 883 which proposes mandating health insurance coverage for adoptive children.

Respectfully submitted,

Clarence A. Holland, Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

CAH:am

Special Advisory Commission on Mandated Health Insurance Benefits

Members of the General Assembly:

The Honorable Clarence A. Holland, Chairman

The Honorable George H. Heilig, Jr., Vice Chairman

The Honorable J. Granger Macfarlane

Members Appointed by the Governor:

James F. Babcock - Major Industry

Thomas W. Hubbard, M.D. - Medical Ethics

Reginia Jamerson - Accident/Health Insurance Industry

Douglas Johnson, Ph.D. - Acute Care Hospital

Carolyn Lambert - Citizen Member

Roger W. Litwiller, M.D. - Physician

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Phyllis C. Marstiller - Accident/Health Insurance Industry

Sidney D. Mason - Small Business

James W. Walker, Chiropractor - Allied Health Professional

Ex-Officio Members:

C. M. G. Buttery, M.D., Commissioner of Health

Steven T. Foster, Commissioner of Insurance

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I. Executive Summary

The Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) was established by the 1990 Virginia General Assembly to advise the Governor and the General Assembly on the social and financial impact of current and proposed mandated benefits and mandated providers. Senate Bill 478 and House Bill 1106 added Sections 9-297 through 9-300 to Chapter 34 of Title 9 and thereby created the Advisory Commission. The Advisory Commission is required to provide assessments of proposed and existing mandated benefits and providers and other studies of mandated benefits and provider issues as requested by the General Assembly.

House Bill 883 was proposed during the 1990 session of the General Assembly to require that all insurers, health services plans and health maintenance organizations (HMOs) provide coverage to adopted children if the contract provides coverage for family members. The bill was carried over during the 1990 session because of the creation of the Advisory Commission.

House Bill 883 was the first bill assessed by the Advisory Commission. It was the subject of a public hearing on September 12, 1990 and deliberations on December 10, 1990.

The Virginia Insurance Code does not use the terms "biological" or "adoptive" in reference to children. Rather, the term "dependent" is used. This term is not defined in the Code. It is defined in the insurance contract. Many insurance contracts do not distinguish between adopted or biological children. The question as to when coverage begins (time of placement versus time of finalization of adoption) is not regulated by the insurance code. The company's practices and contract (policy) language are the determining factors. Insurers' practices vary greatly regarding when coverage begins. Many insurers presently begin coverage from "the time of placement in the insured's residence". Some companies, however, require that the adoption be final before beginning coverage.

The Advisory Commission reviewed information prepared by staff as well as opponents and proponents of the mandates before making its decisions. The Advisory Commission's main concerns were that there be equitable treatment of adoptive and biological children and uniformity of coverage by companies.

The Advisory Commission unanimously recommends that coverage of adoptive children be mandated, if the policy or contract provides coverage for family members, from the date the child is placed for adoption. The Advisory Commission recommends that a child placed within 31 days of birth be considered a newborn child of the insured. The Advisory Commission does not recommend that underwriting practices for adoptive children be limited in any manner that is inconsistent with the underwriting of biological children.

The Advisory Commission believes that the equitable treatment of adoptive and biological children is in the public's best interest. The Advisory Commission also believes that the cost of mandating coverage from the time of placement does not place any undue burden on insurers or policyholders.

1990 SESSION

LD1752548

HOUSE BILL NO. 883

Offered January 23, 1990

A BILL to amend and reenact § 38.2-4319 of the Code of Virginia, and to amend the Code of Virginia by adding a section numbered 38.2-3411.1, and to repeal § 38.2-3419 of the Code of Virginia, all relating to accident and sickness insurance.

Patrons–Plum, Van Landingham and Marshall

Referred to the Committee on Corporations, Insurance and Banking

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Be it enacted by the General Assembly of Virginia:

1. That § 38.2-4319 of the Code of Virginia is amended and reenacted and that the Code of Virginia is amended by adding a section numbered 38.2-3411.1, as follows:

§ 38.2-4319. Statutory construction and relationship to other laws.–A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 of this title, 38.2-1317 through 38.2-1321, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, *38.2-3411.1,* and 38.2-3418.1 shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating t solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

§ 38.2-3411.1. Coverage of adopted children required.–A. Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or major medical coverage on an expense incurred basis, each corporation providing individual or group accident and sickness subscription contracts, and each health maintenance organization providing a health care plan for health care services that offers coverage for a family member of the insured, subscriber, or plan enrollee, shall, as to the family members' coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to adopted children of the insured, subscriber, or plan enrollee.

