

# The Role of Government and Lobbying in the Creation of a Health Profession: The Legal Foundations of Counseling

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The state and federal governments, along with private industry, play an important role in the development of a health profession. State governments establish training standards through licensure laws, and state programs dictate employment and payment opportunities. The federal government unifies a profession through recognition in national health care programs. Private industry provides public access through private health insurance. The counseling profession has spent decades opening these federal, state, and private programs to become an established health profession.

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The development of a health profession is an organic process that evolves over time. Individuals with common interests and orientations join together to implement shared goals, becoming more organized and legitimate. To fully come into existence, however, health professions must be built on sound legal and political foundations.

State and federal governments play an important role in setting the education and training requirements, scope of practice, and payment opportunities for health professions. Countless state and federal laws dictate which professions are eligible for participation and under what circumstances. Managed care organizations, health insurers, and other private payers follow these laws, and their own business interests, to extend access to health professions in the private market.

## Licensure

State governments regulate professions to protect the public from harm. The most comprehensive form of government regulation is state licensure. Health professions require licensure to thrive in the health care delivery system, and all major mental health professions—including counseling, psychiatry, psychology, social work, and marriage and family therapy—are licensed in all 50 states.

It took the counseling profession 33 years to obtain licensure in all 50 states. In 1976, Virginia became the first state to license counselors, and California became the last in 2009. By 1998, 44 states had licensed the profession, but it took more than a decade for the final six states to do so (American Counseling Association [ACA], 2010). This time frame is very similar to that of the other mental health professions and reflects the difficulty of passing legislation in every state.

To obtain licensure, a profession must meet the criteria established by the state. Many states have established similar standards for regulation captured in “sunrise laws.” The Council on Licensure, Enforcement and Regulation (CLEAR) has

described *sunrise* as the process by which a profession seeking licensure proposes the elements of legislation—along with its cost and benefits—and seeks to convince the legislature that the legislation is necessary to avoid harm to the public. CLEAR (2011) indicated that 14 states have adopted sunrise legislation. The Florida “Sunrise Act,” which is representative of such laws, states that the following factors will be considered by their legislature in determining whether regulation of a profession is necessary:

- (a) Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
- (b) Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
- (c) Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
- (d) Whether the public is or can be effectively protected by other means; and
- (e) Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable. (Fl. Statutes, Ch. 11 § 62, 2006)

Meeting the sunrise standards is usually the first step in state regulation and legal recognition. Professional organizations must demonstrate legitimacy by effectively responding to the listed questions and validating their need to be licensed. Once approved, the professions still must shepherd legislation

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through the state legislature, which is often a complicated and costly exercise. It is also a process that requires a great deal of compromise and negotiation. Experienced government relations experts recognize that every modification to the law has the potential to affect the individual professional's ability to be employed, reimbursed, or licensed in another state (commonly referred to as portability).

Although every component of a state licensure law is important, certain sections play a more direct role in a profession's viability and success. Key among these sections is scope of practice. The Federation of State Medical Boards (2005) stated the following:

“Scope of Practice” is defined as the activities that an individual health care practitioner is permitted to perform within a specific profession. Those activities should be based on appropriate education, training, and experience. Scope of practice is established by the practice act of the specific practitioner's board, and the rules adopted pursuant to that act. (Section II, para. 3)

Stated simply, the scope of practice determines what a licensed health care professional is authorized to do under the state licensure law. The scope of practice is often the most hotly contested section of a licensure bill. Medical societies routinely challenge nonphysicians' authority to diagnose disease (American Medical Association, 2006), and psychologists are often protective of psychological testing rights (Naugle, 2009). Other mental health professions will question any encroachment on their ability to advertise or practice in certain areas, and it is common for licensed mental health professions within a state to place restrictive burdens on professions seeking new licensure laws.

