Advocacy Update

Health Reform Law Poses Opportunities and Challenges for MFTs

On March 23, President Obama signed into law the 2,409-page narrowly-passed health reform bill, the Patient Protection and Affordable Care Act (P-PACA, HR 3590 as amended). Thus this bill became Public Law 111-148.

The new law makes sweeping—though phased-in—changes to our entire healthcare financing system. Some of these changes will affect clinical treatment patterns. As detailed below, some MFTs and their clients will gain, while others will lose.

Thus, the AAMFT was officially neutral on the bill as enacted. The AAMFT notes that, as with Medicare MFT coverage, several other mental health provisions passed in 2009 by the House of Representatives, including Medicare LPC coverage and Social Workers’ billing of Medicare for services in Skilled Nursing Facilities, also were not included in the final bill that became law.

In general, MFTs practicing in underserved rural or inner-city areas will gain; those who rely on privately-insured or self-pay revenues may well see problems. Many providers also will face administrative problems from the law’s Medicaid expansion and new “Exchange” health plans to cover 32 million now uninsured people. Third-party payers will increase use of “medical review” and “practice parameters,” thus shaping clinical treatments, but there will be no Death Panels. As most provisions will not begin until 2014, MFTs will have some time to respond in their economic and clinical operations.

Congress has already made changes to the Reform law, such as removing some of its “sweetheart deals” and delaying the law’s taxation of higher-cost health insurance plans, through a process called a Budget Reconciliation “fix” bill (HR 4872). Thirteen states also have filed lawsuits alleging the law is unconstitutional, mainly due to its requirement that nearly all Americans must obtain health insurance coverage (an “individual mandate”).

It is highly unlikely the law will be overturned in court, and its eventual effects will be akin to “managed care on steroids.” Most economic and clinical changes will not be immediate. Managed care took nearly 40 years to go from curiosity to dominant market force, but most of the new law’s major effects will occur in four to eight years.

Like managed care, the Reform law will yield winners and losers among consumers, healthcare economic sub-sectors, and individual practitioners. This diverse impact is because Reform is about income redistribution. For instance, some consumers will benefit; others will lose. There will even be winners and losers within segments of affected groups, such as an increase in Medicare prescription benefits but cuts in benefits for those enrolled in Medicare managed-care plans.

Millions of Americans also will lose financially by owing more taxes, but Reform proponents argue increased taxes will be counterbalanced by minimizing already-insured people’s private health costs for uncompensated care, which are widely “cross-subsidized” by providers charging more to insured people, to offset their losses on the uninsured.

There is a clear need for Reform. Many of the uninsured truly cannot afford health coverage, causing both clinical and economic problems. Though most Americans already have private or public insurance, it often has gaps, most notably in private plans’ excluding coverage of pre-existing conditions and imposing lifetime dollar caps on benefits. And as health costs continue to rise at three times overall inflation, with a rapidly aging population promising more of the same, health expenses of consumers, the private sector, and federal and state governments are out of control.

The problems are clear, but debate continues on whether the Reform law is a good solution. An example shows why the argument is not settled.

Consider three families of four living in St. Louis in 2014, when most uninsured people start to get coverage. The first family is uninsured, with a $20,000 income. They will be enrolled in Medicaid. But
Missouri Medicaid doesn’t cover MFT services, and pays low rates for services it does cover, so many providers do not accept Medicaid enrollees. This family will gain coverage, but still may have problems accessing providers.

The second family also is uninsured. Both parents work for small employers that do not have health plans, but the family’s wages total $85,000. This family will receive a federal financial subsidy to buy one of the new private Exchange plans that will operate in their area. No one knows what any of these plans will cover beyond the law’s mandates such as “basic” mental health, physician, and acute-care hospital services. Likewise, each plan’s future provider panel is unknown, even whether any private practice MFTs will be included. So, this family also gains a basic level of coverage, but that coverage may also have gaps and access problems.

The third family also makes $85,000, but the mother already has a comprehensive health plan through her job at a large firm. This family gets no subsidy, and the mother’s higher cost health plan may be subject to a new tax in 2018. That tax either would be “passed through” as an increased premium or result in her plan reducing benefits (and thus premium costs) in order to stay under the new law’s tax threshold.

Few would argue against the uninsured $20,000 family getting Medicaid. But many would wonder about subsidizing the uninsured $85,000 family, especially when the cost will be paid largely by cutting Medicare reimbursement rates to institutional providers and also by people like the third family that is already insured. Such are the many issues of policy and implementation in the Reform law.

Reform Positives

- Starting in 2014, 32 million now-uninsured Americans will receive some healthcare coverage, half through a national expansion of Medicaid eligibility (to 133% of Federal Poverty Level), and half through federal financial subsidies to enroll in the new Exchange plans for those with incomes higher than Medicaid eligibility (up to $88,200 for a family of four).

