In the last FTM, we outlined how the federal Affordable Care Act (also called Obamacare) is expected to work, and summarized ways in which it may affect MFTs in a variety of practice settings. This article will provide more specifics on how private-practice MFTs will be affected.

For private practitioners, here are the eight key questions you should answer:

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**1.** Does your practice either routinely have at least a 10% rate of unfilled appointments, or are you willing to expand your appointment hours by at least 10%?

IF YES TO EITHER, then your practice likely could take on added clients who will be newly insured under Medicaid and/or Exchange (also called Marketplace) programs. (The 10% figure is used because nationally about 10% more people will gain insurance.)

IF NO, your practice probably is unsuited to taking on these new clients now, but as the reform law affects the entire healthcare financing system, you should re-evaluate your situation at least annually.

**2.** Where is your practice located?

As a general rule, states on the West Coast and in the Northeast will expand Medicaid and run their own Exchange (Marketplace) programs, while Southern and Great Plains States will not. Midwestern States are split. This distinction is generally due to having Democratic versus Republican state leaders making these choices. Yet, even among states in the same region, there will be administrative differences in their Exchange programs.

Despite these administrative differences, all states will have Exchange health insurance plans (called Qualified Health Plans, QHPs), but only half will expand Medicaid. BECAUSE EACH STATE WILL VARY FROM ALL OTHERS, AAMFT HAS DEVELOPED A STATE-BY-STATE DATABASE (available to members only at www.aamft.org/HealthReformStatesDatabase) TO OUTLINE YOU PARTICULAR STATE’S PLANS.

If your practice is located near a state boundary (such as in the tri-state New York City area), some potential clients may live in an adjoining state, but find it convenient to visit your practice (e.g., because they work nearby).

While this is seldom a problem under current health plans, it is unknown how the Exchange and expanded Medicaid programs will address this situation.

**3.** Is your state expanding its Medicaid program?

IF YES TO THIS AND TO QUESTION 1, AND YOUR STATE COVERS PRIVATE PRACTICE MFTS UNDER MEDICAID (see www.aamft.org/HealthReformStatesDatabase), then you should consider becoming a Medicaid provider if you are not already. However, be aware that Medicaid pay rates generally are lower than for other payers, and that most Medicaid clients will be subject to managed care rules, including selective provider contracting. So, you likely would need to be a Medicaid provider panel member.

Yet, because Medicaid clients must have low incomes, serving them has a pro bono element.

IF NO, you likely need do nothing about Medicaid. However, analysts expect an enrollment increase in “regular” Medicaid programs, as outreach efforts identify some people who are already eligible but not Medicaid-enrolled. In non-expanding states that cover private MFTs, there could be new clients who will have very low incomes.
Are you already in multiple private-payer provider networks, especially for Blue Cross and Blue Shield plans?

If you said Yes to Question 1, and are already in multiple private-payer provider networks, especially for Blue Cross and Blue Shield plans, you might expect no effects. But some clients of these types will face changes.

What if my practice is located in a rural or inner-city area? Lack of insurance is more widespread in those locales, as are shortages of behavioral and other healthcare practitioners. If you practice in such an area, you are more likely to see large effects than will private MFTs in suburban locales.

On the one hand, it should be easier to participate in managed-care provider panels, and you should gain more new clients. Though, these new clients’ payments will likely be lower than those for existing clients.

What if my practice has mainly self-pay and/or employer-based insurance clients? Because self-pay clients pay cash, and employer-covered clients already have health plans, you might expect no effects. But some clients of these types will face changes.

A few self-pay clients will gain Exchange coverage, and some employer-covered clients will be transferred to Exchange plans. Other clients—those in lower-paying jobs such as at restaurants, retail stores, and local government—may have their hours cut to under 30 per week, to avoid the law’s coverage mandate applicable to employers with at least 50 full-time staff. Regardless of these specifics, such clients will be less willing or able to pay for all or much of an MFT treatment in cash.

The law also reduces the tax-favored treatment of healthcare expenses that are unreimbursed by insurance, such as costs covered under a Flexible Spending Account (FSA). Previously, people could use an unlimited amount of pre-tax FSA funds to pay for such costs, and also could deduct any unreimbursed costs exceeding 7.5% of their Adjusted Gross Income (AGI). Effective this year, the law limits FSA health funds to $2,500, and raises the Medical Expense deduction threshold to 10% of AGI.

While tax changes will not affect initiation of treatment, some clients may drop out once their annual FSA limit for all unrecovered health costs (including MFT services) is met. There is anecdotal data that “elected” treatments such as most dental and Lasik services have already been reduced by these changes. Clients with several chronic health conditions (typically between 50 and 64 years old) are most likely to be affected.

What if I have a specialty practice such as pediatrics? Most children in low-income families already are covered, either under Medicaid or your state’s version of the Children’s Health Insurance Program (CHIP). While kids will comprise some Exchange plan enrollees, they won’t predominate.

Perhaps the most affected specialty will be substance abuse disorder (SAD). Current health plans’ coverage of SAD is less extensive than for non-SAD mental health, so SAD network providers are relatively few. Because the law requires SAD coverage on the same basis as for physical (and other mental) health conditions, there should be relatively high demand for new SAD network practitioners. However, because SAD is often treated by Substance Abuse Counselors (with their own credentialed system) rather than traditional “mental health” practitioners, the mix of plan networks’ professions (e.g., MFTs vs. SA counselors) is uncertain.

In the next article in our series, coming in the November/December issue, we will update you on the latest developments, especially the launch of Exchange plans on October 1. To stay current on the situation in your state, visit www.aamft.org/HealthReformStatesDatabase often. We welcome members’ reports about your experiences, which may be submitted to advocacy@aamft.org.

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