NEWBORN AND ADOPTED CHILDREN COVERAGE MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the Newborn and Adopted Children Coverage Act.

Drafting Note: In some states existing statutes may provide the commissioner with sufficient authority to promulgate the provisions of this Act in a regulation format. States should review existing authority and determine whether to adopt this model as an act or adapt it to promulgate as a regulation.

Section 2. Purpose and Intent

The purpose of this Act is to provide for uniformity of coverage requirements for newborn and newly adopted children and children placed for adoption under both group and individual health benefit plans.

Drafting Note: This model was designed to promote the uniformity of coverage for newborn infants under both individual and group health benefit plans. It was proposed by outside organizations to the NAIC as a way to clarify that a plan that provides coverage for dependents should cover a newborn from the moment of birth. *1974 Proc I 413, 415*. Since its endorsement in 1973, a majority of health benefit plans now provide coverage consistent with the model's intent and purpose for both individual and group health benefit plans. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, for the group health benefit plans only, health carriers to provide immediate coverage to newborn children from the moment of birth, newly adopted children from the date of adoption and children placed for adoption from the date of placement. This revised model retains the model's purpose to require coverage of newborn children from the moment of birth and extends these coverage requirements for individual health benefit plans to newly adopted children and children placed for adoption, including preexisting exclusion provision requirements.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Covered benefits" or "benefits" means those health care services to which a covered person is entitled under the terms of a health benefit plan.

C. "Covered person" means a policyholder, subscriber, enrollee or other individual participating in a health benefit plan.

D. "Dependent" shall be defined in the same manner as in [insert reference to state insurance law defining dependent].

Drafting Note: States without a statutory definition of dependent may wish to use the definition below. If using the suggested definition, status should insert a maximum age for student dependents that is consistent with other state laws. States also may wish to include other individuals defined as dependents by state law. The term child below is not intended to be limited to natural children of the covered person.

"Dependent" means a spouse, an unmarried child under the age of [nineteen (19)] years, an unmarried child who is a full-time student under the age of [insert maximum age] and who is financially dependent upon the covered person, and an unmarried child of any age who is medically certified as disabled and dependent upon the covered person.

E. "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

F. "Health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease.

G. "Health carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health care services.

H. "Health maintenance organization" means a person that undertakes to provide or arrange for the delivery of health care services to covered persons on a prepaid basis, except for a covered person's responsibility for copayments, coinsurance or deductibles.

Section 4. Applicability

A. Except as provided in Subsection B, this Act shall apply to health benefit plans that provide coverage for a dependent of a covered person.

B. The provisions of this Act shall not apply to a health benefit plan that provides coverage only for a specified disease, specified accident or accident-only coverage, credit, dental, disability income, hospital indemnity or other fixed indemnity coverage, long-term care insurance, as defined by [insert reference in state law that defines long-term care insurance], vision care or any other supplemental benefit or to a Medicare supplement policy, coverage under a plan through Medicare, Medicaid or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplemental to that coverage, any coverage issued as supplemental to liability insurance, workers' compensation or similar insurance, automobile medical-payment insurance or any insurance under which benefits are payable with or without regard to fault, whether written on a group blanket or individual basis.

Section 5. Coverage Requirements

A. Each health benefit plan subject to this Act shall provide coverage to:

(1) A newborn child of a covered person from the moment of birth; or

(2) A newly adopted child of a covered person from the earlier of:

(a) The date of placement for the purpose of adoption and continues in the same manner as other dependents of the covered person unless the placement is disrupted prior to legal adoption and the child is removed from placement;

(b) The date of entry of an order granting the covered person custody of the child for purposes of adoption; or

(c) The effective date of adoption.

B. To the extent the health care service or treatment is a covered benefit under the health benefit plan and the birth, adoption or placement of adoption described under Subsection A occurs while the covered person is eligible for coverage under the health benefit plan, the coverage required under Subsection A:

(1) Shall consist of coverage of injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities; and

(2) Is not subject to any preexisting condition exclusion.

