REPORT OF THE
SPECIAL ADVISORY COMMISSION ON MANDATED
HEALTH INSURANCE BENEFITS

HOUSE BILL 1360 (1996): DIRECT REIMBURSEMENT OF CERTIFIED NURSE-MIDWIVES

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

HOUSE DOCUMENT NO. 35

COMMONWEALTH OF VIRGINIA
RICHMOND
1997

COMMONWEALTH OF VIRGINIA
HOUSE OF DELEGATES
RICHMOND

December 17, 1996

To: The Honorable George Allen
Governor of Virginia
and
The General Assembly of Virginia

The report contained herein has been prepared pursuant to §§ 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 1360 (1996 Session) regarding the proposed mandate of direct reimbursement of certified nurse-midwives.

Respectfully submitted,

George H. Heilig, Jr.
Acting Chairman
Special Advisory Commission on
Mandated Health Insurance Benefits

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INTRODUCTION

During the 1996 Session of the General Assembly, the House Committee on Corporations, Insurance and Banking referred House Bill 1360 to the Special Advisory Commission on Mandated Health Insurance Benefits (Advisory Commission). House Bill 1360 is patroned by Delegate Robert F. McDonnell.

The Advisory Commission held a hearing on August 20, 1996, in Richmond to receive public comments on House Bill 1360. In addition to the patron, eight speakers addressed the proposals. Three representatives from the Virginia Chapter of the American College of Nurse-Midwives, and two concerned citizens spoke in favor of the bill. Representatives of Trigon BlueCross BlueShield and the Health Insurance Association of America spoke in opposition to the measure. A representative of the Medical Society of Virginia also provided comments on the bill. In addition, written comments in support of the bill were provided by Blue Ridge Women's Health Center, P.L.C., Shenandoah Memorial Hospital, Twin County Regional Hospital, Blue Ridge Physicians for Women, Rockingham Memorial Hospital, Virginia Chapter of the American College of Nurse-Midwives, Northern Virginia Regional Perinatal Coordinating Council, Virginia Nurses Association, three certified nurse-midwives, and a concerned citizen. In addition, Virginia Manufacturers Association, Virginia Obstetrical and Gynecological Society, Trigon BlueCross BlueShield, the Virginia Chamber of Commerce, Health Insurance Association of America and Virginia Association of Health Maintenance Organizations submitted comments in opposition to House Bill 1360. The Advisory Commission concluded its review of House Bill 1360 on September 19, 1996.

SUMMARY OF PROPOSED LEGISLATION

The bill requires an accident and sickness insurance policy to provide reimbursement for any services that may be legally performed by a person licensed in this Commonwealth as a certified nurse-midwife if the service is covered by the policy. Reimbursement under the policy shall not be denied because the service is rendered by the licensed practitioner. In addition, 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 certified nurse-midwife licensed to practice in Virginia, if the services rendered (i) are services provided for by the subscription contract and (ii) are services which the certified nurse-midwife is licensed to render in this Commonwealth.

PRIOR REVIEW OF THIS ISSUE

In 1992, the Advisory Commission reviewed House Bill 1089, which would have required that health insurance policies sold in Virginia provide direct reimbursement for covered services performed by certified nurse-midwives. The Advisory Commission's report was published as 1993 House Document No. 38. The Advisory Commission determined that coverage for maternity care was generally available in the absence of a mandate of direct reimbursement to certified nurse-midwives and recommended that House Bill 1089 not be enacted.

In 1994, the Joint Commission on Health Care authored a report pursuant to 1994 Senate Joint Resolution No. 164 regarding study of the optimum use of nurse practitioners. The Joint Commission's report was published as 1995 Senate Document No. 25. The study addressed several existing barriers to optimum nurse practitioners' practice, including reimbursement limitations, educational financing, and acceptance by the public and by physician colleagues. One purpose of the study was to examine the barriers and suggest state interventions to expand and promote the use of nurse practitioners in the provision of primary care services. Suggestions in the report for consideration by the General Assembly included adding nurse practitioners as mandated non-physician health service providers, increasing the amount of state scholarships, and supporting collaborative training models for physicians and nurse practitioners.

