# The Affordable Care Act and its Potential Impacts on Mental Health and Mental Health Professionals

by Sara Kashing, JD
Staff Attorney
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The Patient Protection and Affordable Care Act, otherwise known as the Affordable Care Act ("ACA") or "Obamacare," is a federal statute that was signed into law on March 23, 2010. Although some aspects of the law have already been implemented, the Act will not take full effect until January of 20151. Until then it is difficult to predict what the full impacts of the law will be. Government officials and stakeholders are hopeful, however, that the ACA will reform mental health services and create opportunities for mental health providers in the following ways:

The ACA gives Americans increased access to mental health care services and thereby creates larger client populations for mental health providers.

- The ACA identifies essential health benefits that all individual and small group plans, inside and outside of the health insurance marketplace, must cover.
- The ACA extends the reach of federal parity requirements for coverage of mental health.
- The ACA supports states' expansion of their Medicaid (aka Medi-Cal) programs.
- The ACA promotes the integration of primary health and behavioral health care.
- The ACA prohibits denials of health insurance coverage because of pre-existing conditions such as mental illness or substance abuse.
- The ACA requires health plans to cover preventative care at no cost.
- The ACA prohibits plans from instituting blanket policies that refuse to cover services provided by certain types of mental health professionals.
- The ACA seeks to support and grow the health care workforce.

This article discusses these potential impacts and what mental health professionals can do to prepare for the Act's implementation.

**Increased Access in Health Care including Mental Health Care**
The ACA was enacted to make healthcare more accessible to all Americans. Under the law, employers with more than 50 employees will be required to provide healthcare coverage to their employees. The coverage must pay for 60 percent of medical expenses and should not cost more than 9.5% of a family's income.2 Employers who do not provide healthcare or who have health

care plans that do not meet the standards, will pay a fine. This provision of the Act that had been slated to take affect on January 1st 2014 is being postponed until January 1, 2015 to give businesses more time to comply with the law.

As of October 1, 2013, Americans who are unable to access healthcare through their employers will have access through open health insurance marketplaces (aka health benefit exchanges). These exchanges, run by the states, are designed to pool consumer-buying power and give uninsured Americans new, affordable choices from private insurance plans that must compete for business based on cost and quality. California's health insurance marketplace is called Covered California. Uninsured workers began purchasing more affordable health insurance through Covered California in October. In the first year of operation, open enrollment on the exchanges continues for a six-month period from October 1, 2013 to March 31, 2014. Insurance plans purchased by December 15, 2013 will begin coverage on January 1, 2014. After the first year, open enrollment will start on October 1st and end on December 7th.

CAMFT has attempted to keep members informed about the development of California's health exchange by including information about Covered California in recent issues of The Therapist and by distributing information to CAMFT's Chapters.

For more information on California's health exchange, go to www.coveredca.com.

**The Essential Health Benefits Rule Ensures Coverage of Mental Health and Substance Abuse Disorder Services Under Certain Plans**

Under the ACA, a set of health care service categories called "essential health benefits" must be covered by health plans that are offered in individual and small group markets by January 1, 2014.3 The essential health benefits include items and services in the following 10 categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care

**Mental Health and substance abuse disorder services, including behavioral health treatment**

- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventative and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The U.S. Department of Health and Human Services (HHS) determined that it would allow states to select what it termed a "benchmark" plan from a list of options rather than set a single national standard for the packages. In December 2011, HHS issued guidance for state implementation of the essential health benefits.4 Thereafter, each state selected a plan that reflected the scope and

limits of services for the typical employer in the state. More than 30 states selected an insurance plan offered by Blue Cross and Blue Shield as the benchmark plan.

California selected the Kaiser Small Group HMO 30 plan as its benchmark plan. This selection is set forth in California Senate Bill (SB) 951 which was signed by Governor Brown on September 30, 2012. As of January 1, 2014, all small group and individual health insurance policies issued, amended or renewed in California must cover the health benefits covered by the benchmark Kaiser HMO 30 plan. This law applies to policies sold inside or outside of the California Exchange. SB 951 also bars insurers from making substitutions to the benefits that require coverage, even if those substitutions are actuarially equivalent.