Section 6. Notification Requirements

A. For a newborn child:

(1) If payment of a specific premium or subscription fee is required to provide coverage for a newborn child, as described in Section 5 of this Act, the health benefit plan may require the covered person to notify the health carrier of the birth of the child and furnish payment of the required premium or fees be furnished to the health carrier within sixty (60) days after the date of birth.

(2) If notice is not provided, the health carrier may refuse to continue coverage for the child under the health benefit plan beyond the sixty-day period unless within four (4) months after the birth of the child the covered person makes all past-due payments and in addition pays interest on the payments at the rate of 5 1/2% per year.

(3) If payment of a specific premium or subscription fee is not required to provide coverage for a newborn child under the health benefit plan, the health carrier may request notification of the birth of the child, but shall not deny or refuse to continue coverage if the covered person does not furnish the notice.

B. For a newly adopted child or child placed for adoption:

(1) If payment of a specific premium or subscription fee is required to provide coverage under the health benefit plan for a newly adopted child or child placed for adoption, as described in Section 5 of this Act, the health benefit plan may require the covered person to notify the health carrier of the adoption or placement for adoption and furnish payment of the required premium or fees to the health carrier within sixty (60) days after coverage is required to begin under Section 5A(2) of this Act.

(2) If the covered person fails to provide the notice or make payment within the sixty-day period, the health carrier shall treat the adopted child or child placed for adoption no less favorably than it treats other dependents, other than newborn children, who seek coverage at a time other than when the dependent was first eligible to apply for coverage.

Section 7. Regulations

The commissioner may promulgate regulations to carry out the provisions of this Act. The regulations shall be subject to review in accordance with [insert statutory citation providing for administrative rulemaking and review of regulations].

Section 8. Penalties

A violation of this Act shall [insert appropriate administrative penalty from state law].

Section 9. Effective Date

The requirements of this Act shall apply to all health benefit plans delivered or issued for delivery in this state more than 120 days after the effective date of the Act.

Chronological Summary of Action (all references are to the Proceedings of the NAIC)

1974 Proc. I 12, 14, 405, 413, 425-426 (endorsed but not adopted).
2005 Proc. 1st Quarter 261-262 (amended and adopted as an NAIC model by the parent committee).
2005 Proc. 2nd Quarter 49, 53-56 (reprinted and adopted by the Plenary).

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This chart is intended to provide readers with additional information to more easily access state statutes, regulations, bulletins or administrative rulings related to the NAIC model. Such guidance provides readers with a starting point from which they may review how each state has addressed the model and the topic being covered. The NAIC Legal Division has reviewed each state's activity in this area and has determined whether the citation most appropriately fits in the Model Adoption column or Related State Activity column based on the definitions listed below. The NAIC's interpretation may or may not be shared by the individual states or by interested readers.

This chart does not constitute a formal legal opinion by the NAIC staff on the provisions of state law and should not be relied upon as such. Nor does this state page reflect a determination as to whether a state meets any applicable accreditation standards. Every effort has been made to provide correct and accurate summaries to assist readers in locating useful information. Readers should consult state law for further details and for the most current information.

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KEY:

MODEL ADOPTION: States that have citations identified in this column adopted the most recent version of the NAIC model in a **substantially similar manner**. This requires states to adopt the model in its entirety but does allow for variations in style and format. States that have adopted portions of the current NAIC model will be included in this column with an explanatory note.

RELATED STATE ACTIVITY: Examples of Related State Activity include but are not limited to: older versions of the NAIC model, statutes or regulations addressing the same subject matter, or other administrative guidance such as bulletins and notices. States that have citations identified in this column **only** (and nothing listed in the Model Adoption column) have **not** adopted the most recent version of the NAIC model in a **substantially similar manner.**

NO CURRENT ACTIVITY: No state activity on the topic as of the date of the most recent update. This includes states that have repealed legislation as well as states that have never adopted legislation.

NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Alabama		ALA. CODE § 27-19-38 (1975).
Alaska		ALASKA STAT. § 21.42.345 (1975/1997).
American Samoa	NO CURRENT ACTIVITY	
Arizona		ARIZ. REV. STAT. ANN.§ 20-1342 (1982/1987) (individual); § 20-1402 (1982/1987) (group); § 20-826 (1982/2014) (service corps).
Arkansas		ARK. CODE ANN. § 23-79-129 (1975/2013) (portions of previous version of model); BULLETIN 3-75 (1975).
California		CAL. INS. CODE § 10119 (1971/2013).
Colorado		COLO. REV. STAT. § 10-16-104 (1992/2013) (portions of previous version of model).
Connecticut		CONN. GEN. STAT. § 38a-490 (1974/2012) (portions of previous version of model).
Delaware		DEL. CODE ANN. tit. 18, § 3335 (1975) (portions of previous version of model).
District of Columbia		D.C. CODE §§ 31-3801 to 31-3805 (1979).
Florida		FLA. STAT. § 627.641 (1982/1992) (individual); § 627.6575 (1982/1992) (group).
Georgia		GA. CODE ANN. § 33-24-22 (1974) (portions of previous version of model).
Guam	NO CURRENT ACTIVITY	

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Hawaii		HAW. REV. STAT. § 431:10A-115 (1988) (individual); § 431:10A-206 (1988) (group); § 432:1-602 (1987) (mutual benefit societies).
Idaho		IDAHO CODE ANN. § 41-2140 (1976) (individual); § 41-2210 (1976) (group).
Illinois		215 ILL. COMP. STAT. 5/356c (1979/1987) (portions of previous version of model); 215 ILL. COMP. STAT. 165/15.3 (1979).
Indiana		IND. CODE §§ 27-8-5.6-1 to 27-8-5.6-3 (1975/1987) (previous version of model).
Iowa	IOWA CODE § 514C.1 (1974).	
Kansas		KAN. STAT. ANN. § 40-2,102 (1974/1997) (previous version of model).
Kentucky		KY. REV. STAT. ANN. § 304.17-042 (1976) (individual) (portions of previous version of model); § 304.18-032 (1976) (group); § 304.38-198 (1982) (HMOs).
Louisiana		LA. REV. STAT. ANN. § 22:215.1 (1979); § 22:1065 (2008).
Maine		ME. REV. STAT. ANN. tit. 24, § 2319 (1975) (previous version of model); tit. 24-A, § 2743 (1975); tit. 24-A, § 2834; tit. 24, § 4234-C (1976/1998).
Maryland		MD. CODE ANN., INS. § 15-401 (1975/1997) (previous version of model)
Massachusetts		MASS. GEN. LAWS ch. 175, § 47C (1975) (general); MASS. GEN. LAWS ch. 176A, § 8B (1975) (nonprofit hospital service corp.); MASS. GEN. LAWS ch. 176B, § 4C (1975) (medical service corp).
Michigan		MICH. COMP. LAWS § 500.3403 (1975) (previous version of model).
Minnesota		MINN. STAT. § 62A.042 (1973/1984); § 62C.14(14) (1980) (health service plan corps).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Mississippi		MISS. CODE ANN. § 83-9-33 (1974/1979) (portions of previous version of model).
Missouri		MO. REV. STAT. § 376.406 (1974/1983) (portions of previous version of model).
Montana		MONT. CODE ANN. § 33-22-301 (1974/2003) (individual) (previous version of model); § 33-22-504 (1959/1987) (group) (previous version of model); § 33-30-1001 (1981) (health service corps).
Nebraska		NEB. REV. STAT. § 44-710.19 (1976/1994) (previous version of model).
Nevada		NEV. REV. STAT. § 689A.043 (1975/1989) (individual) (previous version of model); § 689B.033 (1975/2013) (group); § 695C.173 (1975/1989) (HMOs).
New Hampshire		N.H. REV. STAT. ANN. § 415:22 (1975/1996) (portions of previous version of model).
New Jersey		N.J. STAT. ANN. § 17B:27-30 (1976) (group); § 17:48-6(d) (1980) (hospital service corps); § 17:48A-5(d) (1981) (medical service corps).
New Mexico		N.M. STAT. ANN. § 59A-22-34 (1985) (individual) (previous version of model); § 59A-47-27 (1985) (nonprofit health care plans).
New York		N.Y. INS. LAW § 3216(c)(4)(C) (1984/2013) (individual); § 4235(f)(2) (1984/1989) (group); § 4304(d)(1) (1984/1989) (individual hospital service corps); § 4305(c)(1) (1984/1991) (group hospital service corps).
North Carolina		N.C. GEN. STAT. § 58-51-30 (1973/2005).
North Dakota		N.D. CENT. CODE § 26.1-36-07 (1985) (previous version of model)
Northern Marianas	NO CURRENT ACTIVITY	
Ohio		OHIO REV. CODE ANN. § 3923.26 (1973/1978) (previous version of model)
Oklahoma		OKLA. STAT. tit. 36, § 6058 (1975/1985) (previous version of model).

