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

House Bill 1089 (1992): Direct Reimbusement of Certified Nurse-Midwives

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 38

COMMONWEALTH OF VIRGINIA
RICHMOND
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SENATE OF VIRGINIA

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December 30, 1992

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

The report contained herein has been prepared pursuant to sections 9-298 and 9-299 of the Code 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 the medical efficacy of House Bill 1089 (1992 Session) regarding the proposed mandate of direct reimbursement of certified nurse-midwives by insurers.

Respectfully submitted,

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

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INTRODUCTION

House Bill 1089 was referred to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission) for evaluation by the House Committee on Corporations, Insurance and Banking during the 1992 Session of the General Assembly of Virginia. House Bill 1089 is patroned by Delegate Jerrauld C. Jones of Norfolk and requires that health insurance policies sold in Virginia provide direct reimbursement for covered services provided by certified nurse-midwives.

On May 18, 1992 the Advisory Commission held a public hearing to receive comments from all interested parties regarding House Bill 1089. Additional comments were received on June 1. Written comments were received from interested parties both before and after the public hearing.

SUMMARY OF PROPOSED LEGISLATION

House Bill 1089 amends §§38.2-3408 and 38.2-4221 of the Code of Virginia by adding "nurse practitioners who render nurse midwife services" to the list of mandated providers. This proposal requires insurers to provide direct reimbursement to certified nurse-midwives for covered services rendered within the scope of licensure. This bill does not, however, mandate coverage of any services. House Bill 1089 does not apply to health maintenance organizations.

DIRECT REIMBURSEMENT OF CERTIFIED NURSE MIDWIVES

At least twenty-three states, including Maryland, have enacted statutes which mandate direct reimbursement by insurers for nurse-midwives. Twenty of these states enacted their statutes during the 1980's.

Blue Cross and Blue Shield of the National Capital Area (BCBSNCA) submitted 1991 claims information on its block of business subject to the Maryland direct reimbursement mandate. Claims were submitted on behalf of 75 patients who received midwife services. Nurse-midwives attended only 21 deliveries compared to 3,600 for physicians. Most of the nurse-midwife claims were for prenatal care services.

Although insurers are not required directly to reimburse nurse-midwives in Virginia, some do provide this coverage. According to a 1989 publication of the Health Insurance Association of America (HIAA), "[m]ost group policies cover deliveries by midwives as well as physicians and deliveries in other than traditional hospitals" (HIAA, p. 11). Comments filed

with staff by Pacific Mutual Life Insurance and PM Group Life Insurance Companies state:

> It is our practice to cover the services of a nurse practitioner who renders nurse midwife services, when the services are rendered within the scope of the license. Consequently, we anticipate no additional cost for the coverage required by proposed HB 1089.

It should also be noted that Medicaid, Medicare, the Federal Employee Health Benefit Plan (FEHBP), and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) provide direct reimbursement for covered services provided by certified nurse-midwives.

THE PRACTICE OF CERTIFIED NURSE-MIDWIVES IN VIRGINIA

The Department of Health Professions and the Virginia Health Planning Board authored a report pursuant to 1991 House Joint Resolution No. 431 regarding the potential for expansion of the practice of certified nurse-midwives in Virginia. The report was published as 1992 House Document No. 12.

In Virginia, a nurse-midwife is a type of nurse practitioner which is licensed jointly by the Board of Medicine and the Board of Nursing and regulated through a Committee of the Joint Boards for the Licensure of Nurse Practitioners (HD 12, p. 13). Nurse practitioners are defined in Virginia as follows:

> registered nurses with additional training and experience who practice nursing autonomously at an advanced clinical level and perform other acts which constitute the practice of medicine under the supervision of a collaborating physician (HD 12, p. 13).

The practice of nurse-midwifery is defined in Virginia as:

> the independent management of care of essentially normal newborns and women, antepartally, intrapartally, postpartally, and/or gynecologically, occurring within a health care system that provides for medical consultation, collaborative management, or referral (HD 12, p. 13).

The report indicates that there are 76 certified nurse midwives licensed to practice and currently residing in the Commonwealth of Virginia. The study group found, however, that approximately one-third of these licensees are not currently engaged in the practice of midwifery. The report identifies several barriers to the practice of nurse-midwifery in Virginia including the lack of direct third-party reimbursement by private

insurers. Other barriers include difficulty in finding a collaborating physician, difficulty in obtaining hospital privileges, affordability of malpractice insurance, and the absence of a nurse-midwifery education program in Virginia. The report defers to the opinion of the Advisory Commission on the reimbursement issue.

QUALITY OF CARE AND ACCESS TO CARE

In December of 1986, the Office of Technology Assessment of the Congress of the United States (OTA) issued a report entitled Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis. The OTA specifically targeted the issues of quality of care and direct third-party reimbursement in its study. It concluded that the quality of care provided by certified nurse-midwives, within the scope of their training, is comparable to that provided by physicians (OTA, pp. 5, 33). The OTA cited several studies which examined birth outcomes in supporting this position.