In other words, health plans cannot refuse to cover mental health and substance abuse disorder services because those plans are providing coverage for another type of service that costs the same as the services for mental health and substance abuse. The only plans exempt from the requirement to cover benefits covered under the benchmark plan are grandfathered plans5, plans that provide excepted benefits (such as stand-alone dental or vision policies), insured plans of large employers (more than 50 employees6), and self-insured plans of any size. For information about California's benchmark plan, visit https://businessnet.kaiserpermanente.org/health/plans/ca/plans/smallbusiness?contentid=/html/plans/cal/small/ cal_copayment_hmo.html

**The ACA Expands Existing Federal Parity Laws to Better Ensure Equivalent Coverage of Mental Health Services**

The federal parity laws, known as the Mental Health Parity Act of 1996 and the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), were important first steps toward achieving parity for mental health services. The Mental Health Parity Act of 1996 requires parity in annual and aggregate lifetime limits.7 The MHPAEA requires insurers who cover mental health or substance abuse use disorders to provide equivalent levels of benefits for those services as they do for medical care.8 The mental health parity provisions in the ACA extend the applicability of the federal mental health requirements and mandate coverage of certain mental health services by specific plan types.

Under the ACA, new small group and individual plans are subject to the coverage mandate.9 Qualified Health Plans (QHP) are subject to the ACA's parity requirements and the coverage mandate as are Medicaid nonmanaged care benchmark and benchmark equivalent plans 10 Individual plans are subject to the ACA's parity requirements but the coverage mandate will only apply to new plans offered through the individual market.11

**The ACA and its Impacts on the Expansion of Medi-Cal**

When signed into law in 2010, the ACA required states to expand their Medicaid programs. However, in July of last year, the Supreme Court ruled that states could not be forced to expand their programs and could choose not to implement that provision of the ACA.12 Thus far, 26 states, including California, have chosen to expand their Medicaid programs. Thirteen states have opted not to expand Medicaid coverage and 11 states are still deciding how to proceed.

California is expanding Medicaid (called "Medi-Cal" in California) coverage to hundreds of thousands of its residents who have household incomes up to 133 percent of the Federal Poverty level when the ACA takes effect in 2014. Adults without children will be eligible based solely on income. Income thresholds will be increased for families who have children between the ages of 6 and 19. By 2019 between 1.2 and 1.6 more Californians will be enrolled in Medi-Cal. This means Medi-Cal enrollment numbers will rise in every county throughout the state.

According to the UCLA Center for Health Policy Research, Los Angeles, and the remaining Southern California counties, are predicted to get 30 percent of those new enrollees. The San Joaquin Valley is expected to receive 14 percent of the new enrollees. The Greater Bay Area will see 11.4 percent of the new enrollees.

Of course, this anticipated increase in the number of Medi-Cal enrollees will mean increased costs for the state. According to a *Los Angeles Times* article dated December 25, 2012, state officials estimate the cost for the implementation of an expanded Medi-Cal program could be as much as $2.7 billion annually. For more information about the roles the state and counties are expected to play as Medi-Cal is expanded as well as the estimated cost of the expansion, read the 2013-2014 budget report from the Legislative Analyst's Office at http://www.lao.ca.gov/analysis/2013/health/ACA/medi-cal-expansion-021913.pdf

**Integration of Primary Health and Behavioral Health Care**

In addition to increased access to care, another major aim of the ACA is to improve the overall quality of care Americans receive. Since research suggests integrated, coordinated care is beneficial to patients, there is a large emphasis on the need for, and support of, primary and behavioral health care integration under the ACA. For example, a provision in the Act authorizes $50 million in grants for integrated services through the co-location of primary and specialty care in community based mental and behavioral health settings.13 Other initiatives include the creation of consortia of health providers who deliver comprehensive and integrated care services for low-income populations and the establishment of health homes14 and health home teams under Medicaid.15 For more information about the grants available as a result of the ACA, visit hhs.gov/grants. It is unknown at this time what, if any, opportunities there may be for the inclusion of Licensed Marriage and Family Therapists ("LMFTs") as behavioral health providers in these integrated settings.

**Health Plans Cannot Deny Coverage or Exclude Benefits Because of Pre-existing Conditions**

As a result of the ACA, insurance companies, beginning January 1, 2014, must offer the same rates to Americans with pre-existing conditions such as a mental health condition, and cannot deny coverage or exclude benefits to them based upon the existence of pre-existing conditions. This is likely to be a significant reform to the current system given that Americans with mental health conditions are frequently denied coverage because of a mental illness and are forced to pay more expensive premiums in order to secure health coverage.