B. No such policy, subscription contract, or plan, shall contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning adopted children.

C. The coverage required by this section is effective from the date a child is placed with an insured, subscriber or plan enrollee for the purpose of adoption, and shall continue unless the placement is disrupted prior to legal adoption and the child is removed from placement with the insured, subscriber or plan enrollee.

2. That § 38.2-3419 of the Code of Virginia is repealed.

III. Introduction

The Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) was established by the 1990 Virginia General Assembly to advise the Governor and the General Assembly on the social and financial impact of current and proposed mandated benefits and mandated providers. Senate Bill 478 and House Bill 1106 added Sections 9-297 through 9-300 to Chapter 34 of Title 9 and thereby created the Advisory Commission. The Advisory Commission is required to provide assessments of proposed and existing mandated benefits and providers and other studies of mandated benefits and provider issues as requested by the General Assembly.

House Bill 883 was proposed during the 1990 session of the General Assembly to require that all insurers, health services plans and health maintenance organizations (HMOs) provide coverage to adopted children if the contract provides coverage for family members. The bill was carried over during the 1990 session because of the creation of the Advisory Commission.

House Bill 883 was the first bill assessed by the Advisory Commission. It was the subject of a public hearing on September 12, 1990 and was discussed on December 10, 1990.

IV. Insurance Coverage for Adoptive Children

Existing Law and Insurance Company Practices

The Virginia Insurance Code does not use the term "biological" or "adoptive" child. Rather, the term "dependent" is used. This term is not defined in the Code, it is defined in the insurance contract. Many insurance contracts do not distinguish between adopted or biological children. The question as to when coverage begins (time of placement versus time of finalization of adoption) is not regulated by the insurance code. The company's practices and contract (policy) language are the determining factors.

Insurers' practices vary greatly regarding when coverage begins. Many insurers presently begin coverage from "the time of placement in the insured's residence". This language implies that adoption is anticipated and it is that anticipation that many companies require before providing coverage. If the child is a ward, legal custody has been granted, or some type of legal or formal action has begun, or is anticipated to begin, many companies would begin coverage at the time the child moves into the residence.

Some companies, however, require that the adoption be final before beginning coverage. According to insurance industry sources, there is little or no formal data on this particular

issue. The main concern that companies have is that they not be liable when informal arrangements are made, such as an uncle, aunt, or friend of the family providing some care for a child temporarily.

Companies also resist coverage if there is no financial obligation on the part of the insured. For example, someone else is supporting the child and the child is simply "boarding" at the insured's residence. Some insurers rely on Internal Revenue Service (IRS) guidelines for the definition of eligible dependent and some companies use the "time the insured begins providing support for the child".

Underwriting and the use of preexisting condition exclusions also vary among companies. However, companies appear to be consistent as to when they apply the exclusions for biological or adoptive children if they underwrite for biological. Some insurers have reported they do not impose a preexisting period if they are merely adding a child to existing family coverage as opposed to changing coverage from a single to a family basis.

Companies also usually allow 31 days for the insured to inform the company of the addition of an adoptive or biological child.

Presently in Virginia, an individual policy cannot exclude coverage for a dependent child (however it is defined in the policy) whose health condition was present at birth. A group policy may exclude coverage for a preexisting condition for children not covered under the policy as newborns.

Virginia law requires that newborn children be covered from the moment of birth if the individual or group policy provides coverage for family members (§38.2-3411.). The law requires that coverage must include coverage for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities. §38.2-3411 also provides that an insured has 31 days to notify the company of the birth of the child and pay the required premium.

Proposed Legislation

House Bill 883:

- requires family coverage to apply to adoptive children from the date a child is placed with an insured;
- prohibits provisions for preexisting conditions, insurability, eligibility, or underwriting of the adoptive children;

- specifically includes a reference to Section 38.2-4319 (the HMO chapter), but not Chapter 42 (health services plans); and

- repeals Section 38.2-3419 which requires that any mandated coverage effective after July 1, 1982 be optional for group policies.