In addition, the OTA asserted that certified nurse-midwives improve access to care in both rural and urban areas by increasing the number of available providers and lowering financial barriers to care (OTA, pp. 6, 33).

COST OF SERVICES

It has been documented that in general the expenses associated with the delivery of a child are lower when administered by a nurse-midwife than a physician. The HIAA report indicates that the reason for this is two-fold. First, physician charges are generally higher than those by nurse-midwives. Nationally the average nurse-midwife charge for a normal delivery was $994, or 67 percent of the average physician charge of $1,492 (HIAA, p. 9). Secondly, nurse-midwives often perform deliveries in birthing centers or similar facilities which generally charge lower facility fees than hospitals.

REVIEW CRITERIA

Social Impact

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

Nationally, it is estimated that 96% of all deliveries are performed by either general practitioners or obstetricians-gynecologists (HIAA, p. 7). A Virginia study reports that certified nurse midwives attended 1,526 births in Virginia in 1989. This figure represents approximately 1.5 percent of the 96,538 births reported in Virginia in 1989.

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

It is apparent that some commercial insurers provide direct reimbursement for covered services provided by certified nurse-midwives in Virginia. However, it is not known how prevalent this practice is. It has been noted elsewhere that most federally sponsored health insurance programs provide such reimbursement. Additionally, at least twenty-three states mandate such reimbursement be included in policies issued by commercial insurers.

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.

Coverage for maternity care provided by physicians is generally available. Therefore, even if the insureds choice of providers is restricted, coverage is available for the needed services. However, some Virginians may not have access to appropriate primary health care. It has been argued that access to maternity services in rural and urban areas could be improved and costs reduced if certain barriers to the expansion of the practice of certified nurse-midwives in Virginia were removed. Among those barriers is the lack of third-party direct reimbursement.

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.

The extent to which the lack of coverage results in unreasonable financial hardship on those people needing treatment is unknown. As noted above, coverage for maternity care services rendered by physicians is generally available.

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

The level of public demand is unknown, although it is apparent that many rural and urban areas suffer from a lack of access to primary care. There remains uncertainty, however, as to how effective a mandate of direct reimbursement for certified nurse-midwives would be in addressing the problem of access.

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

Studies have shown that patients approve of the quality and level of care provided by certified nurse-midwives. However, no information has been obtained regarding the level of public demand. As a professional group, certified nurse-midwives favor direct reimbursement because they see the absence of such reimbursement as a barrier to establishing stable practices.

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

The level of interest of collective bargaining organizations is not known.

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.

The report recently issued jointly by the Department of Health Professions and the Virginia Health Planning Board supports the expansion of the practice of nurse-midwives in Virginia. However, they defer to the Advisory Commission on the issue of direct reimbursement.

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.

It is unlikely that the cost of insurance coverage would increase significantly if this benefit were added. Information provided by insurers indicated the measure would be largely cost neutral. They did indicate, however, that certain administrative expenses would be incurred by those insurers not currently providing such reimbursement.

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

No evidence has been presented which would indicate that the inappropriate use of maternity care services would increase as a result of enactment of this measure. However, concern was expressed by some that because nurse-midwives cannot practice independently, they should not be able to bill for services independently. Proponents of House Bill 1089 argued that the desire for administrative independence is a separate issue and that certified nurse-midwives are supportive of existing practice requirements.

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

It has been documented in the studies cited above that on average, certified nurse-midwives provide services at a lower cost than physicians for normal deliveries. Reasons given for lower costs include smaller salaries for nurse-midwives and the use of less intensive facilities such as birthing centers.

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.

It is not expected that the number of certified nurse-midwives would increase dramatically over the next five years solely as a result of this bill because of other barriers to practice recently identified in Virginia. However, if other barriers are removed, it is likely that an increase in the number of certified nurse-midwives practicing in Virginia might occur over a longer period of time than five years.

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

Although the impact on premiums is unknown, it can be assumed that certain administrative expenses would be incurred by those insurers which are not currently providing direct reimbursement. One opponent expressed concern with the potential for duplicative billing by physicians and nurse-midwives.

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

It is unknown whether this measure will increase or decrease the total cost of health care if enacted.

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 OTA report indicates that certified nurse-midwives provide a high quality of care within the scope of their training. Additionally, a study conducted by the Obstetrics and Gynecology Department of the Kaiser Permanente Medical Center in Anaheim, California found that certified nurse-midwives did not have an impact on perinatal outcomes when part of a team of providers working in collaboration with physicians. Certified nurse-midwives are trained to recognize signs which indicate the need for specialized care by a physician. In Virginia, certified nurse-midwives must participate in a collaborative arrangement with a physician or group of physicians in order to lawfully practice medicine in Virginia. Opponents of House Bill 1089 did not raise issues of medical efficacy in their comments to the Advisory Commission.

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 already covered.

The information cited in response to the above criterion also applies to this criterion.

