

## HEALTH REFORM

# THE LATEST DEVELOPMENTS



Brian Rasmussen, PhD

In the September/October FTM, we looked at factors that private practice MFTs should consider in responding to the Affordable Care Act's (ACA) many changes in healthcare financing. This article will address recent developments and their effects on MFTs, and answer two more complex operational questions from MFT private practitioners.

### **Status of Marketplace (Exchange) Health Plans for Uninsured Persons**

On October 1, enrollment in these plans became open to all uninsured persons. All of these Exchanges (state-run in 14 states and the District of Columbia; federally-run in the remaining states) have encountered computer glitches, but because coverage doesn't start until January 1, 2014, there is time to correct at least some of those problems.

To help pay insurance premiums, uninsured persons in families with Modified Adjusted Gross Incomes (MAGI, as reported on 2012 Federal Income Tax forms) between 133% and 400% of the Federal Poverty Level are eligible for sliding-scale federal financial subsidies. (In 2014, for a family of 4 in the Lower 48 States, the subsidized MAGI range is \$31,332 to \$94,200 annually; higher in Alaska and Hawaii.)

The Obama Administration projects that 7 million persons will enroll in these plans by March 31, the last day on which enrollment for any period in 2014 is allowed. Although this figure is less than half of all eligible persons, the Administration projects that not all eligible people will enroll in 2014 due to a variety of factors. Enrollment is expected to increase in later years.

One or more insurers have been approved to offer Qualified Health Plans (QHPs) in each State's Marketplace (also known as the Exchange). These plans offer four basic levels of coverage—Bronze, Silver, Gold and Platinum. Bronze plans have the lowest premiums, but the highest enrollee cost-sharing, and vice-versa for Platinum plans. It's expected most enrollees will choose Bronze plans.

Blue Cross and Blue Shield companies are offering QHPs in virtually all states, with many fewer offered by commercial insurers such as Aetna, local health maintenance organizations, and non-profit cooperative (CO-OP) firms (see [www.aamft.org/HealthReformStatesDatabase](http://www.aamft.org/HealthReformStatesDatabase) to see details for your state). QHPs may operate on either a statewide or sub-state basis.

The law also requires the federal Office of Personnel Management (OPM) to establish two so-called "multi-state" or "national" Exchange plans. For now, it appears that in 2014 there will be at least one such plan in 31 states, operated by the Blue Cross Blue Shield system (see the previously-cited website for relevant states). These Blue Cross "multi-state" plans will have somewhat different details than the state-specific QHPs that Blue Cross also will run in most states.

In addition, for uninsured workers (and their family members) employed at firms with 50 or fewer full-time employees, special plans are available through ACA's Small Business Health Options Program (SHOP). Such employers who pay for at least part of SHOP plans' costs may be eligible for a federal tax credit of up to 50% of the

employer's payment. However, in some states, only one SHOP plan will be available in 2014, and in others, none will be available then.

### Exchange Plans Limit Choice of Hospitals and Private Practices, and Pose Bad-Debt Problems

As of this writing, provider network lists were not available for most QHPs. One reason for this is that all but Minnesota's Exchange website require applying for coverage before one has the opportunity to see each insurer's provider lists. Some Minnesota insurers offering QHPs, such as UCare, do include MFTs affiliated with local clinics. For other Minnesota insurers, the provider list does not specify if practitioners are MFTs versus other masters-minimum clinicians.

And it is difficult online to find Minnesota insurers' provider lists, meaning enrollees are very unlikely to choose a plan based on it including

a specific MFT. Indeed, the online Exchanges in nearly all states are structured to emphasize QHP premium and federal subsidy amounts, supporting the widespread prediction that most enrollees will choose based on low price. Lowest-priced (Bronze) plans have very high deductibles (typically \$2,500 to \$6,300 for an individual) and client cost-sharing (typically 50% or higher). This could well create substantial bad debts for providers.

Under a federal regulation (45 CFR § 156.230), provider lists are supposed to be available to the public, but that rule does not address exactly when this is required. Although most QHPs did not have provider lists available at deadline, news articles based on provider self-reports indicate many plans have "narrow" (very limited) networks. For example:

- In Missouri, Anthem Blue Cross,

which covers the state except for the Kansas City area, excludes at least 13 hospitals from its QHPs.

- Of New Hampshire's 30 hospitals, at least 10 are excluded from Exchange plans.
- In Illinois, Indiana and New York, multiple large hospitals are excluded from one or more QHPs in each state.

Hospitals account for a large share of total health spending, so "wholesale pricing" by excluding some from Exchange plans is economically obvious. MFTs at QHP-contracted hospitals may see more clients; MFTs at other hospitals may well see fewer (because some consumers with employment-based coverage will be transitioned to Exchange coverage, thus current managed-care contracts will yield fewer clients).