**Preventative Care is Free under the ACA**

The Act requires all insurers to cover preventative care services at no cost, meaning those with insurance will not have to pay deductibles, co-pays or coinsurance for services that are

considered preventative.16 The following are examples of some services that are preventative, and therefore free, under the Act. For adults preventative services include:

- Alcohol misuse screening and counseling
- Depression screening
- Obesity screening and counseling
- Sexually transmitted infection prevention counseling for adults at higher risk
- Tobacco use cessation interventions

For women, including pregnant women, preventative services include:

- Domestic and interpersonal violence screening and counseling
- HIV screening and counseling, and sexually transmitted infections counseling
- Expanded counseling for pregnant tobacco users

For children preventative services include:

- Alcohol and drug use assessments
- Behavioral assessments
- Depression screening
- Obesity screening and counseling
- Sexually transmitted infection prevention counseling and screening for adolescents at higher risk

A current and complete list of preventative services can found at ww.uspreventiveservicestaskforce.org.

**The Act Prohibits Discrimination Against Mental Health Providers**

Under Section 2706 (a) of the Act, it is unlawful for a group health plan and a health insurance issuer offering group or individual health insurance coverage to discriminate, with respect to participation, against any health care provider who is acting within the scope of that provider's license or certification under applicable State law.17 Although this provision does not require plans to contract with any provider who wants to be on their panel, (i.e. the plans determine how many providers of which types they want) it may prevent health plans from instituting blanket policies that refuse to cover services performed by certain types of mental health professionals. This means while a plan may have a policy that they only contract with providers who have a certain number of years of experience, a plan cannot have a policy that they will only contract with Licensed Clinical Social Workers and will not contract with Licensed Marriage and Family Therapists.

**How the ACA Benefits Members of the Mental Health Workforce**

In an effort to support and grow the health care workforce, including primary care physicians, nurses, physicians assistance, mental health providers, and dentists, Title V of the Act includes more than 40 provisions to fund a multitude of workforce initiatives including education and training grants and loan repayment programs. For example, Section 5306 authorizes the awarding of mental health and behavioral health education and training grants to eligible schools

to support recruitment of future mental health professionals.18 For a complete list of funding opportunities under Title V of the ACA and how to apply for them, go to hhs.gov/grants.

## Concerns about the Implementation of the ACA

### The Availability of Qualified Health Care Providers

A real and significant concern related to the implementation of the ACA is whether there will be enough mental health providers to meet the needs of Americans who seek out services. It is impossible for anyone to forecast exactly how many Americans will attempt to obtain mental health services. However, since 47 million non-elderly Americans were uninsured in 201219 it is reasonable to speculate that due to Americans' increased access to insurance, mental health providers will be in high demand in the coming years.

Title V of the ACA establishes a National Health Care Workforce Commission that is intended to act as a national resource that will develop and commission evaluations of education and training activities to determine whether the demand for health care workers is being met. The commission is responsible for carrying out the following tasks:

- Reviewing current and projected health care workforce supply and demand
- Making recommendations to Congress and the Administration concerning national health care workforce priorities, goals, and policies
- Submitting a yearly report to Congress and the Administration containing the results of such reviews and recommendations
- Submitting a yearly report to Congress and the Administration on, at a minimum, one high priority area.

The Commission's high priority areas include topics such as integrated health care workforce planning; an analysis of the nature, scopes of practice, and demand for health care workers in the enhanced information technology and management workplace; and the education and training capacity, projected demands.

The ACA does not require Medicare to reimburse for services provided by Licensed Marriage and Family Therapists.

Although the original version of the ACA that passed in the House included a provision that would have recognized LMFTS as qualified providers of services under Medicare, the final version of the Act lacked that important health care reform.