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

The American College of Nurse-Midwives has established standards for the practice of nurse-midwifery and guidelines for educational programs. In Virginia, nurse-midwives are licensed jointly by the Board of Medicine and the Board of Nursing and regulated through a Committee of the Joint Boards for the Licensure of Nurse Practitioners (HD 12, p. 13)

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.

Proponents have argued that direct reimbursement for certified nurse-midwives by insurers will help improve access to maternity care for Virginians by creating a more favorable environment for establishing and maintaining such practices. Opponents have questioned whether mandating third party reimbursement is an appropriate means of encouraging the expansion of the practice of midwifery. They point to other barriers including difficulty in finding a collaborating physician, difficulty in obtaining hospital privileges, affordability of malpractice insurance, and the absence of a nurse-midwifery education program in Virginia. They also argue that since certified nurse-midwives must practice in collaboration with physicians, it is not appropriate for them to bill independently.

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

Opponents of House Bill 1089 argue that covered services are available from physicians and that a direct reimbursement mandate for commercial and Blue Cross and Blue Shield plans is not necessary. It is apparent that federal programs, some insurers and some employers with self-funded plans provide coverage for maternity services provided by certified nurse-midwives.

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

Virginia does not currently require an <u>offer</u> of direct reimbursement for any particular provider group. Mandated offers still require insurers who do not routinely provide particular coverages to incur certain administrative expenses as is the case with full mandates. In group contract situations, it is the policyholder and not the individual insureds that make the choice as to whether the offer of reimbursement is selected. Many individual policyholders do not know whether a certain optional coverage is desirable at the time of purchase.

RECOMMENDATION

The Special Advisory Commission on Mandated Health Insurance Benefits hereby recommends to the Governor and the General Assembly of Virginia that the proposed revision of §§ 38.2-3408 and 38.2-4221 of the Code of Virginia contained in House Bill 1089 (1992) and requiring direct reimbursement of certified nurse-midwives not be enacted.

CONCLUSION

The Advisory Commission has determined that coverage for maternity care is generally available in the absence of a mandate of direct reimbursement to certified nurse-midwives. Although it has not been demonstrated that health insurance claim costs would increase as a result of such a mandate, it is apparent that certain administrative costs would be incurred initially by those insurers not currently providing such coverage. Mandating direct reimbursement has not been determined to be an effective or necessarily appropriate means of encouraging expansion of the practice of certified nurse-midwives and therefore, increasing access to care.

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Health Insurance Association of America, Research Bulletin: The Cost of Maternity Care and Childbirth in the United States, 1989, Washington, D.C., December, 1989.

U.S. Congress, Office of Technology Assessment, Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis (Health Technology Case Study 37), OTA-HCS-37 (Washington, DC: U.S. Government Printing Office, December 1986).

Virginia Department of Health Professions and the Virginia Health Planning Board, The Potential for Expansion of the Practice of Nurse Midwives, House Document No. 12, Commonwealth of Virginia, 1992.

1992 SESSION

LD1707312

HOUSE BILL NO. 1089

Offered January 21, 1992

A BILL to amend and reenact §§ 38.2-3408 and 38.2-4221 of the Code of Virginia, relating to certified nurse midwives and mandated providers.

Patrons—Jones, Callahan, Christian, Cooper, Cunningham, J.W., Keating, Melvin, Van Landingham, Van Yahres, Lambert, Scott and Walker

Referred to the Committee on Corporations, Insurance and Banking

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-3408 and 38.2-4221 of the Code of Virginia are amended and reenacted as follows:

§ 38.2-3408. Policy providing for reimbursement for services that may be performed by certain practitioners other than physicians.—A. If an accident and sickness insurance policy provides reimbursement for any service that may be legally performed by a person licensed in this Commonwealth as a chiropractor, optometrist, optician, professional counselor, psychologist, clinical social worker, podiatrist, physical therapist, chiropodist, clinical nurse specialist who renders mental health services, audiologist ~~or~~ , speech pathologist, *or nurse practitioner who renders nurse midwife services,* reimbursement under the policy shall not be denied because the service is rendered by the licensed practitioner.

B. This section shall not apply to Medicaid, or any state fund.

§ 38.2-4221. Services of certain practitioners other than physicians to be covered.—A nonstock corporation shall not fail or refuse, either directly or indirectly, to allow or to pay to a subscriber for all or any part of the health services rendered by any doctor of podiatry, doctor of chiropody, optometrist, optician, chiropractor, professional counselor, psychologist, physical therapist, clinical social worker, clinical nurse specialist who renders mental health services, audiologist ~~or~~ , speech pathologist , *or nurse practitioner who renders nurse midwife services* licensed to practice in Virginia, if the services rendered (i) are services provided for by the subscription contract ; and (ii) are services which the doctor of podiatry, doctor of chiropody, optometrist, optician, chiropractor, professional counselor, psychologist, physical therapist, clinical social worker, clinical nurse specialist who renders mental health services, audiologist ~~or~~ , speech pathologist , *or nurse practitioner who renders nurse midwife services* is licensed to render in this Commonwealth.

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