The Basics of HEALTHCARE REFORM

>>> How will healthcare financing reform under the federal Affordable Care Act (ACA) affect you as an MFT?

Brian Rasmussen, PhD

>>> Most of the Affordable Care Act (ACA) will not go into effect until January 2014, so many details are not yet known. However, some general points are provided in this overview.

If you are a private-practice MFT, you may be able to treat additional, newly-insured clients, but only under certain conditions. In all states, uninsured people with modest incomes (those between 100 to 400 percent of the Federal Poverty Level, detailed on page 7), will be eligible for health insurance plans through the new Exchange system, also known as Marketplaces.

These people will get federal financial subsidies to choose among at least four types of plans (Bronze, Silver, Gold, Platinum), each of which will be offered by one or more insurers such as Blue Cross. To be covered for treating Exchange enrollees, you likely will need to be already contracted with at least one of the relevant insurer's existing provider networks.

The Exchange plans will vary in their enrollee costs for premiums and copayments, with Bronze plans having the lowest premiums, but highest copays, and Platinum plans having the opposite. Research suggests that most enrollees will choose Bronze plans, meaning many of these clients' copayments could be 50 percent or more of allowed fees. So collecting balances due from those clients will be challenging.

If you practice in a state that covers private MFTs under Medicaid, you probably will be able to treat newly-covered Medicaid recipients if your state is among those opting to expand its Medicaid program to all uninsured persons with incomes of 133 percent of the poverty level or lower. About half the states will expand Medicaid. As with the Exchange plans, most newly-covered Medicaid recipients will be in managed-care organizations that require provider network contracting.

Because both Exchange and Medicaid plans will create additional clinical service volume for contracted providers, the managed-care insurers that set up those plans will likely reduce their current payment rates, at least for these new clients. If a provider declines to accept lower pay rates, the plan might drop that provider for all its enrollees, including those with employer-sponsored coverage.

If you treat mainly self-pay clients, at first you shouldn't see much effect. But some of those clients will become eligible for Exchange plans. For other self-pay clients, ACA makes tax changes that will make it more expensive to pay out-of-pocket. For instance, people with healthcare Flexible Spending Accounts may now designate only $2,500 annually tax-free for all healthcare costs not covered by insurance. Although these changes are unlikely to deter clients from starting treatment, they may lead to clients dropping out before maximum clinical gains have occurred.

If you are an MFT employed in a healthcare facility or clinical office, your facility will handle arrangements with the Exchange and Medicaid systems in your state. If you work at a hospital or office in a low-income locale, your facility probably will start treating more people with behavioral problems, as those who will be newly covered have relatively high rates of such maladies.

For instance, when Wisconsin expanded Medicaid eligibility to uninsured low-income childless adults, that group had three times the rate of substance abuse and 1.5 times the rate of depression of the regular Medicaid population. Once these childless adults became Medicaid-covered, they had a 1,024 percent increase in mental health visits. You may be directed to treat more clients without proportionately more staff.

On the other hand, if your facility is in a suburban area, you should see less impact. Yet, as the law also cuts hospitals' Medicare pay rates, there could be a financial "trickle down" effect that hinders employing adequate numbers of staff across clinical departments.

Background on the law

In 2010, Democrats in Congress passed the Affordable Care Act (ACA) with zero Republican votes. The law sets up two new systems to cover uninsured citizens: Medicaid expansion and Exchange.