ACA also cuts Medicare and Medicaid pay rates for acute-care hospitals by \$155 billion over 10 years. (The hospital



**POST. INTERVIEW. HIRE.**  
*It really is that simple...*

Post your jobs with the AAMFT Job Connection and tap into a concentrated talent pool of marriage and family therapist professionals at a fraction of the cost of commercial boards and newspapers.

**> Find Talent First at the AAMFT Job Connection**

- + Search a database of highly qualified resumes
- + Set the skills criteria and let the resumes come to you
- + Complete an Employer Profile - promote your company's culture, benefits, and why it's a great place to work
- + Save and manage applicants and resumes

Visit [JOBCONNECTION.AAMFT.ORG](http://JOBCONNECTION.AAMFT.ORG)  
to attract top talent!



industry accepted this cut on the premise it would be offset by revenue from new Medicaid and Exchange enrollees, but that offset won't happen in many cases.) These pay cuts may cause hospital-based MFTs to be required to "do more with less."

And as QHP-excluded hospitals are highly visible in their local communities, their exclusion implies that small clinical offices, such as those of most private-practice MFTs, also have been excluded.

### **Potential Remedies When Private-Practice MFTs Are Excluded from QHP Provider Networks**

An insurer offering QHPs may use one or more of its existing (employer-sponsored plan) provider networks, but more likely has a network with fewer providers. This raises the issue of what private practice MFTs can do if they are turned down for QHP network participation.

Unfortunately, the law offers few options. ACA Section 2706 states that QHP insurers may not discriminate against any class of practitioner. But the Obama Administration has decided not to issue any regulations to enforce this provision because "that provision is self-enforcing." AAMFT has protested this lack of regulations to federal officials. The Administration advises aggrieved practitioners to contact their state government's insurance agency to seek enforcement. However, some Republican-led states such as Texas have said their states will not be involved in enforcing any ACA provisions.

Despite this, there may be legal remedies, but their use will be challenging. Thirty-one states (see [www.aamft.org/state\\_awp](http://www.aamft.org/state_awp)) have rules requiring state-regulated insurance plans not to discriminate against MFTs by practitioner type ("vendorship"), or to allow any willing provider (AWP)—including MFTs—to contract, or both. However, the legal applicability

of these rules to QHPs is unknown because it is unclear if federal law will override any relevant state rules.

As a result, it likely will be necessary to establish precedents through litigation ("case law"), a costly and time-consuming process. On the one hand, a favorable decision about including chiropractors or physical therapists likely will be a good precedent for MFTs. On the other hand, the delay until such cases are decided could result in a private MFT practice being forced to close, due to lack of QHP contracts, coupled with insurers' reduced payment rates for other clients. It also is unclear whether a favorable decision in one state would be legally relevant to others.

Yet there may be additional legal options. For example, Washington State requires QHPs to treat all mental health and substance-use providers as Essential Community Providers, meaning those who have preferential status for contracting purposes.

### **Status of Medicaid Expansion**

About half the states have chosen not to expand Medicaid in 2014 (see [www.aamft.org/HealthReformStatesDatabase](http://www.aamft.org/HealthReformStatesDatabase)), and three (Arkansas, Iowa, and Pennsylvania) will, or are expected to, expand Medicaid under special "waiver" authority by enrolling their "Medicaid expansion" residents into the relevant state's exchange system. In states that do not expand Medicaid, the law's Individual Mandate that uninsured persons either obtain coverage or pay a fine will not apply to "Medicaid expansion" residents.

Because private MFTs are Medicaid-eligible in only about half the states (often with restrictive requirements), and Medicaid programs generally have low payment rates, Medicaid expansion will be less relevant than Exchanges for most private MFTs.

## **Q&A**

**Q1:** I'm a solo private practitioner who speaks only English. Can Medicaid or Exchange plans bar me from contracting due to this, and if I am referred a client who's not fluent in English, must I treat that client and pay for translation services during sessions? If I use an interpreter, what about confidentiality? What if a non-English-speaking family member is involved in a treatment session?

**A:** An estimated 42% of persons who will enroll in ACA's Medicaid and Exchange plans regularly speak a language other than English, including 39% who speak Spanish. But some of these people also are fluent in English. ACA Section 1557 specifies that ACA-funded healthcare entities may not discriminate based on factors such as race or ethnicity, and this includes "limited English proficiency" (LEP). Providers are required to take "reasonable steps" to comply, and because of situational considerations, further guidance is available at <http://www.hhs.gov/ocr/civilrights/resources/laws/revisedlep.html> and <http://www.lep.gov/>. For example, some LEP persons can speak basic English, while others cannot.