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NAIC MEMBER	MODEL ADOPTION	RELATED STATE ACTIVITY
Oregon	OR. REV. STAT. § 743A.090 (1975) (portions of model).	
Pennsylvania		40 PA. STAT. ANN. § 772 (1975); § 775.1 (1994).
Puerto Rico	26 P.R. LAWS ANN. §§ 10021to 10026 (2011).	
Rhode Island		230 R.I. CODE R. 20-30-1.5 (2001).
South Carolina		S.C. CODE ANN. § 38-71-140 (1988) (previous version of model).
South Dakota		S.D. CODIFIED LAWS §§ 58-17-30.2 to 58-17.30.4 (1974/2001) (previous version of model).
Tennessee		TENN. CODE ANN. § 56-7-2301 (1974/1980) (previous version of model).
Texas		TEX. INS. CODE ANN. §§ 1367.001 to 1367.003 (2005); 28 TEX. ADMIN. CODE §§ 3.3401 to 3.3403 (1976/1982).
Utah		UTAH CODE ANN. § 31A-22-610 (1986/2003).
Vermont		VT. STAT. ANN. tit. 8, § 4092 (1975/2013) (previous version of model).
Virgin Islands	NO CURRENT ACTIVITY	
Virginia		VA. CODE ANN. § 38.2-3411 (1986/2013) (previous version of model).
Washington		WASH. REV. CODE ANN. § 48.20.430 (1974) (individual) (portions of previous version of model); § 48.21.155 (1974) (group); § 48.44.212 (1974) (health care service plan).
West Virginia		W. VA. CODE § 33-6-32 (1975) (previous version of model).
Wisconsin		WIS. STAT. § 632.895 (5) (1976/1992) (previous version of model); WIS. ADMIN. CODE INS. § 3.38 (1977/1992).
Wyoming		WYO. STAT. ANN. §§ 26-20-101 to 26-20-104 (1975/1983) (previous version of model).

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Proceedings Citations
Cited by the Proceedings of the NAIC

The model was designed to promote uniformity of coverage for newborn infants under health insurance contracts in both the individual and group markets. **2005 Proc. 1st Quarter Vol. I 16.**

The comments suggested that provisions in the model regarding the renewal of conversion policies were inconsistent with renewal requirements for the individual market in HIPAA. In light of these concerns, a new draft addressing these concerns will be prepared and circulated for comment within the next few weeks. **2004 Proc. 4th Quarter Vol. 1 683.**

Section 1. Title

Section 2. Purpose and Intent

Section 3. Definitions

Section 4. Applicability

One commenter questioned whether it was reasonable for parents to assume that their newborn was automatically covered given the language in Section 4. Under the revised Section 4, the provisions of the Newborn model apply to health benefit plans that provide coverage for a "dependent of the covered person." The existing model applied to individual and group health insurance policies that provided coverage for a "family member." Mr. Jenkins suggested that specifying "family member coverage" could lead a parent to reasonably assume that a newborn is automatically covered, but "dependent coverage" may not reasonably lead to such an assumption. After some discussion among task force members, it was agreed that the scope had not necessarily been changed, but that a definition of "dependent" should be added to clarify the issue. **2004 Proc. 4th Quarter Vol. I 736.**