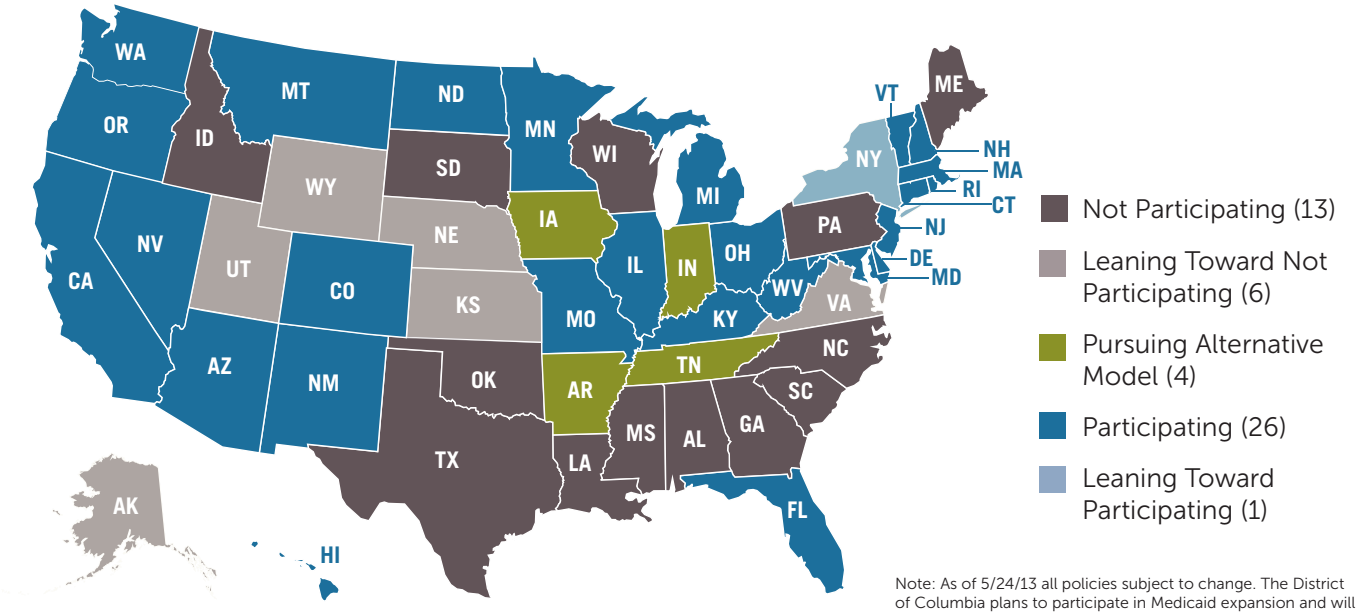
Medicaid expansion. At present, each state sets its own income eligibility for Medicaid, a program paid jointly by the state and the federal government. For instance, New York covers uninsured families with a parent and one or more children when the family has an Adjusted Gross Income up to 133 percent of the Federal Poverty Level (e. g., $31,332 for a family of four). Texas covers such families with incomes up to 73 percent of poverty (e.g. $17,191.50 for a family of four). ACA expands Medicaid to cover all uninsured persons up to 133 percent of poverty.

In 2012, the Supreme Court ruled 5-4 that this expansion must be at state option. As of this writing, 22 states and the District of Columbia planned to expand Medicaid, and four more states leaned toward expansion. If all states expanded Medicaid, it would cover 16 million more persons. Because some states with large uninsured populations will not expand Medicaid, it is projected to cover only 9 million more persons by the end of 2014.

Exchange (Marketplaces) plans. The second new system is the Exchange, also known as Marketplaces. All uninsured persons in families with incomes between 133 to 400 percent of poverty (400 percent = $94,200 for a family of four) are eligible for sliding-scale federal subsidies to buy healthcare coverage through this system.

The law gives states three main options to implement the Exchange system: A *state-run* program, a

Medicaid Expansion: Where the States Stand *as of May 24, 2013*



Note: As of 5/24/13 all policies subject to change. The District of Columbia plans to participate in Medicaid expansion and will operate its own exchange.

partnership program, run jointly by the state and federal government, and a *federally-run* program with no state involvement, also known as a *Federally Facilitated Exchange* (FFE).

In general, states with Democratic elected leaders (e.g., New York) will expand Medicaid and operate their own state exchanges, while the opposite will occur for states with Republican elected leaders (e.g., Texas).

Early information shows that most of the Medicaid-expansion and Exchange enrollees will be in coverage plans run by private insurers using managed-care methods, notably selective contracting with healthcare providers. As of July 2013, Blue Cross plans expected to offer Exchange products in virtually all states except Mississippi. Aetna planned to do so in 14 States, UnitedHealthcare in 12 States, and CIGNA in only five states.