Hartley, Ziller, Lambert, Loux, and Bird (2002) identified several terms that were core to inclusion in a mental health profession's scope of practice: *diagnosis, psychotherapy, assessment, treatment, and counseling*. Counseling and other mental health professional organizations include these core terms in their model licensure bills; however, keeping the language in the legislation as it moves through the legislative process has been a challenge. Presently, 36 states explicitly include the term *diagnosis* in the scope of practice for counselors (ACA, 2010). Although the absence of the term does not preclude counselors from diagnosing, the omission has been used by other professions and individuals as grounds for questioning their practice authority or limiting reimbursement. For example, the Louisiana Counseling Association was forced to pursue legislation to clarify counselors' diagnostic authority because of opposition from the state psychology board and potential limits on Medicaid reimbursement (see Louisiana Legislature, 2010). In Texas, the Board of Examiners of Marriage and Family Therapists is defending a legal challenge by the Texas Medical Association for including diagnosis in regulations when it was not specifically referenced in the state statute (*Texas Medical Association v. Texas State Board of Examiners of Marriage and Family Therapists*, 2008).

Similar battles over scope of practice rights have been waged by every mental health profession throughout the country since states began licensing these professions.

Another key ingredient in any licensure law is the education and training requirement for obtaining the license. Licensure laws are intended to protect the public by establishing minimum standards of preparation and ensuring the professional is qualified to perform the duties defined in the scope of practice. Ideally, the standards will be consistent with national standards and uniform across the states. Variations in the standards are often based on compromises made during the legislative process and individual state preferences and norms. Slight differences from national standards are common, but significant variances can create a host of problems.

While the counseling profession has been saddled with a reputation of having inconsistent licensure laws (U.S. Department of Defense, 2006), a research analysis does not support this hypothesis. The overwhelming majority of states (41) have one or two license tiers, and there are nine different licensure titles across the 50 states. A master's degree is required for the independent practice license in every state. All states require that the degree comes from a counseling program that is accredited by a specialized counseling accrediting body or a regional accrediting agency; most require courses in the core curricular areas established by the Council for Accreditation of Counseling and Related Educational Programs (CACREP) accreditation standards. The experience requirements vary from 1,000 hours to 4,500 hours, but only eight states require fewer than 3,000 hours. Every state requires either the National Counselor Examination for Licensure and Certification (NCE) or the National Clinical Mental Health Counseling Examination (NCMHCE) for licensure (ACA, 2010).

These licensure standards are similar to those of the marriage and family therapy and social work professions. Marriage and family therapy requires a master's degree or higher in marriage and family therapy and between 1,000 and 4,000 experience-hours over 1 to 5 years for independent practice (Association of Marital and Family Therapy Regulatory Boards [AMFTRB], 2009). Social work requires a master's or higher degree in social work and between 1,000 and 5,760 experience-hours over 2 to 4 years. Social work has a patchwork of license categories, including up to six types of licenses in some individual states. Like counseling, social work has two exams that may be required by states for the independent practice license—the Association of Social Work Boards Advanced Generalist Exam or the Clinical Exam (Association of Social Work Boards, 2008).

Title protection is also a key element of a licensure law. States often establish professional titles that are restricted to those who obtain the license. All of the master's-level mental health professions have a variety of licensure titles that represent the independent and supervised practice levels. Marriage and family therapy has the least variation with only five different titles at the highest level of licensure. Counselors and social workers are more varied with nine

and 10 titles, respectively. Differences in titles can create confusion because some states may use one title for independent practice, whereas another may use the same title for supervised practice. For example, in Kansas, the licensed professional counselor and licensed marriage and family therapist are required to be supervised, but in Louisiana, the licensed professional counselor and licensed marriage and family therapist are independent practice licenses (ACA, 2010; AMFTRB, 2009). These differences are common across states and disciplines.

Variations in state licensure training standards can have a significant effect on professionals seeking to move between states. State licensure laws routinely allow licensees from other states to obtain a license if they have substantially similar requirements. Most states recognize out-of-state licenses through the process of endorsement, whereby the state grants a license to an individual with a license from another state who has met equivalent or higher standards. The other form of interstate transferability is reciprocity. Although many states authorize reciprocity, only a few states have formal agreements granting all licensees from a participating state the ability to obtain a license from the other participating state (ACA, 2010). The uniformity of a profession's licensure laws directly affects the portability of the license, which is increasingly important as society becomes more mobile.