- The Exchange plans must have basic behavioral health (mental and substance use) benefits that generally must be equivalent to the plan’s physical health benefits (so called Mental Health Parity).

- Beginning in late 2010, there is a phased in (by age group) prohibition of private plans’ use of pre-existing condition exclusions and a prohibition on lifetime dollar benefit limits.

- $140 million is authorized (but must later be separately approved by Congress) for increasing the number of mental health professionals (e.g., student financial support). Similar added funds are authorized for training primary care physicians, nurses, and public health professionals.

- Starting in 2010, parents may keep a child enrolled on the parent’s private health plan until age 26 (not ending earlier, as at present).

- The law provides several means for small businesses to more easily afford coverage, such as tax credits for certain small businesses that newly provide coverage to their staffs.

- Medicare will increase coverage of prescription drugs and will fully cover certain preventive services.

Reform Negatives

- The Reform law lacks Medicare coverage for independent practice MFTs, despite the original House-passed version including this provision.

- There is no guarantee that any of the 32 million new enrollees in Medicaid and the Exchange plans will have access to MFT services, because the law does not mandate such coverage, let alone that any willing MFT provider will be permitted to contract, even if the MFT is agreeable to the plan’s payment rates and other rules.
As noted earlier, $140 million is authorized to financially support an increase in the number of behavioral healthcare practitioners. But $100 million would be earmarked for psychology, social work, and paraprofessionals; MFTs and all other behavioral health practitioner types would be specifically eligible for only the remaining $40 million. Although such funding is better than nothing, future Congresses will be required to actually provide this funding. Even if full funding occurs, it would be far short of addressing the current mental health practitioner shortages in rural and inner city locales. Broader access problems will grow as Baby Boomer therapists soon retire, while Medicare rolls soar and 32 million now uninsured persons obtain coverage.

The law imposes a new tax on higher cost private health plans, which would disproportionately reduce private plans’ coverage of MFT services starting in 2018. This will result in a disproportionate reduction in mental health benefits beyond the basic level required by “parity” provisions. It also is likely that, among mental health provider services, MFT service coverage will be disproportionately reduced, compared to better-known professions, such as psychology. These cuts may take the form of reduced coverage of “MFT services” and/or of fewer MFT clinical programs being allowed into plans’ provider panels.

The Reform statute increases the Medical Expense deduction threshold for non-elderly federal income taxpayers from current 7.5% of Adjusted Gross Income to 10%, which would reduce self-pay clients’ ability to afford MFT services. Simply put, because unreimbursed health services will now get less favorable tax treatment, consumers will obtain fewer services.

The law also reduces (to $2,500) employees’ maximum annual pre-tax income contributed to Flexible Spending Accounts for unreimbursed health services, likewise reducing clients’ ability to afford MFT health services. (Self-pay is an important revenue source for many MFTs.)

This P-PACA reform law cuts $550 billion over 10 years in Medicare payment rates to hospitals, Skilled Nursing Facilities (acute-care nursing homes and similar hospital units) and Home Health Agencies, as well as Medicare payments to managed care plans (thus reducing plan enrollees’ “enhanced” benefits). This will have a negative impact, though indirect, on these entities’ clinical staffing, and some of these entities may cease operations. P-PACA also establishes an appointed commission that would effectively set future Medicare payment rates, thus reducing providers’ ability to gain relief from Congress for inappropriately low payments.

In summary, throughout the Reform debate, the AAMFT’s guiding principle was “First, do no harm.” While there are good aspects to the new law, there also are provisions that may well harm some MFTs and clients. While no one MFT clinical organization (e.g., hospital or private practice setting) is identical to any other, Reform’s effects on a particular organization will depend on three factors:

1. The clinical program’s current financial and market positions. Entities in rural and inner-city locales likely will benefit, while those in wealthy suburbs may see negative effects. Larger clinical entities that have thrived under managed care will fare better than small private practices, which will find it difficult to participate with the new Exchange plans. Clinics in states where Medicaid programs already cover MFTs will have more potential clients, but resulting reimbursements may be very low.

2. The clinical program’s managerial ability to adapt rapidly. For example, all programs will need to address practical matters such as new, idiosyncratic rules imposed by each of their contracted Exchange plans. Similarly, if the clinic does not currently participate in any managed care provider panels, it will be well behind the learning curve in seeking Exchange plan contracts.

3. The clinical program’s ability to demonstrate efficacy and to offer desired specialty services. Today, a clinic’s ability to compile statistics such as average treatments per episode by diagnostic category is no longer a luxury. Similarly, a clinic’s that provides services not otherwise widely available may gain a competitive edge with Exchange plans. For instance, a program that specializes in treating children may have a market niche not available to another facility that “does everything” but specializes in nothing.