THE PRACTICE OF CERTIFIED NURSE-MIDWIVES

The American College of Nurse-Midwives (ACNM) is the professional association of Certified Nurse-Midwives (CNMs). The ACNM defines the practice of nurse-midwifery as the independent management of women's health care, focusing particularly on pregnancy, childbirth, the postpartum period, care of the newborn, and the family planning and gynecological needs of women. CNMs practice within a health care system that provides for medical consultation, and collaborative management or referral as indicated by the health status of the client. CNMs work interdependently with physicians with whom they consult and to whom they refer patients who develop complications requiring their care.

The practice of nurse-midwifery varies from self-employment to employment by physicians, hospitals, birthing centers, health maintenance organizations, and government and military establishments. CNMs are one of three categories of nurse practitioners. Nurse practitioners are jointly licensed by the Virginia Board of Nursing and the Virginia Board of Medicine and are regulated through a Committee of the Joint Boards of Nursing and Medicine. As

of March 25, 1996, the Department of Health Professions reports there were 121 midwives licensed to practice in the Commonwealth of Virginia.

EDUCATION

The Journal of Nurse-Midwifery (July/August 1995) notes the Division of Accreditation (DOA) of the ACNM establishes the criteria for Pre-Accreditation and Accreditation of Education Programs in Nurse-Midwifery. Upon successful completion of the nurse-midwifery program, a graduate is eligible to sit for the national certification examination in order to become a certified nurse-midwife. All individuals eligible for this program must be licensed registered nurses in one of the 50 states, the District of Columbia, or U.S. territories, and must provide evidence of formal recognition as a midwife in the country or state of preparation. Currently, 46 accredited programs are educating nurse-midwives and nationally about 400 candidates take the CNM certification exam each year. CNMs must complete a required minimum of continuing education units in a five-year cycle to remain certified.

ACCESS TO PRIMARY CARE

Public Health Reports (November/December 1994) "A Rural-urban Comparative Study of Non-physician Providers in Community and Migrant Health Centers" suggests that non-physician providers, in particular nurse practitioners and certified nurse midwives, primarily serve as physician substitutes. They are more likely to be employed by Migrant Health Centers that are larger and have affiliations with non-physician provider training programs. The use of non-physician providers is an important way to achieve cost containment and improve access to quality care for individuals residing in medically underserved areas. Medically underserved areas are urban or rural communities that have a shortage of personal health services.

The Department of Health conducted a survey of local health directors in mid-1991 as reported in House Document No. 12 (1992) "The Potential for Expansion of the Practice of Nurse Midwives." The public health directors described a serious shortage of obstetricians in medically underserved and rural areas. The report demonstrated a poor match between prenatal and obstetrical care needs and provider availability in the Commonwealth.

The 1990 Virginia Health Planning Board review of obstetric access indicated that in 51 of the state's 99 counties, the local health department clinic served as the only source of perinatal health care for medically indigent women.

CURRENT INDUSTRY PRACTICES

The State Corporation Commission's Bureau of Insurance surveyed 50 of the top writers of accident and sickness insurance in Virginia regarding three of the bills to be reviewed by the Advisory Commission in 1996. Thirty-four companies responded by April 19, 1996. Eight of those responding to the survey indicated that they have little or no applicable health insurance business in force in Virginia and, therefore, could not provide the information requested. Of the 26 respondents that completed the survey, 13 reported that they provide reimbursement for nurse-midwives to their Virginia policyholders. Other companies, however, indicated that they reimburse nurse-midwives indirectly if they are employed by a hospital or physician.

FINANCIAL IMPACT

Respondents to the State Corporation Commission Bureau of Insurance survey provided cost figures that ranged from $.03 to $2.08 per month per individual policyholder and from $.03 to $2.00 per month per group certificateholder to provide reimbursement for CNMs. Time Insurance Company noted that maternity is currently covered as an optional rider. The company assumed that nurse-midwife services would be offset by a decrease in physician costs and believes this mandate will not result in a cost increase.

According to the ACNM and Sandra Jacobs' "Having Your Baby with a Nurse-Midwife," nurse-midwives are growing in popularity, not only because they meet the needs of women and families, but also because they are cost-efficient. In practices where the nurse-midwife is employed by the physician and women receive care from both, there may be one uniform fee. Otherwise, a nurse-midwife's fee tends to be lower than a physician's. Although there is no absolute rule, and variations occur in every community and practice, obstetricians charge about 30 to 40 percent more (excluding hospital costs) than nurse-midwives for professional services. When you are in a hospital and receiving care from a nurse-midwife, the hospital bill is generally lower because less intervention is used.