Currently, there is a bill, S. 562, that would give LMFTs Medicare provider status. It was reintroduced by Senator Ron Wyden (D-OR) and co-sponsored by Sen. John Barrasso (RWY) for the 113th Congress. Senator Barbara Boxer (D-CA) has co-sponsored this bill as well, and while Senator Diane Feinstein has not yet agreed to sign on, CAMFT has put forward a grassroots effort to encourage members to write Senator Feinstein to become a co-signer. To date, Senator Feinstein has been contacted by 400 plus CAMFT members. This bill recently also received another Republican co-sponsor (Sen. Susan Collins), which gives the bill two Republican co-sponsors for this legislation. Part of the delay in admitting LMFTs into Medicare, is the perceived cost it would have. Accordingly, in June 2013, the CAMFT Board of Directors voted to co-commission with AAMFT a research project which will develop a model of the costs

and savings that could accrue to Medicare if private-practice LMFTs were to be recognized providers eligible for direct reimbursement from Medicare. This model would allow CAMFT and AAMFT to incorporate annual changes in Medicare rates and numbers of beneficiaries, which could be used while discussing Medicare legislation on Capitol Hill.

The research firm submitted an interim report in September 2013 and will submit a final report by March 2014.

**How Mental Health Providers Can Prepare for the ACA's Health Care Reforms**
Many of the most important provisions of the ACA will go into effect as of January 1, 2014. Mental health providers can prepare themselves for these changes by doing the following:

- Applying to become providers with health insurance plans
- Understanding the basics about how parity applies to mental health services
- Understanding the basics about essential health benefits and California's benchmark plan

**Conclusion**
It is evident because of the many topics discussed in this article that there are numerous pieces to the puzzle that make up the ACA. Therefore, until all of the pieces are put into place and the stakeholders have had an opportunity to study its impacts it is impossible to determine exactly what the ACA will mean for mental health and mental health providers. You can, however, be assured that CAMFT's staff will continue to learn about the ACA and share that information with our members. Look for upcoming articles in *The Therapist* on the ACA and its impacts.

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*Sara Kashing, JD, is a staff attorney for CAMFT. Sara is available to answer member calls regarding legal, ethical, and licensure issues.*

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**Endnotes**
1 ACA became law on March 23, 2010.
2 ACA §1401, adding §36B(c)(2)(c)(i)(II) and (c)(2)(C)(ii)
3 ACA §1302(b). 42 U.S.C. §18022
4 45 CFR 147,155, and 156
5 Grandfathered health plans under the Patient Protection and Affordable Care Act are those existing without major changes to their provisions since March 23, 2010, the date of the ACA's enactment.
6 Although certain employers may be required to provide notice to their employees about the existence of the health care exchanges as of October 1, 2013, the ACA's employer shared responsibility provisions which will impact employers with 50 or more employees do not take effect until 2015. At that time, employers with 50 or more full-time/full-time equivalent employees who do not offer affordable health insurance that provides minimum value to their full-time employees (and dependents) may be required to pay an assessment if at least one of their full-time employees is certified to receive a premium tax credit in an individual health insurance Marketplace. It is important to note that the plans of these employers do not have to cover all ten essential health benefits. The ACA does, however, requires large-employer-insured

plans and all self-insured plans, whether offered by large or small employers, to meet similar standards for benefit generosity and plan affordability. For more information on which employers must provide notice to their employees about the health care exchanges, visit the United States Department of Labor's website at http://www.dol.gov/ebsa/newsroom/tr13-02.html
7 MHPA, P.L. 104-204
8 MHPAEA, P.L. 110-343
9 ACA §1201, adding new PHSA §2707(a)
10 ACA §1311(j), ACA §1301(a)(I)B)
11 ACA §1563(c)(4)
12 National Federation of Independent Business et. al. v. Sebelius. Secretary of Health & Human Services, et. al. 648 F.3d 1235 13 ACA §3502
14 A health home is a Medicaid State Plan Option that provides a comprehensive system of care coordination for Medicaid individuals with chronic conditions. Health home providers will integrate and coordinate all primary, acute, behavioral health and long term services and supports to treat the "whole-person" across the lifespan.
15 ACA §§10333 and 2703
16 ACA §2713, 42 U.S.C. 300 gg 13
17 ACA §2706(a), 42 U.S.C. 300 gg 51
18 ACA §5306, adding §756 of the PHSA, 42 U.S.C. 294e1
19 Information from the Henry J. Kaiser Family Foundation's website at http://kff.org/uninsured/fact-sheet/key-facts-aboutthe-uninsured-population/