Reform will follow an uncharted course, but MFTs can see gains if circumstances and planning work in their favor. While there will undoubtedly be some future changes to the law, you should start considering
Division Advocacy

Hawaii
In January, the MFT profession in Hawaii faced a very serious challenge. The Hawaii Association for Marriage and Family Therapy (HAMFT) discovered a bill was filed in the Hawaii House of Representatives that sought to eliminate licensure for several professions, including MFT. HAMFT immediately sought advice and assistance from the AAMFT and both organizations worked collaboratively to defeat this threat to the profession. Lobbyist Alexander Santiago, who had worked with the HAMFT in its successful effort to obtain vendorship for MFTs, was again hired to represent the profession in fighting this legislation.

A legislative strategy was implemented and Santiago made contact with legislators. The House Finance Committee was scheduled to hear public testimony concerning HB 2029 on February 19. In preparation for this hearing, the HAMFT mobilized its membership by encouraging members to write letters of opposition to the bill and to attend the hearing. This strategy was very successful. Over 100 HAMFT supporters wrote letters of opposition, and a letter written by HAMFT president, Paul D. Kai Swigart, was also submitted. Additionally, supporters of MFT licensure in Hawaii, such as the Hawaii State Department of Health, the Hawaii Medical Service Association, and the National Association of Social Workers–Hawaii Chapter, wrote letters opposing this effort to eliminate MFT licensure.

Over 25 HAMFT members attended the hearing held by the House Finance Committee. During the hearing, the vice chair of the committee asked all attendees opposed to the elimination of MFT licensure to stand up. All attendees, including attendees representing other provider groups, also stood up. When the vice chair asked for supporters of the termination of MFT licensure to stand up, no one stood in support.

A few days after the hearing, the House Finance Committee decided to indefinitely defer HB 2029. Meaning, this legislation is essentially dead for the 2010 legislative session. The HAMFT Board of Directors and other HAMFT leaders did a great job in mobilizing opposition to this legislation. The letters of opposition from HAMFT members and members’ attendance at the hearing were important factors in the defeat.

Missouri
The Missouri Division is working on legislation that would provide licensure for associate MFTs. House Bill 2226 is the MFT provisional licensure bill. This legislation passed the House on March 31. The Missouri Senate will now consider this important legislation.

Mississippi
The Mississippi Division was successful in its efforts to pass legislation that will allow MFTs to perform covered services that are authorized under state law. House Bill 947 states that if a state law or policy authorizes or allows licensed clinical social workers to perform services, then these services may also be performed by licensed MFTs. This legislation was signed by the governor on March 15. Congratulations to the division on this important accomplishment!

Nebraska
In July 2009, the Nebraska Medicaid agency decided not to reimburse associate MFTs and other provisionally licensed mental health practitioners. Due in large part to pressure by the Nebraska division, the Nebraska Medicaid agency agreed, effective in March, to reopen reimbursement for provisionally licensed MFTs and other providers who work in all but three counties in Nebraska. Congratulations to the Nebraska division for its successful advocacy on behalf of its associate members!

Pennsylvania
The Pennsylvania division is supporting a bill, House Bill 1250, which would provide practice protection for MFTs. This legislation would prohibit individuals from practicing marriage and family therapy, unless they fall within a specified exemption. HB 1250 makes some other changes to the MFT licensure law. On March 9, HB 1250 passed the House. The bill now goes to the Senate for consideration.

Tennessee
The Tennessee division has been working on legislation that would provide vendorship (freedom of choice) for MFTs. The division filed vendorship bills in both chambers of the legislature. The legislation will allow MFTs to be recognized by insurance companies as eligible providers. On March 17, the vendorship bill unanimously passed the Senate. On March 25, the legislation unanimously passed the House. The bill has been presented to the governor for his signature.

Washington
The Washington division was successful in removing provisions harmful to the profession from two bills. One bill, House Bill 2617, was introduced with language that would have eliminated the MFT board that advises the Washington state MFT regulatory agency. The division successfully lobbied the legislature to have the MFT advisory board removed from the list of committees that were to be terminated. The other bill, House Bill 3006, originally would have banned associate MFTs from working in a private practice setting. The division was successful in having the bill amended to allow associates to practice in a private practice setting with supervision. HB 3006 eventually died in committee. Congratulations to the division on its successful efforts in advocating for changes in these bills.

West Virginia
In 2009, West Virginia became the 49th state to license MFTs. Due to issues with some of the language in the 2009 licensure law, the West Virginia division sponsored legislation that would make some needed corrections to the law. House Bill 4133 passed the legislature and was signed by the governor on March 16. The division is working on House Bill 4108, which would allow the initial MFT rules to take effect. HB 4108 was passed by the House on February 24 and by the Senate on March 5. This bill has been sent to the governor for his approval.