One proponent cited financial data collected from a small nonprofit community hospital which showed an average of $1,000 savings on a normal vaginal delivery by a CNM.

SIMILAR LEGISLATION IN OTHER STATES

According to information published by the National Association of Insurance Commissioners and the American College of Nurse-Midwives "Nurse-Midwifery Today: A Handbook of State Legislation (1995)," at least 23 states currently mandate direct reimbursement by insurers for nurse-midwives (see attached chart). An additional nine states have enacted "Any Willing Provider" laws that include nurse-midwives (Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Oklahoma, Utah, and Wyoming), and one state (Michigan) requires reimbursement because of an attorney general's opinion.

REVIEW CRITERIA

SOCIAL IMPACT

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

The American College of Nurse-Midwives reports that certified nurse-midwives attending births increased for the 18th consecutive year. CNMs attended over 196,000 births in 1993. According to the National Center for Health Statistics, CNM-attended births have increased consistently each year since 1975. The 1993 total for CNMs represents a 7% gain over the 1992 total and a 16% increase since 1991.

The Virginia Department Of Health Statistics reports that CNMs attended the births of 2,345 Virginia babies in 1994, accounting for about 2.5 percent of the 94,355 resident births that year.

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

The Federal Employee Health Benefit Plan (FEHBP), Medicaid, Medicare, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) provide direct reimbursement for services provided by CNMs. A survey of accident and sickness insurers by the State Corporation Commission's Bureau of Insurance found that 13 of 26 respondents (50%) provide reimbursement for nurse-midwives to their Virginia policyholders. Other companies, however, indicated that they reimburse nurse-midwives indirectly if they are employed by a hospital or physician. Additionally, at least 23 states mandate direct reimbursement to CNMs for covered obstetrical services.

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 OB/GYN physicians is generally available. However, over two-thirds of the clients seen by CNMs are categorized as "vulnerable" (the criteria of age less than 16, education less than 8 years, race/ethnicity other than white, and payment source of Medicaid, Medicare, Indian Health Service, free or self-pay). Over one-third of the women and infants seen by CNMs are living in areas where a higher than average number of people are living below the poverty level.

Historically, nurse-midwives have been credited with an increased willingness to practice in underserved rural and inner city areas, thus improving the geographical distribution of care. The 1990 Virginia Health Planning Board review of obstetric access indicated that in 51 of the state's 99 counties, the local health department clinic served as the only source of perinatal health care.

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.*

Two citizens voiced their concern regarding the impact of lack of reimbursement on their families at the Advisory Commission's hearing on August 20, 1996. They both experienced financial hardship by having to pay for the services of a CNM out-of-pocket at a cost of approximately $1,500 of after-tax income. One of the consumers had previously been covered for CNM services because they lived in a state that mandated direct reimbursement.

However, one opponent stated that direct reimbursement for nurse-midwives or the numerous other classes of nurse practitioners would not solve the access problem in rural Virginia because nurse-midwives still need physicians' backup; and whether physician backup is available would continue to depend on the number of physicians practicing in sparsely populated areas of the state.

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

According to the Virginia Department of Health Statistics, CNMs attended the births of 2,345 Virginia babies in 1994. Nationally, CNMs attended over 196,000 births in 1993. One proponent stated that women in the Harrisonburg area appreciate the opportunity to be cared for by a nurse-midwife, not only during their pregnancy and birth experience, but also for their GYN, family

planning, menopausal and other concerns. Proponents stated that more women are seeking the personalized care that nurse-midwives provide, with its emphasis on less intervention and more patient education and control in health care decisions.

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

A consumer speaking on behalf of CNMs submitted a petition at the hearing signed by 584 consumers in Virginia supporting House Bill 1360, which adds CNMs to the list of providers for whom reimbursement is mandated. CNMs stated that the level of public demand for their services is increasing as women become more aware of the care provided by CNMs. They seek to be included in mandated reimbursement because of their varied practice settings, and diverse administrative and employment arrangements that exist in their practice across the state. Client satisfaction is generally regarded as a hallmark of nurse-midwifery care. At times, the motivation to have a CNM-attended birth is so great that patients will pay out-of-pocket for midwifery care. However, this approach may not be feasible for the majority of Virginians. The Virginia Chapter of the American College of Certified Nurse-Midwives believes that it should not be a decision of the private insurers whether to reimburse for CNMs' services or to require that a CNM be an employee of a physician to receive reimbursement.