Like all professions, the portability of the counselor license suffers from state variations in education and training requirements. Differences in the minimum degree hours, supervised experience hours, and exams can require state boards to evaluate individual applicants instead of accepting all licensees from a given state. Unifying licensure standards would further define the profession and facilitate portability. National standards such as the National Certified Counselor from the National Board for Certified Counselors (NBCC) provide a model for state laws. The credential establishes degree hours with content from the CACREP core curriculum and experience and exam requirements. Revising state licensure laws to more closely reflect national standards will facilitate interstate transferability and further define counselor identity.

### State Government

Licensure laws convey state recognition of a health profession, but they do not guarantee employment or reimbursement. Once established, professions will need to revise other laws to ensure parity and accessibility. These laws can determine whether a profession is eligible for employment with a state agency or private health facility and can even influence third-party insurers. Inclusion in these laws will directly affect the viability of the license.

One of the primary programs that must be addressed through state law is recognition by the Medicaid program. Medicaid is the health care program covering the poor and underserved. It is jointly funded by federal and state governments, but is administered by the states. Medicaid is the largest payer for mental health services in the United States (Substance Abuse and Mental Health Services Administration, 2003), providing

services and support to more than 58 million Americans (Centers for Medicare and Medicaid Services, 2011).

States establish covered Medicaid providers through statute and regulation. Recognition by the program is often a political struggle that may meet resistance from other disciplines or state administrators. The scope of practice or licensure requirements may also play a role in the decision to include the profession. Counselors are recognized as Medicaid providers in many states, but there are states that do not allow for independent reimbursement. For instance, the Medicaid program in Florida currently reimburses mental health counselors, psychologists, and licensed social workers (Home and Community-Based Services Waivers, 2005), but California reimburses only psychologists (California Welfare and Institutions Code, 2011). The exclusion of counselors from the California Medicaid program is attributable to the recent passage of the licensure law and sequential process for developing a profession. Medicaid recognition in all states is vital to the growth of a profession because of the breadth of the program and its effect on other government and private programs.

Although Medicaid is the most influential state program, there are many other policies that affect the viability of the license. For instance, every state provides health benefits to state employees through state-run health plans. In addition to establishing covered services, the state will determine which providers are eligible to receive reimbursement for service delivery. These state plans may establish provider classes through statute, regulation, or policy. In large states, these programs can cover hundreds of thousands of people and help validate approved professions. Counselors are covered providers in many state employees' health plans, but as with Medicaid, work must take place before counselors are included in all state plans.

States also distinguish professions through government job titles. These state job classifications determine who can be hired by the state government and what services they can provide. Most states do not have a separate classification for professional counselors, although they routinely have titles for social workers and psychologists. Consequently, counselors must be hired under existing classifications that may have limitations on independent practice, pay, and promotion. NBCC has long-term goals to create job titles for counselors in every state.

The aforementioned programs and policies are prominent and common across the states, but there are many that are not listed. Furthermore, there are many state programs that may be unique to one state or limited to a group or region of states. These programs can relate to adoption, foster care, education, transportation, and countless other areas. Before a profession can attain its full potential, it must ensure that it is recognized in all programs and policies that provide services covered under its scope of practice.

### Federal Government

The federal government has fewer programs and policies addressing health professions than the states, but it can have a

much greater impact due to its scale. Federal health programs cover tens of millions of Americans and directly and indirectly influence state and private policies. Provider classes are often established in statute, which means adding a new profession must be accomplished by passing legislation through Congress. Every effort to pass federal legislation requires a significant investment of time, money, and resources. Most initiatives take years, if not decades, to succeed, as demonstrated by the effort to provide Medicare reimbursement of counselors described as follows.

The flagship federal health care program is Medicare. Medicare is the largest health care program in the country, covering more than 41 million Americans (DeNavas-Walt, Proctor, & Smith, 2008). Medicare recognition of a profession is also seen as a seal of good quality that is followed by insurers and managed care organizations. Furthermore, Medicare is often a significant revenue source for many public health clinics and agencies, so reimbursement may be required for employment. No health profession can achieve its full potential without Medicare recognition.