The proposed legislation was requested in part because of the problems involved with the adoption of "special needs" children. According to information from the Department of Social Services, in fiscal year July 1, 1988 to June 30, 1988, there were 2,573, adoptions of children. From July 1, 1988 to June 30, 1989, there were 2,480, and from July 1, 1989 to June 30, 1990, 2,335 children were adopted. Of the 2,480 children adopted in 1988-89, approximately 95% were "special needs adoptions". A child with special needs is defined in Section 63.1-238.1 of the Welfare (Social Services) Code.

A child with special needs means any child (i) in the custody of a local board of public welfare or social services which has the authority to place the child for adoption and consent thereto in accordance with the provisions of Section 63.1-56 or (ii) in the custody of a licensed child-placing agency, for whom it has been determined that it is unlikely that the child will be adopted within a reasonable period of time due to one or more factors including, but not limited to:

1. physical, mental, or emotional conditions existing prior to adoption;

2. hereditary tendency, congenital problem or birth injury leading to substantial risk of future disability; or

3. individual circumstances of the child related to age, racial or ethnic background, or close relationship with one or more siblings.

The special needs category also includes a child for whom the above factors are present at the time of the adoption but are not diagnosed until after the final order of adoption is entered (for up to one year after the final order).

Adoptive parents of special needs children are eligible for subsidy payments to provide special services to the child which the adoptive parents cannot afford, and which are not covered by insurance or otherwise, including, but not limited to:

1. medical, surgical, and dental care;

2. hospitalization;

3. legal services in effecting adoption;

4. individual remedial educational services;

5. psychological and psychiatric treatment;

6. speech and physical therapy;

7. special services, equipment, treatment, and training for physical and mental handicaps; and

8. cost of adoptive home study and placement by a child-placing agency other than the local board.

Subsidy payments end when the child reaches age 18, but can be continued up to age 21 if there is a mental or physical handicap or educational delay. The subsidy is based on agreement between the adoptive parents and the local board (and the licensed child-placing agency if the child is in their custody). Payments may be made under this chapter from appropriations for foster care services for maintenance and medical or other services for children who have special needs.

The length of the adoption process is another reason for the concern which has led to the proposed legislation. The adoption process includes a probationary period, and requires thorough investigation over a period of time that can easily lengthen the process to one year. During this period of time the adoptive child could be without insurance coverage, depending on the insurer's contract and/or position on this issue. According to the Department of Social Services, a family could be providing care for a child for six months prior to filing the adoption petition. When the petition is filed the following steps must then be completed:

Petition Filed	60 days for agency to investigate and report to the Commissioner
Commissioner	15 days to acknowledge receipt to court
Commissioner	90 days to investigate and report to court
Interlocutory Order Issued	Six month probationary period
Final Order Issued	
Total Time	Up to 11 1/2 months

A preexisting condition exclusion could add an additional year to the time that a child is without coverage for some illnesses or conditions.

Adopted Children Mandates in Other States

Fourteen states have enacted statutes which require adopted children to be covered under health insurance contracts. Each state mandates that the adopted child be covered in the same manner as any other dependent child would be under the contract. Thirteen states require coverage to begin at the time the child is placed with the insured or on the date the petition for adoption is filed. This is in contrast to coverage beginning on the date the adoption is finalized.

Seven states specifically allow for the termination of coverage upon the disapproval of a petition to adopt or a disruption in the adoption process in which the child is removed from the custody of the insured.

Only three states specifically prohibit insurers from restricting coverage by use of preexisting condition limitations. None of the states we have contacted have supplied data regarding the cost or effectiveness of the mandate, with the exception of an estimate from the state of Wisconsin. The estimate from Wisconsin was based on the average expenditure for individuals covered by Medicaid and was not specific to adoptive children.

Public Hearing

Four speakers addressed the Advisory Commission on House Bill 883. The proponents were representing adoptive parents and a local adoption agency. The opponents of the legislation were representatives of Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) and Blue Cross and Blue Shield of Virginia (BCBSVA).

The proponents of the legislation addressed the lack of uniformity in company practices with regard to adoptive children, the length of the adoption process, the barrier a lack of coverage creates to finding homes for some special needs children and the difficulty encountered changing from single coverage to family coverage. One of the proponents was a single parent awaiting her adoptive child, and was up to that point without coverage for the child. The adoption agency representative cited the example of a child that was scheduled to be placed in a permanent home for adoption that is now in foster care because the parents were unable to obtain health insurance for the child. Both proponents addressed the inequity of the system that works against an adoptive parent in their efforts to provide care for the child they bring into their family. Proponents took the position that an adoptive child is a newborn to the family regardless of age and should be treated that way for purposes of insurance.