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 in negotiating privately for inclusion of this coverage in group contracts is unknown.

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.

Senate Joint Resolution No. 164 of the 1994 Session requested the Joint Commission on Health Care to study the optimum use of nurse practitioners. The report addressed several strategies and incentives in providing and promoting cost-effective, high quality health care services for the citizens of Virginia. Suggestions in the report for consideration by the General Assembly included adding nurse practitioners as mandated non-physician health service providers, increasing the amount of state scholarships, and supporting collaborative training models for physicians and nurse practitioners.

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.*

The proposed coverage is not expected to increase or decrease the cost of treatment or service. However, some administrative costs would be incurred by those insurers not currently providing direct reimbursement for CNMs. Proponents made the argument that CNM care is less expensive than physician care.

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

The appropriate use of the service may increase if CNMs are chosen by more women who prefer their services, especially in rural and medically underserved areas of Virginia where physicians are sparse. Appropriate use may also increase if more CNMs become licensed due to the removal of a barrier to practice.

No information was provided regarding a possible increase in the inappropriate use of CNMs. Opponents of the bill did express concern about the effect of the mandate on the collaboration with a physician required for CNM practice.

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

Proponents have compared the cost of a patient utilizing a CNM's services versus a physician's services and say that the cost is consistently lower for a CNM's services. CNMs have demonstrated the cost-effective care they have provided for their patients given the decrease in cesarean rates, the decrease in the use of costly interventions, the lowered infant mortality rates and increase in birthweights.

Unpublished data from 1993 for Shenandoah County reported a $1,000 savings on average for a normal vaginal delivery by a CNM. A recent study at two Kaiser Permanente Medical Centers in California showed a 13%, or $292,000, reduction in payroll costs at one center and 7%, or $2 million, reduction at another center when CNMs were added to the obstetric team.

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 likely that the proposed mandate would affect the number of providers because the lack of direct reimbursement has been identified as a barrier for nurse practitioners and nurse-midwives to practice in the Commonwealth of Virginia. It has been suggested that third-party reimbursement would make Virginia an attractive place for CNMs to practice with a collaborative physician.

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.*

Respondents to the State Corporation Commission Bureau of Insurance survey provided cost figures that ranged from $.03 to $2.08 per month per individual policyholder and from $.03 to $2.00 per month per group certificateholder to provide direct reimbursement to CNMs. There may be some increase in the administrative expenses of those insurers not currently reimbursing CNMs.

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

The total cost of healthcare is expected to decrease because of the decreased use of costly interventions, the decreased cesarean rates, and the lowered infant mortality rate and increased in birthweights.

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 Congressional Office of Technology Assessment (OTA) conducted a (1986) study that looked at patient satisfaction with CNMs as compared to physicians. The results demonstrated that the quality of certified nurse-midwives care was equivalent to that provided by physicians. The OTA study

also reported that patients were satisfied with the care provided by CNMs within the areas of communication and preventive care. Additionally, Public Citizen's Health Research Group, published a report entitled "Encouraging the Use of Nurse-Midwives: A Report for Policymakers" (1995) that concludes that CNMs provide safe, effective maternity care, and seeks minimal intervention in the birth process for their patients. They believe that access to nurse-midwifery care for all childbearing women can improve birth outcomes and enrich women's childbearing experiences while remaining cost-effective. Opponents of the bill did not question the medical efficacy of using the services of CNMs.

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 ACNM is the professional association of CNMs. CNMs practice in accordance with the standards for the practice of nurse-midwifery as defined by ACNM. The Division of Accreditation (DOA) of the ACNM establishes the criteria for Pre-Accreditation and Accreditation of Education Programs in Nurse-Midwifery. Currently, 46 accredited programs are educating nurse-midwives in the United States. CNMs must complete a required minimum of Continuing Education Units in a five-year cycle in order to remain certified. Peer review committees are also active in the ACNM state chapters and at the national association level. Certified nurse-midwives are one of three categories of nurse practitioners. Nurse practitioners are jointly licensed by the Virginia Board of Nursing and the Virginia Board of Medicine and are regulated through a Committee of the Joint Boards of Nursing and Medicine.