Counselors are not currently authorized Medicare providers, although the profession has spent more than a decade actively pursuing this recognition. The first bill (S. 1760, 2001) to extend Medicare reimbursement to professional counselors and marriage and family therapists (MFTs) was introduced in 2001 by Senators Craig Thomas (Republican-Wyoming) and Blanche Lincoln (Democrat-Arkansas). Three other bills were introduced in the 107th Congress to accomplish the same goal. Since that time, there have been more than 30 bills seeking to allow counselors and MFTs to serve as Medicare providers, eight in the 111th Congress alone. The legislation has passed the Senate twice and House twice, but never concurrently. NBCC, ACA, the American Mental Health Counselors Association, American Association for Marriage and Family Therapy, and California Association of Marriage and Family Therapists, which collectively represent more than 150,000 counselors and MFTs throughout the country, have been lobbying this issue for more than a decade. Some of the most influential lobbying firms in Washington, DC, have also been retained to support this initiative. Despite these efforts, Medicare recognition continues to elude counselors, demonstrating the challenge of passing federal legislation.

Although Medicare is the zenith of health care recognition, there are many other federal programs that can help define a profession. The U.S. Department of Veterans Affairs (VA) is a large and influential health care system that provides benefits to more than 5 million military veterans. In 2009, more than 1.2 million veterans had a mental health diagnosis, which was a 40% increase over 2004 (Budget Request for FY2012, 2011). As the media brought attention to the rising psychological effects of the wars in Afghanistan and Iraq, Congress also began to take notice. This context created the opportunity for the professional organizations to pass legislation adding counselors and MFTs to the list of recognized VA providers.

On December 26, 2006, the president signed into law S. 3421, the Veterans Benefits, Health Care, and Information Technology Act of 2006. Section 201 of the bill added licensed professional mental health counselors and marriage and family therapists to the list of professionals who may serve veterans. Although passage of the law was facilitated by current events, implementation of the law took longer than expected and required continued pressure and lobbying from the professional groups. Finally, on September 30, 2010, the VA released qualification standards establishing the criteria and authority for the hiring of licensed professional mental health counselors. The standards require a degree from a program accredited by CACREP, an unrestricted license to independently practice mental health counseling, and a certain level of experience based on the position (U.S. Department of Veterans Affairs, 2010).

Although requiring a master's or doctoral degree and an independent practice license was consistent with past legislation, specifying a CACREP-accredited degree was a first. This requirement limited the number of eligible counselors beyond those with a license. The VA applies the same accreditation standard to all mental health professions seeking employment with the VA, but it was the first time that the counseling profession was subject to more stringent federal criteria. In taking this step, the federal government demonstrated how it can play a role in setting the education standards for a health profession.

At the same time that the VA was developing its qualification standards, the Institute of Medicine (IOM) was researching the counseling profession for the U.S. Department of Defense. The IOM was directed to study counselors by Congress through language included in the National Defense Authorization Act for Fiscal Year 2008. The purpose of the study was

- (1) conducting an independent study of the credentials, preparation and training of individuals practicing as licensed mental health counselors; and
- (2) making recommendations for permitting licensed mental health counselors to practice independently under the TRICARE program. (Ike Skelton National Defense Authorization Act for Fiscal Year 2011)

TRICARE is the civilian care component of the Military Health System that provides civilian health benefits to military personnel, military retirees, and their families. TRICARE covers more than 9 million beneficiaries and is a combination of health care from uniformed services and private providers (TRICARE Management Activity, 2011). TRICARE's size and political significance ensures that it plays an active role in setting health care policy.

On February 12, 2010, the IOM's Committee on the Qualifications of Professionals Providing Mental Health Counseling Services released its report titled "Provision of Mental Health Counseling Services under TRICARE." The report recommended removal of the physician referral and supervision requirements for counselors in TRICARE, restrictions that are not placed on other mental health professionals in the system (IOM, 2010).

The IOM (2010) did not find problems specific to mental health counselors, noting “the committee did not identify any evidence that distinguishes mental health counselors from other classes of practitioners in ability to serve in an independent professional capacity or to provide high-quality care consistent with education, licensure, and clinical experience” (p. 9). However, the IOM found in its 2006 report that “the education of all health professionals was lacking” (as cited in IOM, 2010, p. 8) and concluded that “there are widespread deficiencies in the training of providers and in the infrastructure that supports their practice” (IOM, 2010, p. 9). To address the determination that all professions have insufficient training, the IOM established high standards for counselor independent practice:

- A master’s or higher-level degree in counseling from a program in mental health counseling or clinical mental health counseling that is accredited by CACREP.
- A state license in mental health counseling at the “clinical” or the higher or highest level available in states that have tiered licensing schemes.
- Passage of the NCMHCE.
- A well-defined scope of practice for practitioners. (IOM, 2010, p. 10)

Although the IOM report was issued several months prior to release of the final VA qualification standards, it went well beyond the VA in narrowing the pool of recognized counselors. Not only did the report recommend a CACREP-accredited degree, but the degree had to be in mental health counseling or clinical mental health counseling. The report also required passage of the NCMHCE. If adopted into law, these two requirements will dramatically reduce the number of counselors beyond those who are licensed to practice independently. In April 2011, there were 603 programs accredited by CACREP, 74 (12%) of which were mental health or clinical mental health counseling programs. There are another 167 (27%) community counseling programs that will likely transition to clinical mental health counseling in accordance with the new 2009 CACREP Accreditation Standards (CACREP, 2009). In 2010, only one third of counselors who passed the exam for licensure took the NCMHCE, versus two thirds who took the NCE. The number of counselors who meet both criteria is significantly less.

The IOM report was only advisory to Congress and the U.S. Defense Department and has no enforcement authority. However, the IOM is a well-respected research organization, and its analysis and conclusions will likely influence government policy. The IOM has set a national standard for counselors that far exceeds what is required in most states for licensure. The criteria were included in legislation in the 111th Congress but were not part of the final language in the Ike Skelton National Defense Authorization Act for Fiscal Year 2011. The approved language directs the secretary of defense to implement regulations authorizing licensed mental health counselors to practice independently by June 20, 2011.

The U.S. Department of Defense is in the process of crafting these regulations. Whether the regulations will follow the IOM criteria is unknown, but these criteria will certainly be considered during the development process. The IOM findings and conclusions will also likely find their way into future state and federal policy discussions, demonstrating how even federal reports can influence policy and affect standards.

Although federal recognition by major health care programs is critical to the growth of a health profession, federal employment is also important. According to the U.S. Office of Personnel Management (OPM, 2007), the federal government employs approximately 2 million civilians in a range of positions. The positions that are advertised and filled are based on an occupational system run by OPM. OPM standards are the following:

- Define the various classes of positions in terms of duties, responsibilities, and qualification requirements.
- Establish official class titles.
- Set forth the grades in which the classes of positions have been placed. (OPM, 2009, p. 2)

OPM creates job series for individual professions based on the needs of its agencies. If there is no specific series for a health profession, then individuals seeking federal employment must be hired under existing series. Usually the series have limitations on practice areas, salary, and promotion. Counseling does not presently have a separate occupational series, although social work and psychology do. Creation of a job series for counselors is important for federal employment and professional identity. At the suggestion of NBCC, the VA has requested the creation of a series for counselors based on the new qualification standards, and the OPM is considering this request.

## Private Industry

The final major player in the development of a profession is the private industry. Insurers, managed care organizations, third-party administrators, and individual businesses define the private health care market. These organizations establish, manage, and purchase health services, and in that role determine which providers are eligible for reimbursement. Other payers and administrators play a role in health care delivery outside health insurance—such as workers’ compensation, liability insurance, or employee assistance plans—but the limited market plays only a tertiary role in the growth of a profession.

The majority of Americans receive their health insurance through the private market. Although more than 85% of Americans have health insurance, two thirds of those are covered by private insurance (BlueCross BlueShield Association [BCBSA], 2010). Private insurance pays for 36% of total personal health expenditures in the United States and provides some form coverage to more than 200 million individuals (DeNavas-Walt et al., 2008).

Inclusion in private payer networks is critical to the success and viability of a health profession because it extends access to the public. Each health plan makes individual determinations as

to what classes of providers are eligible to participate. According to Jenkins (2008), there are more than 5,000 health plans in the United States, so advocating for inclusion in excluded plans can be a complicated process. However, the largest health plans in the country cover the majority of Americans, so outreach can be focused on those plans. For instance, more than 100 million individuals are covered by the BCBSA plans. BCBSA is a federation of 39 individual health insurance organizations and companies (BCBSA, 2011). BCBSA organizations often administer the largest health plan in any given state. Although there is no research providing accurate statistics, experience and reports from the field suggest that the majority of health plans cover services provided by licensed counselors.