If you are denied an Exchange plan contract, the plan is not required to state the reason(s), and even if lack of fluency in another language were the cause, that may be considered appropriate in view of the need for some therapists who speak languages other than English.

On the other hand, many private insurers address language barriers by having contracted providers list their fluency in non-English language(s), so that clients fluent in such languages may self-select those practitioners from the insurer's provider directory. For those insurers, practitioners' fluency in other languages is an asset, but not

a requirement. In some cases, your provider contract may allow you to decline clients who are LEP.

Although the AAMFT Code of Ethics does not address the use of interpreters specifically, you can look to Subprinciples 1.1, 1.2, 1.12, 2.1 and 2.2 for guidance on issues related to non-discrimination, informed consent and confidentiality. For further guidance on working with LEP persons and interpreters, you can refer back to the links provided earlier in this section or members can contact AAMFT for a legal/ethics consult at 703-838-9808 or [ethics@aamft.org](mailto:ethics@aamft.org).

Also be aware that some states, such as California, require all licensed healthcare providers to meet LEP-client standards beyond those of ACA.

**Q2:** I'm a solo private practitioner, and my state's private insurance market is dominated by one insurer. I'm already contracted in this insurer's provider panels for its private plans. The insurer will permit (not require) me to contract with its Exchange plans, the only such plans that will operate in my state, but, the insurer will reduce my payment rates for all its enrollees. It justifies those rate cuts because I might get additional clients from its Exchange enrollees if I contract for those plans. Even if I decline the Exchange plans, the insurer will nonetheless cut my pay rates for its private plans. I don't think I can stay in operation under the lowered pay rates, even if I do sign with the Exchange plans and obtain more clients up to my scheduling capacity. What can I do?

**A:** This insurer is not forcing you to contract with its Exchange plans in order to stay on its private plan panels, so that would not seem an unlawful "tying arrangement." Unless an insurer is guilty of such anti-

competitive actions, it can reduce pay rates at any time and to any levels that are permissible under its provider contracts and any other applicable legal constraints.

If you sign with the Exchange plans, you likely will obtain added clients, whose payments would partly offset the overall pay-rate cuts, though you would need to work more hours. You should weigh at least two scenarios to see if that might work financially.

For example, assume you are willing to work 10 additional one-hour sessions per week. You already have been told the insurer's average allowed payment for each such session (e.g., \$X for CPT 90837, "Psychotherapy, 60 minutes with patient and/or family member"). Now, assume exchange clients would fill either 4 or 8 of those 10 sessions. You then find that your gross additional allowed payments likely would be somewhere between four and eight times \$X. From that amount, now subtract your usual bad-debt write-off factor for some clients who don't remit their copayments, and you derive an expected range of additional weekly income. Is it enough to offset the weekly income lost from the lower rates under your existing contracts?

Another option is for you to document to the insurer's provider relations staff why you are particularly valuable. Among possible reasons are that you:

- serve a rural locale lacking nearby therapists (check the insurer's provider directories);
- offer specialized services such as pediatric behavioral therapy; and
- document that your clinical practice patterns and/or client satisfaction are very good. For instance, in the past year, what was the average number of visits for your clients with anxiety disorders, and is that lower than national or local norms? Insurers have wide discretion in

choosing providers, and such factors can result in a special exception.

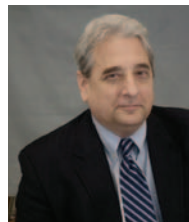
There also is strength in numbers. Some therapists may adapt to health reform by merging into group practices. Others may set up provider-run multi-therapist networks in order to bargain collectively with insurers. Still others may choose to become employed by a larger entity such as a hospital, where there is no need to struggle with financial issues. All of these approaches are increasing among physicians and other non-physician practitioners

### Outlook

In 2014, many questions about the law will begin to be answered. The most important of these questions is: will younger and healthier people enroll in numbers sufficient to cross-subsidize older and sicker enrollees, as the law requires? If a sufficient number of younger and healthier people don't enroll, insurers will lose money, likely drop their Exchange plans, and the entire system could collapse.

In 2015, additional parts of the law are scheduled to start, notably the availability in the Exchanges of low-cost "basic" plans for certain young or very low-income persons, and of SHOP plans in those states lacking them in 2014.

Health reform will continue to be a work in progress for years, and only over time will all its outcomes become clear. Good luck, and inform AAMFT of any good or bad experiences at [advocacy@aamft.org](mailto:advocacy@aamft.org). Look for updates in future issues of FTM.



**Brian Rasmussen, PhD,** is the government affairs manager at AAMFT.