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.*

House Bill 1360 addresses a medical need to treat individuals who choose CNMs to guide them through their pregnancies, to deliver their babies, to care for them after childbirth, and to provide gynecology services. Direct reimbursement for CNMs is consistent with the role of health insurance. Nurse-midwifery services are covered by many private medical insurance carriers.

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

The cost of mandating the reimbursement of CNMs is expected to be low. Time Insurance Company assumed that the cost of nurse-midwife services would be offset by a decrease in physician costs and believed that this mandated benefit would not result in a cost increase.

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 offer 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 Advisory Commission voted (5-Yes, 3-No) on September 19, 1996 to recommend passage of House Bill 1360.

CONCLUSION

The Advisory Commission has determined that House Bill 1360 does not mandate coverage of any services of a CNM, it only mandates direct payment. Although maternity coverage is generally available; maternity care is not available in all parts of the state, especially in the rural areas of Virginia. Access to CNMs is expected to improve with direct reimbursement, and CNMs are expected to provide care in areas where there is a shortage of physicians, particularly Obstetricians/Gynecologists.

The cost associated with adding CNMs as a mandated provider is not expected to increase significantly the cost of health coverage, and may result in lower overall healthcare costs. CNMs must practice in collaboration with a physician even with direct reimbursement, and the quality of care should not be adversely affected by passage of this legislation.

961767312

HOUSE BILL NO. 1360

Offered January 22, 1996

A BILL to amend and reenact §§ 38.2-3408 and 38.2-4221 of the Code of Virginia, relating to accident and sickness insurance; reimbursement for health services rendered by certified nurse midwives.

Patrons—McDonnell, Hamilton, Jones, J.C., Mims and Rhodes; Senator: Miller, Y.B.

Referred to 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 certified nurse midwife*, 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 certified nurse midwife* 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 certified nurse midwife* is licensed to render in this Commonwealth.

Official Use By Clerks			
Passed By The House of Delegates		**Passed By The Senate**	
without amendment	☐	without amendment	☐
with amendment	☐	with amendment	☐
substitute	☐	substitute	☐
substitute w/amdt	☐	substitute w/amdt	☐
Date: _____		Date: _____	
Clerk of the House of Delegates		Clerk of the Senate	

Reimbursement of Certified Nurse-Midwives

State	Citation	Summary
Alaska	§ 21.42.355 § 21.36.090	Services may be provided under this subsection only if the advanced nurse practitioner is certified to practice as nurse mid-wife in accordance with regulations and the services provided are within the scope of practice authorized by that certification.
California	§ 10353 § 10354 § 11512.07	Coverage for perinatal services shall contain a provision providing for direct reimbursement to certified nurse-midwives for perinatal services.
Colorado	§ 1.10-8-103	Indemnity health insurance companies are required to reimburse Certified Nurse Midwife services.
Connecticut	§ 38a-499 (individual) § 38a-526 (group)	Provides coverage for the services of certified nurse-midwives if such services are within the individual's area of professional competence as established by education and certification and are currently reimbursed when rendered by any other licensed health care provider.
Delaware	18 § 3553 (group) 18 § 3336 (Individual)	Provides for reimbursement for any health care services which is within those area of practice for which a midwife may be licensed.
Florida	§ 627.6574 (group) § 627.6406 (individual)	Provides coverage for maternity care shall also cover the services of certified nurse-midwives.
Georgia	§ 33-20-16 § 33-30-25	Enacted an Any Willing Provider Law, the terms of which cover all providers and all insurer-based PPO's. All providers within the PPO's defined service area, who are qualified and who meet the insurer's standards, must be given the opportunity to become a participating provider.
Idaho	§ 41-3937	Enacted an Any Willing Provider law requires HMOs to admit all health care providers to participating provider status.