The determination to include a profession in a health plan network is a purely internal business decision. Large plans have been persuaded to add professions to their networks at the urging of professional organizations and individual practitioners, but plans have also denied these requests. Exclusion can drive large numbers of health care consumers to other covered professionals. There is no method for requiring a private plan to add a provider group without a government mandate.

State legislatures have stepped into the private market and crafted laws that mandate coverage of certain professionals. These laws regulate state insurance plans but do not have jurisdiction over employer-sponsored plans, which comprise 60% of the insured market (BCBSA, 2010). The laws are usually mandates to cover listed professionals who provide services covered by the plan or to add to their networks any licensed health care professional who accepts the terms and conditions for participation in the plan. According to ACA (2010), 21 states have such laws including professional counselors (p. 100). The laws provide the counseling profession, and all health professions, the opportunity to influence private payer network decisions. And although the laws do not directly affect the employer-sponsored plans, many of the insurers and managed care organizations administer both state and employer plans and often use the same providers in their networks. Consequently, these laws can have an indirect effect on the entire private market.

Private payers can also dictate professional standards through their panel terms and coverage decisions. Insurance plans make distinctions between different levels of licensure and place service restrictions on areas of practice. These payers have also refused to include professions in their networks because they do not deem their training or scope of practice adequate. These decisions can drive professions to modify their licensure law to meet the expectations of large payers. Through this process, insurers, managed care organizations, and businesses can influence professional standards in addition to professional viability.

## Conclusion and Recommendations

Health care professions may start as loose-knit affiliations, but they grow and prosper through legal and political advancements. State governments define a profession by establishing education and training requirements and practice authority

through licensure laws. The federal government provides credibility through recognition in sweeping health care programs. The private industry, representing the largest share of health care beneficiaries, dictates access and viability through inclusion in health plan networks. Collectively, these forces influence the qualifications, payment, and employment of a health profession and its attractiveness to practitioners and consumers.

The counseling profession has spent 3 decades obtaining licensure in all 50 states and seeking recognition through state and federal laws. These efforts have created common minimum professional standards that continue to evolve and become more uniform. National and state counseling organizations in collaboration with individual counselors have pushed policy makers to include counselors in state health care programs and policies. Coalitions of organizations have joined forces to persuade Congress to add counselors to major federal programs. These efforts, coupled with targeted outreach and education, have resulted in counselors' participation in most private payer networks. Many major initiatives remain, but counseling has established itself as a thriving profession that is recognized in law and positioned to continue growing.

The future of the counseling profession can be enhanced by a strategic approach to influencing state and federal policy. Parity with other professions and recognition in all major programs and plans requires commitment and coordination. Counseling organizations must work together to promote a unified vision and platform for success. The following recommendations can influence the future of the profession and the pace for achieving equality:

1. Counseling organizations should join forces to provide a uniform voice and strategy for public and private acceptance. The organizations should coordinate messaging, lobbying, and counselor advocacy to maximize resources and ensure clarity. A program should be developed to ensure that state and local organizations and individual counselors are active participants in the process and convey local interests to state and federal policy makers.

2. Counseling organizations should agree to a model licensure law that will create a uniform standard for the independent practice of counselors in every state. The law should establish degree, hours, experience, and exam requirements that cannot be questioned, such as a CACREP-accredited degree, 60-degree-semester-hours, 3,000 hours of supervised clinical experience, and the NCE or NCMHCE. The law should ensure that the independent practice license is clinical and provides a comprehensive scope of practice. One title should be established for the independent practice license that clearly describes the profession. A "grandparenting" provision must be included to allow currently licensed counselors and those in the training pipeline to be licensed at the independent practice level. The law should also include a portability provision that allows all practitioners who meet the minimum standards to easily obtain a license in another state.

3. Counseling organizations should establish a plan for adopting the model licensure law in every state. The plan should

provide a time line with benchmarks. The plan should be flexible to account for the vagaries of individual state legislatures.

4. National and state counseling organizations should collaborate to ensure counselors are recognized in all federal and state programs and private health plans. The organizations should develop a strategy for identifying and addressing federal and state laws, including Medicare, Medicaid, state employees' health plans, and providing a state job classification.

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