Section 4A states that the Newborn model applies to health benefit plans that provide coverage for a dependent of a covered person. One commenter suggested that the word "provide" be replaced with "offer." This revision would ensure that all health benefit plans whether they currently provide dependent coverage or not must offer such coverage. Another commenter suggested alternative wording: "provide or offer." Another commenter questioned whether either suggested revision would resolve the underwriting issue. Another commenter agreed that they would not. Another commenter stated that the suggested revisions would change the scope of the Newborn model. The revisions would require a health carrier in the individual market offering an individual policy with no family coverage to offer family coverage. **2005 Proc. 1st Quarter Vol. I 262.**

A representative for an insurer suggested that changing "provide" to "offer" or "provide or offer" could lead to overinsurance in the situation where each parent has an individual policy. He also stated that the current draft raises two issues: (1) whether the parent has right to add a newborn without medical underwriting; and (2) whether other policyholders should subsidize what is really a 60-day period of free coverage. He suggested the possibility of parents using this 60-day period to game the system and questioned whether it would be better to have a claim denied sooner rather than later in order to give parents notice that they need to enroll their newborn. **2005 Proc. 1st Quarter Vol. I 262.**

Section 5. Coverage Requirements

Section 6. Notification Requirements

One commenter stated that parents educated on the notice requirement would provide the notice in a timely fashion. However, he was concerned about those who do not, particularly when it turns out that the child has a congenital birth defect. Another commenter suggested that the task force should reconsider including Section 6A(2) in the Newborn model revisions. Another commenter acknowledged that the provisions of Section 6A(2) resolves some problems. However, she suggested that the task force should give considerable thought on whether to add this language and weigh the pros and cons before deciding to include such a provision. **2004 Proc. 4th Quarter Vol. I 736.**

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Section 6 (cont.)

One commenter asked the committee to look at Section 6A(2) of the Newborn model. He stated this section calls for a look back period for all policyholders to add a child to the policy up to four months after birth. He stated this presented an anti-selection problem for insurers. Another Commenter responded that this issue had been discussed at some length in two separate meetings of the task force. The original draft amendment called for a one-year provision, provided premium was paid at 5 1/2% interest. The contention by insurers was that the provision allowed gaming of the system. Regulators believed that contention was dubious at best; most risk is for congenital defects at birth, not waiting four months for problems to develop. On the other hand, when presented with health issues in a newborn, the parents are quite upset and forget that in current practice they only have one month to sign up the child for insurance. **2004 Proc. 4th Quarter Vol. I 735; 2005 Proc. 1st Quarter Vol. I 217.**

Section 6A(1) permits a health carrier to refuse to continue coverage of a newborn if the parent fails to provide notice within 60 days after the birth of the child. However, under Section 6A(2), if the parent, within one year following the birth, makes all past-due payments and pays interest, then the health carrier must continue the coverage. Ms. Jackson urged the task force to remove Section 6A(2) because of problems with adverse selection and administrative concerns. She also noted that only one state had such a provision in its law and, as such, questioned whether this provision was appropriate for inclusion in a model law. **2004 Proc. 4th Quarter Vol. I 735; 2005 Proc. 1st Quarter Vol. I 261.**

The only controversial issue that was raised was the length of time that a parent should be given to notify the health carrier of a newly born child or newly adopted child. The original model provided for a 31-day notification period. Task force members were concerned that this time frame was too short and a 60-day notification period was proposed. One task force member suggested having a 1-year notification period for newborn children. After extensive discussion, the task force compromised and approved, for newborns only, a four-month notification period. **2005 Proc. 1st Quarter Vol. I 270.**

Section 7. Regulations

Section 8. Penalties

Section 9. Effective Date

Chronological Summary of Action

December 1974: Endorsed but not adopted
March 2005: Amended to make model consistent with HIPAA while also extending coverage to the individual market and adopted