Adopted Children Mandates in Other States

	Coverage as a Dependent	Coverage to begin at time of placement	Coverage begins some time during the adoption process	Coverage Terminated Upon denial of Adoption	Preexisting Condition Limitations Prohibited
Arizona	X		X		
Arkansas	X		X	X	
Florida	X	X		X	
Georgia	X				
Illinois	X		X		
Louisiana	X		X		
Massachusetts	X		X		
Minnesota	X	X		X	X
New Mexico	X	X		X	X
Ohio	X		X	X	
Oklahoma	X		X		
South Dakota	X	X			
Utah	X	X		X	
Washington	X	X			
Wisconsin	X	X		X	X

Opponents agreed that there should be uniformity in when coverage begins and also favored eligibility for coverage beginning with placement of the child. Both BCBSVA and BCBSNCA said that they currently provide coverage for adoptive children prior to the finalization of adoption. However, BCBSVA vigorously opposed the prohibition of preexisting condition exclusions of coverage. BCBSVA was concerned with the cost shift from care currently paid for by the state to insurance companies.

BCBSVA pointed out that only 3 of the 13 states mandating coverage prohibit preexisting conditions exclusions and that even the BCBSVA open enrollment contract contains those exclusions. BCBSVA proposed language that would require eligibility for coverage from the date of adoptive or parental placement and coverage for a newborn from time of birth. BCBSVA said the cost shift from possible state assistance to private insurance coverage would force the cost of health insurance up and the mandate would not affect those self-insured. BCBSNCA suggested language that would require that policies treat adopted children and other insureds equally.

A representative of the Department of Social Services clarified that for children not in the custody of an agency the state has no responsibility for the child. Furthermore, Social Services must attempt to place a child in a non-subsidized family before placing a child in a situation where state funds will be needed. It was the opinion of the representative from the Department of Social Services that coverage containing preexisting condition exclusions are an impediment to special needs adoptions.

There was no opposition to the proposal of requiring coverage from the date of placement.

V. Evaluation of House Bill 883 Based on Review Criteria

The review criteria for mandated benefit and mandated provider legislation was adopted by the Advisory Commission on September 12, 1990. Staff analysis and information from opponents on the adoptive children mandate were prepared prior to the adoption of that criteria. However, the bill was reviewed according to the criteria for the purpose of this report.

Social Impact

a. The extent to which the treatment or service is generally utilized by a significant portion of the population.

There are approximately 2,500 children adopted in Virginia per year. This figure includes all adoptions, agency or non-agency. A number of these adoptions are step-parent adoptions.

In fiscal year 1989-90, 2,335 children were adopted and 1,249 of those adoptions were by step-parents. Coverage for adoptive children is generally available. However, there is inconsistency as to when coverage begins. Coverage usually begins at either the time of placement of the child in the home or the finalization of the adoption. Insurers report that underwriting restrictions and preexisting condition exclusions are utilized when the insured is changing from single coverage to family coverage. Insurers also make the argument however, that this is consistent with their underwriting of biological children.

b. The extent to which insurance coverage for the treatment or service is already generally available.

The coverage is available from some insurers but not all. No formal industry data on this subject was obtained by staff.

c. If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatments.

Some children may go without medical care in the absence of this mandate. For others, care may be delayed. Proponents emphasized that some children may go without homes and remain in the foster care system indefinitely if prospective parents are unable to obtain insurance coverage.

d. If the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment.

If there is no coverage available, some children are eligible for subsidy payments if they are placed by an agency or, the adoptive parent can pay for care themselves. There is no data available on the expenditures by adoptive parents. Proponents of the legislation have made the point that without insurance coverage some children are not adopted and remain in the foster care without a permanent home.

e. The level of public demand for the treatment or service.

There is some demand and the level is related to the low numbers of children adopted in the state (2,500 per year). The Bureau of Insurance receives a few complaints each year. The Department of Social Services related that it has been a problem for some prospective parents, however, Social Services did not have any statistics on the extent of the problem.

f. The level of public demand and the level of demand from providers for individual or group insurance coverage of the treatment or service.