Illinois	§ 370h	Any Willing Provider law covers all noninstitutional providers and all preferred provider organizations (PPOs).
Indiana	§ 27-8-11-3(b-c)	Enacted an Any Willing Provider law which covers all providers and applies to PPOs (preferred provider organizations).
Kansas	§ 40-2250	Provides for reimbursement for any services within the lawful scope of practice of an advanced registered nurse practitioner within the state of Kansas (nurse midwives are one of four categories of nurse practitioner).
Kentucky	Ch. 34, subtitle 17A	Enacted an Any Willing Provider law which covers all providers and all carriers. It prohibits health plan from discriminating against any provider willing to meet the plan's term and conditions.
Louisiana	§ 22:1214(15) § 40:2201	Enacted an Any Willing Provider law in 1992 which covers all licensed providers (other than hospitals). The law governs HMOs and PPOs.
Maryland	48 § 490A-2 48 § 354N (nonprofits)	Provides for reimbursement for any service which is within the lawful scope of practice of a licensed or certified nurse midwife, the insured, or any other person covered, shall be entitled to reimbursement for such service, whether the service is performed by a doctor of medicine or a licensed or certificate nurse midwife.
Massachusetts	C.175 § 47E C.176B § 46 (nonprofits)	Provides benefits for services of a certified nurse midwife.
Michigan*	Opinion 6567	An attorney General's opinion stated that a state law which required Blue Cross/Blue Shield to reimburse certain categories of licensed health care providers applied to and required reimbursement of specialty certified registered nurse services.
Minnesota	§ 62A.03 (individual) § 62A.15 (group)	Provides payment of benefits for treatment and services by a licensed registered nurse certified in advanced nursing practice.

Nevada	§ 689A.0495 (individual) § 689B.045 (group)	Provides coverage for services which are within the authorized scope of practice of a registered nurse.
New Hampshire	§ 415:5 § 419:5 § 415: 18-a	Provides for reimbursement for any service which may be legally performed by a person licensed as an advanced registered nurse practitioner.
New Jersey	§ 17:48A -34 (nonprofits)	Benefits shall not be denied to any eligible individual for eligible services when the services are performed or rendered those individuals by a certified nurse-midwife within the scope of his practice.
New Mexico	59A-22-32 (individual) 59A-23-4 (group) 59A-47-28.1	Provides for obstetrical and/or maternity benefits on a service basis shall include coverage for the services of a certified nurse-midwife.
New York	§ 4303 (nonprofits) § 3216 (individual)	Provides coverage for maternity care shall include the services of a certified nurse-midwife.
North Dakota	§ 26.1-36-05 (group) § 26.1-36-04 (individual) § 26.1-17-12.1 (nonprofits) § 26.1-18-12 (HMOs)	Provides for reimbursement of payment for service that are within the scope of practice of an advanced practice registered nurse (certified nurse midwives are one of four categories of advanced practice registered nurse).
Ohio	36 § 3923.233 (group) 36 § 3923.301	Provides for reimbursement for any service that may be legally performed by a nurse-midwife.
Oklahoma	Tit. 36 § 3634	Enacted an Any Willing Provider law which applies to all providers and all carriers.
Oregon	§ 743.128 § 743.712	Policy of health insurance provides for reimbursement for any services which is within the lawful scope of practice of a duly licensed and certified nurse practitioner.
Pennsylvania	40 P.S.§ 3002	Provides for reimbursement for any health care services which is within those areas of practice for which a midwife may be licensed
Rhode Island	§ 27-18-31 § 27-20-5 (nonprofits) § 27-41-34 (HMOs)	Provides coverage for the services of licensed midwives.

South Dakota	§ 58-17-54	Third party reimbursement is mandated for all licensed health care providers, including certified nurse midwives.
Utah	§ 31A-22-617	Enacted an Any Willing Provider Law covers all health providers and PPOs
Washington	§ 48.44.290	Benefits shall not be denied under such contract for any health care service performed by a holder of a license for registered nursing practice or advanced registered nursing practice.
West Virginia	§ 33-15-4b (individual) § 33-16-3e (group) § 33-24-7a (nonprofit)	Provides coverage for primary health care nursing services, if such services are currently being reimbursed when rendered by any other duly licensed health care practitioners.
Wyoming	§ 26-22-503(a)(1)	Enacted Any Willing Provider statute which covers all providers, all HMOs, and PPOs.

Opinion Attorney General No. 6567