Unresolved implementation issues

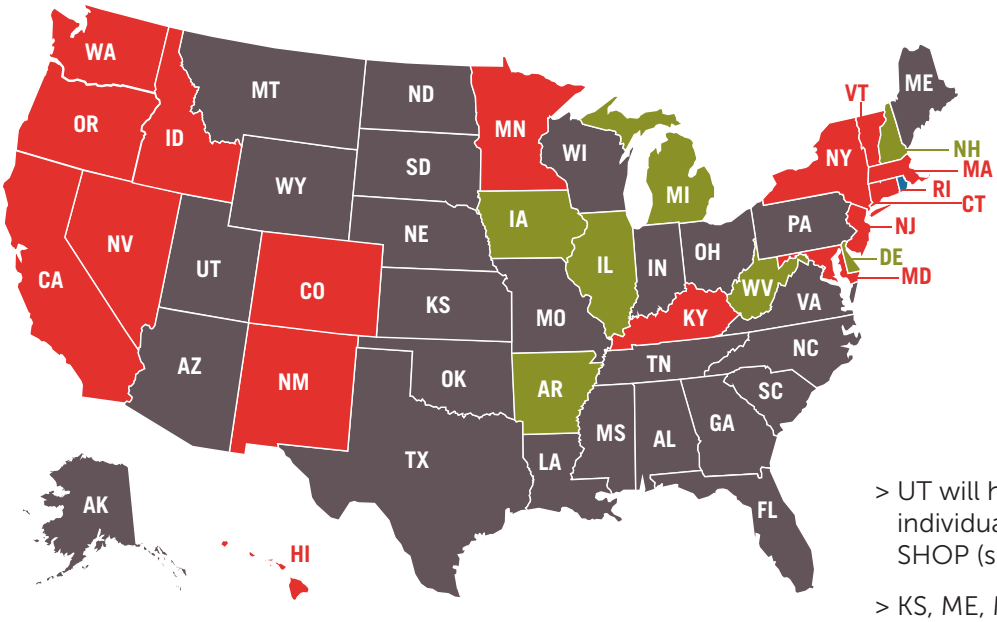
Enrollment in exchange plans will run from October 1 through December 15, and coverage will begin January 1, 2014. States may begin Medicaid-expansion enrollment and coverage at any time in 2013-14, and they may later elect to participate (or not) each calendar year. However, some important implementation issues are not yet resolved.

All Exchange plans must cover 10 categories of "essential" clinical services. These include services for mental health and substance use, which must be covered "at parity," on the same basis as for physical health services. A plan may not have higher client cost-sharing for a mental health visit than for a physical health one. Likewise, a plan may not have a $5,000 mental health deductible, but only a $1,000 physical health deductible. AAMFT strongly supports this parity provision.

But the federal government has not issued rules defining other aspects of parity. For instance, it is unknown if parity means a plan must cover all drugs approved to treat schizophrenia, or simply one such drug. This is a problem because different clients respond differently to various treatments.

In addition, the law lacks strong rules requiring plans to accept all

State, Partnership, or Federal Health Insurance Exchange: Where the States Stand *as of May 24, 2013*



- 16 states and D.C. have been conditionally approved for a state-based exchange
- 7 states conditionally approved for a partnership exchange
- 27 states will have a federal exchange

> UT will have a federally facilitated individual exchange and a state-run SHOP (small group option program)

> KS, ME, MT, NE, OH, SD and VA will take on additional plan management functions in a "Marketplace Plan Management" model

Sources: State Refor(u)m Exchange Governance Chart
http://statereforum.org/exchange-governance-chart

State Refor(u)m Exchange Blueprint Chart
http://statereforum.org/exchange-blueprint-chart

State Refor(u)m Exchange Policy Decisions Chart
http://statereforum.org/exchange-policy-decisions-chart

willing providers as part of plans' networks. That occurred despite the efforts of AAMFT and many other provider associations.

About 16 million now-uninsured Americans will be eligible for Exchange subsidies, and another 15 million would be eligible for Medicaid if all states expanded that program. Of these 31 million, 12 million speak Spanish. Because several states initially have decided not to expand Medicaid, the actual number of new Medicaid recipients in 2014 will be substantially less than 15 million.

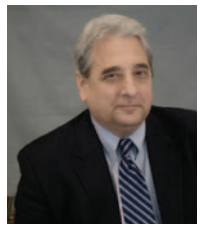
At present, many other details of ACA implementation are unknown. The two most important issues to consider are the extents to which:

- private MFTs will be allowed to, and actually will, participate in the new plans, and
- eligible uninsured people will actually enroll in Exchange plans.

Most newly-eligible Medicaid recipients will enroll because there is no enrollment cost to them. Exchange plan enrollment is uncertain because enrollees at higher income levels will face substantial premiums and other out-of-pocket costs. The law sets a fine for most people who are Exchange-eligible but don't enroll. But in 2014, that will be merely the higher of $95 or one percent of Adjusted Gross Income (e.g., $300 for an Adjusted Gross Income of $30,000). The fine will gradually increase in later years.

Although eligible people who are old or sick are likely to enroll in the Exchanges, if many young people don't enroll, that would create financial losses for insurers because by law, premiums of the young must cross-subsidize those of the older and sicker. If that happened, some insurers would drop their plans in 2015.

In the next issue of FTM, we will cover special cases and new developments.



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

AAMFT members may visit **www.aamft.org/HealthReformStatesDatabase** to find information about their state's situation.