There was no indication that providers actively desire coverage for adoptive children. Adoptive parents with insurance coverage feel strongly that their coverage should apply to their adoptive children.

g. The level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts.

The Advisory Commission is not aware of the interest of any collective bargaining organizations in negotiating for inclusion of this coverage. Some insurers indicated that if a group contract holder desires coverage for adoptive children, then that request is generally accommodated.

h. Any relevant findings of the state health planning agency or the appropriate health system agency relating to the social impact of the mandated benefit.

No findings were submitted from other agencies on the social impact of the mandate.

Financial Impact

a. The extent to which the proposed insurance coverage would increase or decrease the cost of treatment or service over the next five years.

Proponents argue that there should be little additional cost for coverage of adoptive children because the insurers can assess the individual who is converting from single to family coverage in accordance with its existing rate structure. The majority of adoptive children are healthy and only a few have considerable medical problems. According to estimates from the Department of Social Services, they provide an average of approximately $700 a year per child for health care for those children for which they are responsible. Opponents of the legislation objected to the shift of costs from the public sector to insurers but did not supply cost estimates.

b. The extent to which the mandated treatment or service might increase the appropriate or inappropriate use of the treatment.

The mandated coverage should not affect the inappropriate use of treatment. The appropriate use of treatment would theoretically increase, but the amount of the increase should be limited because of the small number of individuals affected.

c. The extent to which the mandated treatment or service might serve as an alternative for more expensive or less expensive treatment or service.

Mandating that coverage for adoptive children begin when the child is placed in a home, will allow for early medical intervention. This could result in savings because of conditions and illnesses being treated in an early stage requiring less costly treatment and less total resources.

d. The extent to which the insurance coverage may affect the number and types of providers of the mandated treatment or service over the next five years.

There should be no affect on the number and types of providers because of the mandate.

e. The extent to which insurance coverage might be expected to increase or decrease the administrative expense of insurance companies and the premium and administrative expenses of policyholders.

There will be some administrative expenses incurred by those companies not already providing coverage from the date of placement. Policy forms and company manuals will need to be revised. Policyholders converting from single to family coverage can be assessed the additional cost for family coverage, which will cover much of the additional cost of this mandate. Insurers presented no estimates of the amount they anticipate paying in claims and/or its affect on premiums if the mandate is passed. A premium increase could be significant in the case of a small group that is experience rated and incurs a large claim resulting from treating a condition that would have been excluded for a year or not covered at all because the adoption of a child had not been finalized.

f. The impact of coverage on the total cost of health care.

There should be little if any impact on the total cost of health care. Children in the care of the Department of Social Services are receiving care subsidized by state and federal funds. Other children may be going without some care but are more likely receiving delayed care.

Medical Efficacy

a. The contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service.

The health status of adopted children will be improved considerably assuming some children are currently going without necessary care.

b. If the legislation seeks to mandate coverage of an additional class of practitioners:

1) The results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those covered.

Does not apply.

2) The methods of the appropriate professional organization that assure clinical proficiency.

Does not apply.

Effects of Balancing the Social, Financial and Medical Efficacy Considerations

a. The extent to which the benefit addresses a medical or a broader social need and whether it is consistent with the role of health insurance.

The benefit addresses medical and social needs. From a social perspective, adoptive children can currently be treated less favorably than biological children depending on their parents' insurance company. Society has a concern that these children should be treated as fairly and equitably as possible. For some of these children, medical care is necessary beyond preventive or well-baby care and in that regard there is a medical need. Equitable treatment of similar risks is entirely consistent with the role of health insurance.

b. The extent to which the need for coverage outweighs the costs of mandating the benefit for all policyholders.

The cost of mandating the benefit for all policyholders should be minimal. Some of the cost will be assessed directly upon those affected by charging the adoptive parents more when changing from single coverage to family coverage. The premiums for experience rated groups will be adjusted to reflect the actual claims paid under those contracts.

The need for consistency and equitable treatment outweighs the minimal cost that may be attributed to other policyholders.

c. The extent to which the need for coverage may be solved by mandating the availability of the coverage as an option for policyholders.

The majority of those Virginians covered by health insurance are covered by group health insurance available through employment. The offer of coverage for adoptive children to an employer would not guarantee the availability of coverage to those desiring it.

In a 1986 survey conducted for the State Corporation Commission, The Degree of Health Insurance Coverage of the General Population of Virginia study, 83% of families that were insured for health care obtained that coverage through employment.

In addition, opponents of mandates argue that administrative expenses would not be reduced by offering coverage and insurers would be more susceptible to adverse selection with a mandated offering.

VI. Recommendations

The Advisory Commission unanimously recommends that insurers, health service plans and health maintenance organizations be required to provide coverage for adoptive children if the policy or contract provides coverage for family members. The Advisory Commission further recommends that the coverage begin from the date the child is placed for adoption. The language proposed by BCBSVA was the language voted on by the Advisory Commission. Two modifications were recommended. The first change to the BCBSVA language allows an insured with a child who has been placed within thirty-one days of birth to be considered a newborn child of the insured. The BCBSVA language required placement to have occurred within ten days of birth. Thirty-one days are allowed for insureds to notify a company of the birth of a child according to §38.2-3411. The Department of Social Services does not place a child for adoption until the child is ten days old. The Advisory Commission believes that equitable treatment requires that the same number of days be allowed for an adoptive child to be added to the policy as a newborn. The second change adds a requirement that the parent notify the insurer of the adoption of the child within 31 days. A requirement of notice within thirty-one days is also consistent with §38.2-3411.

The Advisory Commission does not recommend that underwriting practices, preexisting condition exclusions, or other such provisions be limited for adoptive children in any manner that is inconsistent with the application of those practices or privisions to biological children. For that reason, the language in House Bill 883 restricting the use of preexisting condition limitations, insurability, eligibility or underwriting approval are not a part of the Advisory Commission's recommendations.

VII. Conclusion

The Advisory Commission believes that equitable treatment of adoptive and biological children is in the public's best interest. The Advisory Commission also believes that the cost of mandating coverage from the time of placement does not place any undue burden on insurers or policyholders.

HOUSE BILL NO. 883

AMENDMENT IN THE NATURE OF A SUBSTITUTE

§38.2-3411.2 Coverage of Adopted Children Required. - A. Each insurer proposing to issue individual or group accident and sickness insurance policies providing hospital, medical and surgical or Major Medical coverage on an expense incurred basis, each corporation providing or group accident and sickness subscription contracts, and each health maintenance organization providing a health care plan for health care services that offers coverage for a family member of the insured, subscriber, or plan enrollee, shall, as to the family member's coverage, also provide that the accident and sickness insurance benefits applicable for children shall be payable with respect to adopted children of the insured, subscriber, or plan enrollee.

B. The coverage of ~~No~~ such policy, subscription, or plan, applicable to family members of the insured, subscriber or enrollee, shall apply in the same manner and to the same but no greater extent to adopted children of the insured, subscriber or enrollee. ~~shall contain any provision concerning preexisting condition limitations, insurability, eligibility, or health underwriting approval concerning adopted children.~~

C. An adopted child shall be eligible for ~~T~~the coverage required by this section ~~is effective~~ from the date of adoptive or parental placement ~~a child is placed~~ with an insured, subscriber or plan enrollee for the purpose of adoption; and, in addition as to a child whose adoptive or parental placement has occurred within thirty-one days of birth, such child shall be considered a newborn child of the insured, subscriber or plan enrollee as of the date of adoptive or parental placement. ~~and~~ Once coverage is in effect, it shall continue, according to the terms of the policy, subscription contract, or plan, unless the said placement is disrupted prior to final decree of ~~legal~~ adoption and the child is removed from placement with the insured, subscriber or plan enrollee.

D. If payment of a specific premium or subscription fee is required to provide coverage for a child, the policy or subscription contract may require notification of the placement of an adoptive child and payment of the required premium or fees shall be furnished to the insurer issuing the policy or corporation issuing the subscription contract within thirty-one days after the date of parental or adoptive placement in order to have the coverage continue beyond the thirty-one day period.

§38.2-4319. Statutory construction and relationship to other laws. -A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §38.2-100, 38.2-200, 38.2-210 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 of this title, 38.2-1317 through 38.2-1321, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3407.1, 38.2-3411.1, 38.2-3418.1, 38.2-3419.1, 38.2-3542, and Chapter 53 of this title shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 of this title except with respect to the activities of its health maintenance organization.

B. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

C. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.